Course Objectives: In addition to the course objectives listed, this course addresses the following content areas related to aging and long term care:

✓ Counseling theory and practice
✓ Social and Cultural Foundations
✓ Assessment
✓ Professional practice issues
✓ Wellness and prevention
✓ Human growth and development

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1. Aging Definitions and Demographic Information

Aging is defined as “the accumulation of changes in an organism over time.” Aging is also a multidimensional process of physical, psychological, and social change (Source: Masoro E.J. & Austad S.N. eds: Handbook of the Biology of Aging, Sixth Edition. Academic Press. San Diego, CA, USA). Some dimensions of aging grow and expand over time, while others decline. For example, although reaction time may decrease with age, knowledge of world events and wisdom may increase. Research shows that even late in life potential exists for physical, mental, and social growth and development (Strawbridge, W.J., Wallhagen, M.I. & Cohen, R., Successful aging and well-being: Self-rated compared with Rowe and Kahn, The Gerontologist).

Aging is an important part of all human societies which not only reflects the biological changes that occur, but also the cultural and societal conventions (Masoro E.J. & Austad S.N.. eds: Handbook of the Biology of Aging, Sixth Edition. Academic Press. San Diego, CA, USA).

(Please note that as of this publication from 2017-2018, The CDC 2010-2011 data is the most comprehensive empirically validated data published.). In 2011, the oldest members of the “Baby Boom” generation (that is, Americans born between 1946 and 1964) turned 65. As has been the case since the birth of this cohort, this very large generation will bring important challenges to the systems and institutions that support and enhance American life. Although many Federal agencies provide data on aspects of older Americans’ lives, it can be difficult to fit the pieces together. Thus, it has become increasingly important for policymakers and the general public to have an accessible, easy-to-understand portrait of how older Americans fare.

*Older Americans 2012: Key Indicators of Well-Being* is one in a series of periodic reports to the nation on the condition of older adults in the United States. In this report, 37 indicators depict the well-being of older Americans in the areas of demographic characteristics, economic circumstances, health status, health risks and behaviors, and cost and use of health care services.

**Population**

The demographics of aging continue to change dramatically. The older population is growing rapidly, and the aging of the “Baby Boomers” born between 1946 and 1964, are accelerating this growth. This large population of older Americans will be more racially diverse and better
In 2010, there were 40 million people age 65 and over in the United States, accounting for 13 percent of the total population. The older population in 2030 is projected to be twice as large as in 2000, growing from 35 million to 72 million and representing nearly 20 percent of the total U.S. population.
(See “Indicator 1: Number of Older Americans”).

INDICATOR 1  Number of Older Americans

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

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

![Graph showing population growth](image)

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

Reference population: These data refer to the resident population.

INDICATOR 2  Racial and Ethnic Composition

As the older population grows larger, it will also grow more diverse, reflecting the demographic changes in the U.S. population as a whole over the last several decades. By 2050, programs and services for older people will require greater flexibility to meet the needs of a more diverse population.

Population age 65 and over, by race and Hispanic origin, 2010 and projected 2050

<table>
<thead>
<tr>
<th>Race and Hispanic Origin</th>
<th>2010</th>
<th>2050 (projected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic White alone</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Black alone</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Asian alone</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>All other races alone</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>or in combination</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Hispanic (of any race)</td>
<td>7</td>
<td>20</td>
</tr>
</tbody>
</table>

NOTE: These projections are based on Census 2000 and are not consistent with the 2010 Census results. Projections based on the 2010 Census will be released in late 2012. The term "non-Hispanic White alone" is used to refer to people who reported being White and no other race and who are not Hispanic. The term "Black alone" is used to refer to people who reported being Black or African American and no other race, and the term "Asian alone" is used to refer to people who reported only Asian as their race. The use of single-race populations in this chart does not imply that this is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches. The race group "All other races alone or in combination" includes American Indian and Alaska Native alone; Native Hawaiian and Other Pacific Islander alone; and all people who reported two or more races.

Reference population: These data refer to the resident population.
In 1965, 24 percent of the older population had graduated from high school, and only 5 percent had at least a Bachelor’s degree. By 2010, 80 percent were high school graduates or more, and 23 percent had a Bachelor’s degree or more (See “Indicator 4: Educational Attainment”).

**Economics**

There have been decreases in the proportion of older people living in poverty or in the low-income group just above the poverty line, both in recent years and over the longer term. Among older Americans, the share of income coming from earnings has increased since the mid-1980s, partly because more people, especially women, continue to work past age 55. In addition, net worth increased almost 80 percent, on average, for older Americans between 1988 and 2007.

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

Between 1974 and 2010, there was a decrease in the proportion of older people with income below poverty from 15 percent to 9 percent and with low income from 35 percent to 26 percent; and an increase in the proportion of people with high income from 18 percent to 31 percent (See “Indicator 8: Income”).

In 2007, the median net worth of households headed by white people age 65 and over ($248,300) was almost three times that of older black households ($87,800). This difference is less than in 1998 when the median net worth of households headed by older white people was about six times higher than that of households headed by older black people. The large increase in net worth in past years may not continue into the future due to recent declines in housing values (See “Indicator 10: Net Worth”).
**INDICATOR 10  Net Worth**

Net worth (the value of real estate, stocks, bonds, retirement investment accounts and other assets minus debts) is an important indicator of economic security and well-being. Greater net worth allows a family to maintain its standard of living when income falls because of job loss, health problems, or family changes such as divorce.

Median household net worth in 2007 dollars, by race of head of household age 65 and over, selected years 1983–2007

NOTE: The Survey of Consumer Finances has replaced the Panel Study of Income Dynamics as the data source for this indicator. Median net worth is measured in constant 2007 dollars. Net worth includes housing wealth, financial assets, and investment retirement accounts such as IRAs, Keoghs, and 401(k) type plans. Data are weighted. The term "household" here is similar to the Census Bureau's household definition. See Indicator 10 data source for more detail.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Survey of Consumer Finances.

Median household net worth in 2007 dollars, by educational attainment of head of household, age 65 and over, selected years 1983–2007

NOTE: The Survey of Consumer Finances has replaced the Panel Study of Income Dynamics as the data source for this indicator. Median net worth is measured in constant 2007 dollars. Net worth includes housing wealth, financial assets, and investment retirement accounts such as IRAs, Keoghs, and 401(k) type plans. Data are weighted. The term "household" here is similar to the Census Bureau's household definition. See Indicator 10 data source for more detail.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Survey of Consumer Finances.
Over the past four decades, labor force participation rates have risen for women age 55 and over. This trend continued during the recent recession. Among men age 55 and over, the rise in participation rates that started in the mid-1990s also has continued, although to a smaller extent. As “Baby Boomers” approach older ages, they are remaining in the labor force at higher rates than previous generations (See “Indicator 11: Participation
In 2009, approximately 40 percent of older American households had housing cost burden (expenditures on housing and utilities that exceed 30 percent of household income). In addition to having cost burden as the most dominant housing problem, crowded housing was also fairly prevalent for some older American households with children in their homes.

**Health Status**

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

Life expectancy at age 65 in the United States was lower than that of many other industrialized nations. In 2009, women age 65 in Japan could expect to live on average 3.7 years longer than women in the United States. Among
Death rates for heart disease and stroke declined by slightly more than 50 percent since 1981. Death rates for chronic lower respiratory disease increased by 57 percent in the same time period (See “Indicator 15: Life Expectancy”).
The prevalence of certain chronic conditions differed by sex. Women reported higher levels of arthritis than men (56 percent versus 45 percent).
percent). Men reported higher levels of heart disease (37 percent versus 26 percent) (See “Indicator 16: Chronic Health Conditions”).

**INDICATOR 16  Chronic Health Conditions**

Chronic diseases are long-term illnesses that are rarely cured. Chronic diseases such as heart disease, stroke, cancer, and diabetes are among the most common and costly health conditions. Chronic health conditions negatively affect quality of life, contributing to declines in functioning and the inability to remain in the community. Many chronic conditions can be prevented or modified with behavioral interventions. Six of the seven leading causes of death among older Americans are chronic diseases (see “Indicator 15: Mortality”).

During the period 2008–2010, 76 percent of people age 65 and over rated their health as good, very good, or excellent. Non-Hispanic Whites were more likely to report good health than their non-Hispanic Black or Hispanic
Health Risks and Behaviors

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

In 2010, about 11 percent of people age 65 and over reported participating in leisure-time aerobic and muscle-strengthening activities that met the 2008 Federal physical activity guidelines (See “Indicator 24: Physical
As with other age groups, the percentage of people age 65 and over who are obese has increased since 1988–1994. In 2009–2010, 38 percent of people age 65 and over were obese, compared with 22 percent in 1988–1994. Over the past several years however, that trend has leveled off for older women, with no statistically significant change in obesity between 1999–2000 and 2009–2010. During this same time period, the obesity prevalence
increased for older men (See “Indicator 25: Obesity”).

The percentage of people age 65 and over living in counties that experienced poor air quality for any air pollutant decreased from 64 percent in 2000 to 36
percent in 2010 (See “Indicator 27: Air Quality”).

The proportion of leisure time that older Americans spent socializing and communicating—such as visiting friends or attending or hosting social events—declined with age. For Americans age 55–64, about 11 percent of leisure time was spent socializing and communicating compared with 8
Health Care
In the 1990’s and early 2000’s, health care costs rose rapidly for older Americans. However, average health care costs did not increase further between 2006 and 2008, after adjustment for inflation. Older Americans in the poor/near poor income category continued to spend a high proportion of their household income on health care services through 2009. In recent years increasing numbers of Medicare beneficiaries enrolled in HMOs and other health plans under the Medicare Advantage (MA) program. After adjustment for inflation, health care costs increased significantly among older Americans from $9,850 in 1992 to $15,709 in 2008. There was no significant change between 2006 and 2008 (See “Indicator 30:...
From 1977 to 2009, the percentage of household income that people age 65 and over allocated to out-of-pocket spending for health care services increased among those in the poor/near poor income category from 12
percent to 22 percent (See “Indicator 33: Out-of-Pocket Health Care Expenditures”).

Enrollment in health maintenance organizations (HMOs) and other health plans under the Medicare Advantage (MA) program has grown rapidly in recent years. In 2005, 16 percent of Medicare beneficiaries age 65 or
over were enrolled in an MA plan, compared with 28 percent in 2009 (See “Indicator 32: Sources of Health Insurance”).

End of Life
In the last decade there has been a substantial rise in the use of hospice services among older Americans. During that time, there has also been a smaller increase in the use of intensive care unit (ICU) and coronary care unit (CCU) services at the end of life. The percent of deaths among older Americans that occurred in hospitals declined over the last 20 years, with an increase in the percent dying at home.

Use of hospice in the last month of life increased from 19 percent of decedents in 1999, to 43 percent in 2009. Use of ICU/CCU services grew from 22 percent of decedents in 1999, to 27 percent in 2009.

Neoplasms accounted for 53 percent of hospice stays in 1999 and only 32 percent in 2009. The next most common primary diagnoses in 2009 were diseases of the circulatory system (19 percent) and symptoms, signs, and ill-defined conditions (17 percent).

Among older Americans, 49 percent of deaths occurred in hospitals in 1989,
declining to 32 percent in 2009. The percent dying at home increased from 15 in 1989, to 24 percent in 2009.

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

Cognitive Impact
Deterioration and/or decline occur in many cognitive processes throughout the lifespan. A great deal of research has focused on memory and aging, and has found decline in many types of memory with aging, but not in semantic memory or general knowledge such as vocabulary definitions, which typically increases or remains steady. Early studies on changes in cognition with age generally found declines in intelligence in the elderly, but studies were cross-sectional rather than longitudinal and thus results may be an artifact of cohort rather than a true example of decline. Intelligence may decline with age, though the rate may vary depending on the type, and may
in fact remain steady throughout most of the lifespan, dropping suddenly only as people near the end of their lives. Individual variations in rate of cognitive decline may therefore be explained in terms of people having different lengths of life (Mather, M., & Carstensen, L. L., 2005. Aging and motivated cognition: The positivity effect in attention and memory. Trends in Cognitive Sciences).

2. Aging, Stigma, and Culture

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

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

For example:

- One study found that, among Latinos and Latinas, acculturation is positively correlated with large and frequent alcohol consumption and high rates of drug abuse.

- A recent secondary analysis of the National Institute of Mental Health Collaborative Psychiatric Epidemiological Studies data set compared the rates of lifetime and 12-month psychiatric disorders among several older adult populations. The analysis found that the rates of depressive disorders are significantly higher among Latinos than the rates are among non-Latinos, attesting to the increased illness burden of common mental disorders among Latinos.
Behavioral health conditions are less prevalent among African Americans ages 55 and older who live in the South, compared with those living in other regions of the country.

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

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

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

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

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

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

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

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

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

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

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

- Using nonjudgmental motivational approaches;
- Empowering and engaging the older adult in decision-making;
- Avoiding stigmatizing terms (e.g., alcoholic, addict);
- Working with older adults in the setting they prefer (e.g., primary care, senior center, home);
- Using an active “warm hand-off” from the primary clinician to the person addressing behavioral health concerns;
- Engaging professionals who have a trusted relationship with the older adult;
- Taking an educational prevention/intervention approach to engaging the older adult;
- Addressing physical barriers (e.g., providing assistance with transportation); and
- Tailoring approaches to cultural views while maintaining fidelity to essential components of evidence-based practices.
Cultural Competence
The culture from which people come affects all aspects of behavioral health and illness, including the types of stresses they confront, whether they seek help, the types of help they seek, the symptoms and concerns they bring to clinical attention, and the types of coping styles and social supports they possess. Culture also affects individuals’ exposures to behavioral health risk factors, health status, and the quantity and quality of health care resources available to them. Cultural considerations include race and ethnicity, country of origin, gender, sexual orientation, age cohort, religious affiliation, and physical and cognitive ability.

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

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

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

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

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

Area Agency on Aging (AAA) Offers behavioral health services with cultural adaptations
http://www.esmv.org/specializedservices.asp#mentalhealthsupport

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

Alcohol and Drug Council
Engages older African Americans
www.council-houston.org/family-friends/seniors-2/
Senior Center
Engages older African Americans with Depression
Information about Beat the Blues Training
is available from Laura Gitlin, PhD, at Johns Hopkins University lgitlin1@jhu.edu

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

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

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

The results of their discussions include the following:

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

Manifestations of Stigma and Discrimination
Roundtable participants identified three types of stigma and discrimination:
➢ **self-stigma**—older adults may be fearful of acknowledging their own mental illnesses;
➢ **public stigma**—providers, employers, and the general public view older adults with mental illnesses as people who will not get better with treatment, or worse, people who are not worth treating;
➢ **institutional stigma**—assumptions about older adults with mental illnesses are translated into public policy and funding decisions that stigmatize and discriminate against these individuals.

Research Findings on Older Adults and Mental Health
The roundtables reviewed the research findings on older adults and mental health. Many facts were found that must be taken into account when developing action plans for the future of mental health care for older adults (adults age 65 and older). Some of the trends for older adults and mental illnesses are illustrated here.

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

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

**Depression in Older Adults and Health Care Costs**

Older adults with significant depression have total health care costs that are roughly 50 percent higher than those without depression. They have a higher use of services in all categories of medical care, including inpatient admissions, outpatient visits, laboratory tests, emergency department visits, the number of prescriptions, and ancillary and optometry visits (Unützer et al.).
3. Long Term Care

Long-term care (LTC) refers to a broad range of services designed to provide assistance over prolonged periods to compensate for loss of function due to chronic illness or physical or mental disability. LTC includes hands-on, direct care as well as general supervisory assistance. The type, frequency, and intensity of services vary; some people need assistance for a few hours each week, whereas others need full-time support. LTC differs from acute or episodic medical interventions because it is integrated into an individual’s daily life over an extended time.

LTC spans three realms: (1) assistance with essential, routine activities such as eating, bathing, dressing, and tasks required to maintain independence, such as preparing meals, managing medications, shopping for groceries, and using transportation; (2) housing; and (3) medical care. Often, LTC is associated with institutional settings such as nursing homes (NHs). However, LTC is also provided in a variety of non-institutional settings collectively referred to as Home and Community-Based Services (HCBS).

Care through HCBS may be provided in a variety of settings, including recipients’ homes; group living arrangements such as congregate housing, adult foster care, residential care (RC) and assisted living (AL) facilities (the last two terms are often used interchangeably although they are not always synonymous—we use the term AL throughout this document); and community settings such as adult daycare and adult day health. Services provided via HCBS may include care coordination or case management, personal care assistant service, personal attendant service, homemaker and personal care agency services, home hospice, home-delivered meals, home reconfiguration or renovation, medication management, skilled nursing, escort service, telephone reassurance service, emergency help lines, equipment rental and exchange, and transportation. HCBS also include educational and supportive group services for consumers or their families. Some services provided through HCBS are construed as respite care meant to relieve family caregivers. Services may need to be pieced together from multiple agencies and independent providers, with or without overall coordination or management.
NHs are State-licensed institutional facilities offering 24-hour room and board, supervision, and nursing care. NH services may include personal care, activities of daily living (ADL) support, medical management, nursing management, medication management, restorative nursing, palliative care, physical rehabilitation (either as a short-term service associated with post-acute care or as maintenance rehabilitation), social activities, and transportation. NH care may also include family councils and support groups for informal caregivers.

AL first appeared as a care modality in the 1980s and is now offered and licensed under a variety of names. AL presents a taxonomic problem because it varies so widely in the degree of privacy and space of the living arrangements offered and in the extent and range of services provided. The variation stems both from State licensure policies (that either require or prohibit specified services or living characteristics) and from the business models of the providers. AL rarely offers the intensity of care, especially nursing care, found in NHs. Nonetheless, AL is an institution, albeit often a more livable one. Further complicating this picture is the emergence of so-called comprehensive care retirement communities in which a single campus offers services ranging from unassisted housing to AL to NHs. For this review, we examined the services individually.

Currently, more than 11 million individuals need LTC to assist them with life’s daily activities. The majority of these individuals (55%) are 65 years or older. About two-thirds of Americans age 65 and older will eventually need some type of LTC for an average of 2 years. LTC needs are met through a combination of unpaid services provided by family members and paid assistance. More than three-quarters of community-dwelling adults rely exclusively on unpaid LTC assistance from family members. Paid LTC services are financed through both public and private means. Medicaid, the public program jointly funded by Federal and State governments and administered by the States, is the largest source of public funding for LTC. Medicaid finances 40 percent of total national LTC spending.

Almost 1.4 million individuals currently live in NHs. NH care is a mandatory benefit under Medicaid for individuals who meet the eligibility criteria. In 2009, NH expenditures accounted for about 64 percent of Medicaid LTC expenditures for older adults and people with physical disabilities. Costs per individual for NH care generally exceed those for HCBS. Therefore, state governments (the major decision-makers for LTC
policies and care), have increasingly prioritized HCBS as a method to restrain LTC costs. The increased focus on HCBS has also been fueled by other factors. For example, consumers have expressed a preference for more LTC in the community, and the Supreme Court Olmstead decision stated that LTC services should be provided in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

Medicaid spending is rising faster for HCBS than for NHs. The national percentage of Medicaid spending on HCBS more than doubled from 1995 to 2009, from 19 percent to 43 percent. Within Medicaid, spending for HCBS varies among different populations. In 2009, HCBS expenditures made up about 36 percent of LTC expenditures for older adults and people with physical disabilities. States have options for financing HCBS through Medicaid, including HCBS waivers, mandatory home health State plan services, and optional personal care State plan services. For individuals who meet the eligibility requirements, these services are provided in lieu of NH services. States may also use funds from the Older Americans Act (OAA) and from general revenue to provide HCBS.

Both NHs and HCBS may offer equivalent services, but they differ in philosophy and emphasis. Meaningful comparisons require that the nuanced strengths and weaknesses of each setting be given careful attention. Outcomes in LTC result from a complex interplay among the characteristics of older adults, the environment, and the services delivered. A successful mode of care meets the need for assistance, moderates the rate of functional decline, and improves quality of life. For older adults who need LTC, the choice of one form of care over the other requires a careful evaluation of the tradeoffs between competing priorities—for example, between safety and independence. The process of choosing a mode and setting of care may be influenced by multiple factors such as access, affordability, availability of informal support, and individual preferences. In addition, State regulatory frameworks and reimbursement policies profoundly affect the type of services offered and their availability across settings.

Most civilized societies such as The United States, Western Europe and Japan, have aging populations. While the effects on society are complex, there is concern about the impact on health care demand. Numerous suggestions found in literature for specific interventions to cope with the expected increase in demand for long-term care in aging societies can be organized under four headings: improve system performance; redesign service delivery; support informal caregivers; and shift demographic
parameters. However, the annual growth in national health spending is not mainly due to increasing demand from aging populations, but rather has been driven by rising incomes, costly new medical technology, a shortage of health care workers and informational differences between providers and patients (Source: AARP, Staying Ahead of the Curve).

The Centers for Medicare and Medicaid Services (CMS) estimates that by 2020, approximately 12 million older Americans will require long-term care. It is anticipated that most will be cared for at home; family and friends are the sole caregivers for 70 percent of the elderly. A study by The U.S. Department of Health and Human Services says that people who reach age 65 will likely have a 40 percent chance of entering a nursing home. About 10 percent of the people who enter a nursing home will stay there five years or more (Source: AARP, Staying Ahead of the Curve).

A study conducted by AARP found that most Americans are unaware of the costs associated with long-term care and overestimate the amount that government programs such as Medicare will pay.

**Long Term Care Services to the United States**

Long-Term care services provided by paid, regulated providers are a significant component of personal health care spending in the United States. The following presents descriptive results from the first wave of the National Study of Long-Term Care Providers (NSLTCP), which was conducted by the Centers for Disease Control and Prevention’s National Center for Health Statistics (NCHS). Data presented are drawn from five sources: NCHS surveys of adult day services centers and residential care communities, and administrative records obtained from the Centers for Medicare & Medicaid Services on home health agencies, hospices, and nursing homes. This report provides information on the supply, organizational characteristics, staffing, and services offered by providers of long-term care services; and the demographic, health, and functional composition of users of these services. Service users include residents of nursing homes and residential care communities, patients of home health agencies and hospices, and participants of adult day services centers.

**Key Findings**

In 2012, about 58,500 paid, regulated long-term care services providers served about 8 million people in the United States. Long-term care services
were provided by 4,800 adult day services centers, 12,200 home health agencies, 3,700 hospices, 15,700 nursing homes, and 22,200 assisted living and similar residential care communities. Each day in 2012, there were 273,200 participants enrolled in adult day services centers, 1,383,700 residents in nursing homes, and 713,300 residents in residential care communities; in 2011, about 4,742,500 patients received services from home health agencies, and 1,244,500 patients received services from hospices.

Provider sectors differed in ownership, and average size and supply varied by region. The majority of providers in four of the five sectors were for profit, whereas the majority of adult day services centers were nonprofit. The average size of a provider, based on the number of people served, varied by sector. On average, a nursing home served more than twice as many people daily as an adult day services center or residential care community. On an annual basis, a home health agency served more patients on average than a hospice. In the West, the supply of residential care beds and nursing home beds per 1,000 persons aged 65 and over was comparable, whereas nursing home beds far outnumbered residential care beds in all other regions. The supply of nursing home and residential care beds and the capacity of adult day services centers varied by region, suggesting geographic differences in access for consumers of long-term care services. For example, the supply of residential care beds was higher in the Midwest and West than in the Northeast and the South, and the capacity of adult day services centers was higher in the West than in the South.

Provider sectors differed in their nursing staffing levels, use of social workers, and variety of services offered. For every measure of nursing staff type examined, the average daily staff hours per resident or participant day was higher in nursing homes than in residential care communities and adult day services centers. This difference may reflect the higher functional needs of nursing home residents relative to service users in other sectors. Sectors varied in their use of social workers, ranging from most hospices employing at least one social worker, to just over one-tenth of residential care communities doing so. In terms of services offered, more hospices and nursing homes offered mental health and counseling services compared with adult day services centers and residential care communities.

Rates of use of long-term care services varied by sector and state. Reflecting similar differences found when comparing supply, the daily-use rate among individuals aged 65 and over per 1,000 persons aged 65 and over varied by sector. The highest daily-use rate was for nursing home residents, followed by residential care residents; the lowest rate was for adult day services...
centers. However, in about a dozen states, the nursing home daily-use rate was similar to or lower than the residential care daily-use rate. Within each of the five sectors, the use rate varied by state. For example, average adult day daily-use rates ranged from a low of less than 1 participant per 1,000 persons in West Virginia, to a high of 12 participants in New Jersey. Average residential care community daily-use rates ranged from as few as 2 residents per 1,000 persons in Iowa, to 40 residents in North Dakota.

Users of long-term care services varied by sector in their demographic and health characteristics and functional status. Adult day services center participants and home health patients tended to be younger than users in other sectors. Adult day services center participants were the most racially and ethnically diverse among the five sectors: 20.1% were Hispanic and 16.7% were non-Hispanic black. Alzheimer’s disease and other dementias ranged in prevalence from 30.1% among home health patients, to 48.5% among nursing home residents. Depression ranged in prevalence from 22.2% among hospice patients, to 48.5% of nursing home residents. Although the need for assistance with activities of daily living was common in all sectors, functional ability varied by sector. A higher percentage of nursing home residents needed assistance in bathing, dressing, toileting, and eating compared to users in other sectors.

The NSLTCP findings in this report provide a current national picture of providers and users of five major sectors of paid, regulated long-term care services in the United States.

Long-Term Care Services
Individuals may receive long-term care services in a variety of settings: in the home from a home health agency or from family and friends, in the community from an adult day services center, in residential settings from assisted living communities, or in institutions from nursing homes, for example. Long-term care services provided by paid, regulated providers are a significant component of personal health care spending in the United States (O’Shaughnessy, 2013). Estimates of expenditures for long-term care services vary, depending on what types of providers, populations, and services are included. Recent estimates for the amount spent annually on paid, long-term care services are between $210.9 billion (O’Shaughnessy, 2013) and $306 billion (Colello, Girvan, Mulvey, & Talaga, 2012; Genworth Financial, 2012; MetLife Mature Market Institute, 2012).

Finding a way to pay for long-term care services is a growing concern for older adults, persons with disabilities, and their families, and is a major
challenge facing state and federal governments (Commission on Long-Term Care, 2013; Reinhard, Kassner, Houser, & Mollica, 2011). Medicaid finances a major portion of paid, long-term care services, followed by Medicare and out-of-pocket payments by individuals.

Historically, the term “long-term care” has been used to refer to services and supports to help frail older adults and younger persons with disabilities maintain their daily lives. Recently, alternative terms have gained wider use, including “long-term services and supports.” The Patient Protection and Affordable Care Act (ACA, P.L. 111–148, as amended) uses the term “long term services and supports,” and defines the term to include certain institutionally based and non-institutionally based long-term services and supports [Section 10202(f)(1)]. This report uses “long-term care services” to reflect both the changing vocabulary and the fact that these services can include both health care-related and non-health care-related services.

The need for long-term care services is generally defined based on functional limitations (need for assistance with or supervision in ADLs and IADLs) regardless of cause, age of the person, where the person is receiving assistance, whether the assistance is human or mechanical, and whether the assistance is paid or unpaid.

This $306 billion estimate for 2010 is based on analysis by the Congressional Research Service of National Health Expenditure Account data obtained from the Centers for Medicare & Medicaid Services, Office of the Actuary, prepared November 15, 2011. Excluding Medicare spending on home health and skilled nursing facilities, total long-term care services spending was $237.7 billion in 2010. The $210.9 billion estimate for 2011 is based on analysis by the National Health Policy Forum using published (Hartman, Martin, Benson, Caitlin, & National Health Expenditure Accounts Team, 2013) and unpublished data from the National Health Expenditure Account.

Medicaid finances a variety of long-term care services through multiple mechanisms (e.g., Medicaid State Plan, home- and community-based services waiver programs, and other options for community-based long-term care families (Colello et al., 2012; O’Shaughnessy, 2013). However, the distribution of financing sources varies by provider sector and by population. For example, most residents pay out-of-pocket for assisted living (Mollica, 2009), with a small percentage using Medicaid to help pay for services (Caffrey et al., 2012). In contrast, the largest single payer for long-term nursing home care is Medicaid, whereas Medicare finances hospice costs
and a major portion of the costs for short-stay, post-acute care in skilled
nursing facilities for Medicare beneficiaries (Federal Interagency Forum on

The number of people using nursing facilities, alternative residential care places, or home care services is projected to increase from 15 million in 2000 to 27 million in 2050. Most of this increase will be due to growth in the older adult population who need such services. Although people of all ages may need long-term care services, the risk of needing these services increases with age. Recent projections estimate that over two-thirds of individuals who reach age 65 will need long-term care services during their lifetime (Kemper, Komisar, & Alecxih). Largely due to aging baby boomers, the population is expected to become much older, with the number of Americans over age 65 projected to more than double, from 40.2 million in 2010 to 88.5 million in 2050 (Vincent & Velkoff). The estimated increase in the number of the “oldest old”—those aged 85 and over—is even more striking. The oldest old are projected to almost triple, from 6.3 million in 2015 to 17.9 million in 2050, accounting for 4.5% of the total population (U.S. Census Bureau, 2012).

This oldest old population tends to have the highest disability rate and need for long-term care services, and they also are more likely to be widowed and without assistance with ADLs (Feder & Komisar, 2012; Houser, Fox-Grage, & Ujvari, 2012). Decreasing family size and increasing employment rates among women may reduce the traditional pool of family caregivers, further stimulating demand for paid long-term care services (Congressional Budget Office, 2004). Among persons who need long-term care services, adults aged 65 and over are more likely than younger adults to receive paid help (Kaye, Harrington, & LaPlante). Recent studies project that the number of older adults using paid, long-term care services will grow substantially (Johnson, Toohey, & Wiener; Kaye, 2013; Stone; The Lewin Group). A substantial share of paid, long-term care services is publicly funded through programs such as Medicaid and Medicare; accurate, timely statistical information can help guide those programs and inform relevant policy decisions.

The National Study of Long-Term Care Providers
The long-term care services delivery system in the United States has changed substantially over the last 30 years. For example, although nursing homes are still a major provider of long-term care services, there is growing use of skilled nursing facilities for short-term, post-acute care and rehabilitation. Further, consumers’ desire to stay in their own homes, and federal and state policy developments (e.g., the Supreme Court’s Olmstead
ruling, introduction of the Medicare Prospective Payment System, and balancing Medicaid-financed services from institutional to non-institutional settings) have led to growth in a variety of home- and community-based alternatives (Doty; Wiener, 2013). The major sectors of paid, long-term care services providers now also include adult day services centers, assisted living and similar residential care communities, home health agencies, and hospices.

This report does not address all long-term care services financed by Medicaid. For example, intermediate care facilities for people with intellectual or developmental disabilities are excluded.

Experts disagree on whether Medicare expenditures for skilled nursing facilities and home health agencies should be considered long-term care services, because they are post-acute services. This report includes Medicare-certified skilled nursing facilities and home health agencies. See Technical Notes for details on the types of providers included. In 2011, the National Center for Health Statistics (NCHS) launched the National Study of Long-Term Care Providers (NSLTCP)—an integrated strategy for efficiently obtaining and providing statistical information about the supply and use of major sectors of paid, regulated long-term care services providers in the United States. NSLTCP provides relevant, timely, and credible information to monitor trends and examine the effects of policy changes on the supply, use, and characteristics of the major sectors of long-term care services providers.

NSLTCP has these main goals:
- Estimate the supply of paid, regulated long-term care services providers
- Estimate key policy-relevant characteristics of these providers
- Estimate the number of long-term care services users
- Estimate key policy-relevant characteristics of these users
- Compare provider sectors
- Produce national and state estimates, where feasible
- Monitor trends over time

NSLTCP replaces NCHS’ periodic National Nursing Home Survey and National Home and Hospice Care Survey, and the one-time National Survey
of Residential Care Facilities. The NSLTCP core is designed to (1) broaden
NCHS’ ongoing coverage of paid, regulated long-term care services
providers beyond nursing homes, home health agencies, and hospices to
include assisted living or similar residential care communities (referred to in
this report as residential care communities) and adult day services centers;
(2) broaden the study over time to add other types of paid, regulated long-
term care services providers (e.g., home care agencies); (3) use national
administrative data from the Centers for Medicare & Medicaid Services
(CMS) on nursing homes, home health agencies, and hospices; (4) collect
primary data every other year from cross-sectional, nationally representative,
establishment-based surveys of adult day services centers and residential
care communities (administrative data do not exist); and (5) monitor trends
more frequently than in the past decade.

In addition to the core content, the NSLTCP data collection system provides
the infrastructure on which to build provider-specific surveys, cross-provider
topical modules, more in-depth surveys to respond to evolving or emerging
policy issues, and sampling and collecting information on individual users
(e.g., nursing home residents).

**National Profile of Providers of Long-Term Care Services**

As of 2012 in the United States, there were an estimated 4,800 adult day
services centers, 12,200 home health agencies, 3,700 hospices, 15,700
nursing homes, and 22,201 residential care communities. Of these
approximately 58,5002 regulated,3 long-term care services providers, about
two-thirds provided care in residential settings (26.8% were nursing homes
and 37.9% were residential care communities), and about one-third provided
care in home- and community-based settings (8.2% were adult day services
centers, 20.9% were home health agencies, and 6.3% were hospices).

**Supply of Long-Term Care Services Providers**

**Geographic distribution**
The supply of providers in the five long-term care services sectors varied in
their geographic distribution. The largest share of adult day services centers
(32.4%), home health agencies (48.3%), hospices (42.4%), and nursing
homes (34.5%) was in the South, while the largest share of residential care
communities (36.4%) was in the West.
The vast majority of providers in all five long-term care services sectors were in MSAs. This distribution reflects the higher population density in these areas. The proportion of adult day services centers (36.8%) located in areas that were neither metropolitan nor micropolitan was two to five times as large as the proportion of providers in the other four sectors located in these areas.
Capacity
Based on the maximum number of participants allowed, the 4,800 adult day services centers in the country together could serve 276,500 participants daily (Appendix B, Table 1). The allowable daily capacity of adult day services centers ranged from 1 to 780, with an average of 58 participants. The 15,700 nursing homes in the country provided a total of 1,669,100 certified beds. Nursing homes ranged in capacity from 2 to 1,389 certified beds, with an average of 106 certified beds. The 22,200 residential care communities in the United States provided 851,400 licensed beds. Residential care communities ranged in capacity from 4 to 582 licensed beds, with an average of 38 licensed beds. The supply of nursing home and residential care beds and adult day services center capacity varied by region (Figure 3). Compared with other regions, the Midwest had the largest supply of nursing home beds (51) and the smallest supply of adult day services center capacity (3) per 1,000 persons aged 65 and over.
In the West, the supply of residential care beds (24) and nursing home beds (25) per 1,000 persons aged 65 and over was comparable, whereas nursing home beds far outnumbered residential care beds in all other regions.

Organizational Characteristics of Long-Term Care Services Providers

Ownership type

In all sectors except adult day services centers, the majority of long-term care services providers were for profit (Figure 4). Home health agencies (78.7%) and residential care communities (78.4%) had the highest proportion of for-profit ownership, while adult day services centers (40.0%) had the lowest proportion. The majority of adult day services centers were nonprofit (54.9%).
Medicare and Medicaid certification
All data on nursing homes and home health agencies used in this report were only for Medicare- or Medicaid-certified providers, and all data on hospices were only for Medicare-certified hospices. Almost all nursing homes (95.0%), about three-quarters of adult day services centers (77.1%) and home health agencies (77.5%), and one-half of residential care communities (51.8%) were authorized or certified to participate in Medicaid. Information was not available on whether any of the Medicare-certified hospices were also certified by Medicaid. Virtually all home health agencies (98.6%), hospices (100.0%), and nursing homes (96.5%) were Medicare certified (data not shown). Medicare does not certify or reimburse for services provided by adult day care services centers or residential care communities; therefore, these providers were not asked about Medicare certification.

Number of people served
In terms of persons actually served, a nursing home served on average, more than twice the number of people daily as an adult day services center or a
residential care community. A nursing home housed an average of 88 current residents, while an adult day services center had a mean weekday daily attendance of 39 participants, and a residential care community served an average of 32 residents daily (Appendix B, Table 1). The majority of nursing homes (61.7%) served between 26 and 100 residents daily, while the majority of residential care communities (59.9%) served 25 or fewer residents daily. Adult day services centers were about evenly split between those serving 25 or fewer participants daily (47.4%) and those serving 26 to 100 participants daily (47.3%).

The proportion of nursing homes (32.8%) serving more than 100 persons daily was about six times as large as the proportion of adult day services centers (5.2%) and residential care communities (5.5%) doing so.

**Staffing: Nursing and Social Work Employees**

This section focuses on workers employed directly by adult day services centers, home health agencies, hospices, nursing homes, and residential care communities. Information is provided about registered nurses (RNs), licensed practical nurses (LPNs) or licensed vocational nurses (LVNs), aides, and social workers. Contract staff that work for these providers were
excluded because comparable information on contract staff was not available for all five sectors.

**Nursing employee full-time equivalents**

In 2012, nearly 1.5 million nursing employee full-time equivalents (FTEs) were working in the five sectors, including RNs, LPNs and LVNs, and aides (Figure 6). Of these nursing employees, almost two-thirds (65.5% or 952,100 FTEs) worked in nursing homes, almost one-fifth (19.2% or 278,600 FTEs) were employees of residential care communities, about one-tenth (9.9% or 143,600 FTEs) were employed by home health agencies, and less than one-twentieth were employed by hospices (4.0% or 57,800 FTEs) and adult day services centers (1.4% or 20,700 FTEs).

The relative distribution of staff types of nursing employee FTEs varied across sectors. The majority of nursing employee FTEs in residential care communities (82.1%), adult day services centers (69.4%), and nursing homes (65.4%) were aides. However, in hospices (54.7%) and home health agencies (54.4%), the majority of nursing employee FTEs were RNs.7

![Figure 6. Total number and percent distribution of nursing employee full-time equivalents, by provider type and staff type: United States, 2012](image)

Among the four staff types examined, employing any aides showed the least variation by sector (Figure 7). In all five sectors, the vast majority of providers employed aides; nursing homes (98.3%) were most likely and
adult day services centers (74.4%) were least likely to have any aides on staff.

With the exception of residential care communities, the majority of providers employed licensed nursing staff (RNs or LPNs and LVNs). Because virtually all home health agencies, hospices, and nursing homes in this report are Medicare-certified, it is to be expected that nearly all of them employed at least one RN. In contrast, 59.2% of adult day services centers and 46.3% of residential care communities employed any RNs. The majority of nursing homes (98.2%), home health agencies (68.7%), and hospices (56.4%)
Mental health or counseling services
Mental health or counseling services were offered by most hospices (97.2%), nursing homes (86.6%), and residential care communities (77.8%), while less than one-half of adult day services centers (47.3%) offered these services (Figure 10).

Therapeutic services
Virtually all nursing homes (99.3%), hospices (98.4%), and home health agencies (96.6%) offered therapeutic services, and most residential care communities (88.7%) did so. The majority of adult day service centers (63.8%) offered therapeutic service.

Pharmacy or pharmacist services
Nearly all nursing homes (97.4%) and residential care communities (92.6%) offered pharmacy or pharmacist services, while fewer adult day services centers (34.9%) and home health agencies (5.5%) provided these services (Figure 13).
Hospice services

A greater percentage of residential care communities (89.4%) offered hospice services than did nursing homes (78.6%). Fewer adult day services centers (24.4%) offered hospice services, and only a small percentage of home health agencies (5.6%) offered hospice services (Figure 14).

Figure 13. Percentage of long-term care services providers that provide pharmacy or pharmacist services, by provider type: United States, 2012

NOTES: See Appendix A for definitions of pharmacy or pharmacist services for each provider type. Percentages are based on the unrounded numbers.

SOURCES: CDC/NCHS, National Study of Long-Term Care Providers and Table 3 in Appendix B.
National Profile of Users of Long-Term Care Services

Introduction
On any given day in 2012, there were 273,200 participants enrolled in adult day services centers, 11,383,700 residents in nursing homes, and 713,300 residents living in residential care communities. In 2011, about 4,742,500 patients received services from home health agencies, and 1,244,500 patients received services from hospices. Overall, these five long-term care services provider sectors served about 8,357,100 people annually. This section provides an overview of the use rate and demographic, health, and functional composition of users of long-term care services, by provider type. Demographic measures include age, race and ethnicity, and sex. Measures of health status include diagnosis of Alzheimer’s disease and other dementias and depression. Measures of functional status include needing assistance with selected activities of daily living [(ADLs) i.e., bathing, dressing, toileting, and eating].

Users of Long-Term Care Services
Participants in adult day services centers and residents in nursing homes and residential care communities are current users on any given day in 2012. Home health patients refer to patients who received and ended care any time in 2011. Hospice patients refer to patients who received care any time in 2011. Use of long-term care services by individuals aged 65 and over per 1,000 persons aged 65 and over varied by provider type and state (Figures 15–19). The daily-use rate was higher for nursing homes (26 per 1,000), compared with residential care communities (15 per 1,000) and adult day services centers (4 per 1,000). The annual-use rate was higher for home health agencies (94 per 1,000) compared with hospices (28 per 1,000).

Daily enrollment in adult day services centers
In 2012, national daily enrollment in adult day services centers was 4 participants aged 65 and over (Figure 15). This rate varied by state in 2012, from a high of 12 participants per 1,000 persons in New Jersey, to a low of less than 1 participant in West Virginia (Appendix B, Table 5). Daily enrollment fell below the national rate in over 30 states, indicating that the nationwide rate was being driven by a few large states, including California, New York, Texas, and New Jersey.
Daily use of nursing homes
Nationally in 2012, daily nursing home use was 26 residents aged 65 and over (Figure 16), and ranged from 7 residents in Alaska to 49 residents in
North Dakota. About 40% of states had a rate that was higher than the national rate; these states were largely concentrated in the South and the Midwest, with a few in the Northeast. States on the west and east coasts had use rates that were below the national rate.

**Annual use of home health agencies**

In 2011, national annual use of home health care was 94 patients aged 65 and over (Figure 18), and ranged from 28 in Hawaii to 138 in Massachusetts. All of the states in the Northeast and most of the states in the South had rates that were not statistically different from the national rate. Most of the states where use of home health care was lower than the national rate were located in the West, with some in the Midwest. Only Texas and Florida in the South, and Illinois and Michigan in the Midwest had rates higher than the national rate.
Annual use of hospices
In 2011, the national annual use of hospice care was 28 patients aged 65 and over (Figure 19). The annual rate ranged from 7 in Alaska to 39 in Delaware and Utah. All but 4 states (Alaska, California, New York, and Wyoming) had annual rates that were not statistically different from the national rate.

Demographic Characteristics of Users of Long-Term Care Services

Use of long-term care services by age
The majority of long-term care service users were aged 65 and over: 94.5% of hospice patients, 93.3% of residential care residents, 85.1% of nursing home residents, 82.4% of home health patients, and 63.5% of participants in adult day services centers (Figure 20). The age composition of services users varied by sector, with residential care communities (50.5%), hospices (46.8%), and nursing homes (42.3%) serving more persons aged 85 and over, and adult day services centers (36.5%) serving more persons under age 65 than other sectors.
Figure 20. Percent distribution of long-term care services providers, by provider type and age group: United States, 2011 and 2012

NOTES: Denominators used to calculate percentages for adult day services centers, nursing homes, and residential care communities were the number of participants enrolled in adult day services centers, the number of residents in nursing homes, and the number of residents in residential care communities on a given day in 2012. Denominators used to calculate percentages for home health agencies and hospices were the number of patients whose episode of care in a home health agency ended at any time in 2011, and the number of patients who received care from Medicare-certified hospices at any time in 2011. See Appendix A and Technical Notes for more information on the data sources used for each provider type. Percentages may not add to 100 because of rounding. Percentages are based on the unrounded numbers.

SOURCES: CDC/NCHS, National Study of Long-Term Care Providers and Table 4 in Appendix B.

Figure 21. Percent distribution of users of long-term care services, by provider type and sex: United States, 2011 and 2012

NOTES: Denominators used to calculate percentages for adult day services centers, nursing homes, and residential care communities were the number of participants enrolled in adult day services centers, the number of residents in nursing homes, and the number of residents in residential care communities on a given day in 2012. Denominators used to calculate percentages for home health agencies and hospices were the number of patients whose episode of care in a home health agency ended at any time in 2011, and the number of patients who received care from Medicare-certified hospices at any time in 2011. See Appendix A and Technical Notes for more information on the data sources used for each provider type. Percentages may not add to 100 because of rounding. Percentages are based on the unrounded numbers.

SOURCES: CDC/NCHS, National Study of Long-Term Care Providers and Table 4 in Appendix B.
Use of long-term care services by sex
In all five sectors, the users of long-term care services were overwhelmingly women (Figure 21), with the highest proportion in residential care communities (72.0%).

Use of long-term care services by race and ethnicity
Non-Hispanic white persons accounted for at least three-quarters of users in all long-term care services sectors, except adult day services centers (Figure 22). The proportion of non-Hispanic white persons was highest in residential care communities (87.3%), followed by hospices (85.3%), nursing homes (78.7%), and home health agencies (74.5%). Less than one-half of the participants in adult day services centers were non-Hispanic white (47.3%). The proportion of non-Hispanic black persons was highest in adult day services centers (16.8%). Over one-tenth of home health patients and nursing home residents were non-Hispanic black. About 8.1% of hospice patients and 4.0% of residential care residents were non-Hispanic black. Adult day services centers were the most racially and ethnically diverse among the five sectors: 16.8% of users were non-Hispanic black, and 20.2% of users were Hispanic.

![Figure 22. Percent distribution of users of long-term care services, by provider type and race and Hispanic origin: United States, 2011 and 2012](image-url)
Health and Functional Characteristics of Users of Long-Term Care Services

Alzheimer’s disease or other dementias were most prevalent among nursing home residents (48.5%), and were least prevalent among home health patients (30.1%) (Figure 23). The percentage of users of long-term care services with a diagnosis of depression was highest in nursing homes (48.5%), and lowest in residential care communities (24.8%), adult day services centers (23.5%), and hospices (22.2%).

Assistance with activities of daily living

The need for ADL assistance can be used to measure physical and cognitive functioning among users of long-term care services (Katz, Down, Cash, & Grotz, 1970). Bathing, dressing, toileting, and eating are the ADLs used in this report to monitor functioning among residents in nursing homes and residential care communities, patients in home health care, and participants in adult day services centers.

Within each sector, the need for assistance with bathing was most common, whereas the need for assistance with eating was least common (Figure 24).
Overall, functional ability varied by sector. More nursing home residents needed assistance in each of the four ADLs, followed by home health patients. Equal proportions of adult day services center participants (36.2%) and residential care community residents (36.8%) needed assistance with toileting. More adult day services center participants (25.3%) than residential care community residents (17.7%) needed help with eating. Although the prevalence of ADL needs differed by sector, at least 40.0% of long-term care services users in all sectors needed assistance with at least one ADL.

Summary
In 2012, there were approximately 58,500 paid, regulated long-term care services providers in the United States, including 4,800 adult day services centers, 12,200 home health agencies, 3,700 hospices, 15,700 nursing homes, and 22,200 residential care communities. In total, long-term care services providers in these five sectors served about 8,357,100 people annually. Specifically, on any given day in 2012, there were
273,200 participants enrolled in adult day services centers, 1,383,700 residents living in nursing homes, and 713,300 residents living in residential care communities. In 2011, about 4,742,500 patients received services from home health agencies, and 1,244,500 patients received services from hospices.

Supply and Use of Long-Term Care Services

The supply of different long-term care services options was measured by examining the number of beds or allowable daily capacity per 1,000 persons aged 65 and over. In the United States, the supply of nursing home beds was almost twice the supply of residential care community beds, and about six times the allowable daily capacity of adult day services centers. The supply of nursing home and residential care beds and the capacity of adult day services centers varied by region, suggesting possible geographic differences in access. There is also geographic variation in the relative mix of long-term care services options available to consumers. In the West, the supply of residential care beds and nursing home beds per 1,000 persons was comparable, whereas nursing home beds far outnumbered residential care beds in all other regions.

Use of long-term care services varied by provider type, reflecting similar differences found when comparing supply. When comparing rates of daily use nationally among individuals aged 65 and over, use was highest in the nursing home sector and lowest in the adult day services center sector. Use of services also varied geographically. For example, in Texas the daily-use rate of adult day services centers and nursing homes was higher than the national rate, while the state’s residential care daily-use rate was lower than the national rate. In contrast, in Virginia the daily-use rate of adult day services centers and nursing homes was lower than the national rate, while the state’s residential care daily-use rate was higher than the national rate. Although previous research found that the use of home- and community-based services is increasing at a greater rate than the use of nursing homes (Houser et al., 2012), findings from the National Study of Long-Term Care Providers (NSLTCP) suggest that in most areas of the country the supply and use of nursing homes are still greater than those of other long-term care services options. A recent analysis by the ARP Public Policy Institute found that states vary tremendously on a variety of characteristics of their long-term care services systems (Reinhard et al.). The NSLTCP state-level findings in this report add to this picture of diversity among states.
Characteristics of Long-Term Care Services Providers and Users

Paid long-term care services are provided by a wide array of trained professionals and paraprofessionals, with the largest share being direct-care workers that include certified nursing assistants, personal care aides, and home health aides, generally referred to as aides (The SCAN Foundation, 2012). In all sectors, aide hours were the most frequently used nursing hours: these findings corroborate other studies showing that direct-care workers provide an estimated 70% to 80% of the paid, hands-on, long-term care services in the United States (Paraprofessional Healthcare Institute, 2012). Previous studies have provided evidence that higher nurse-staffing levels are associated with higher quality of care outcomes for nursing home, and nursing homes are required to meet minimum nurse staffing ratios for participation in Medicare and Medicaid. Less research has been conducted on staffing levels and outcomes in adult day, residential care (for an exception see Stearns et al.), home health, and hospice settings. For every measure of nursing staff type examined, the average staff hours per resident or participant day was higher in nursing homes than in residential care communities and adult day services centers.

These differences in nurse-staffing levels among sectors reflect the higher functional needs of nursing home residents, relative to service users in other sectors. When comparing activities of daily living (ADLs) across sectors, more nursing home residents and home health patients needed assistance with each of four ADLs than did adult day participants and residential care residents. Fewer residential care community residents needed help eating than did users in other sectors. Although ADL needs varied by sector, at least 40% of long-term care services users in all four sectors needed assistance with at least one ADL. Based on estimates from the Aging, Demographics, and Memory Study, a nationally representative sample of older adults, 13.9% of people aged 71 and over in the United States have Alzheimer’s disease or other types of dementia (Plasman et al.). NSLTCP findings show that a sizeable portion of service users in all five sectors had a diagnosis of Alzheimer’s disease or other dementias —almost one-third of adult day services center participants and home health patients, about four-tenths of residential care residents, and almost one-half of nursing home residents. These results suggest that this condition is a common precipitating factor for using formal long-term care services (Alzheimer’s Association, 2013).
The Institute of Medicine has documented the growing need for gerontological social workers and the lack of interest among social workers in working with older adults (*Institute of Medicine*).

According to a recent study, about 36,100 to 44,200 professional social workers were employed in long-term care settings, and approximately 110,000 social workers would be needed in these settings by 2050. The NSLTCP findings show that the five long-term care services sectors varied in the prevalence of employing licensed social workers. The majority of hospices and nursing homes employed licensed social workers, whereas a minority of adult day services centers, home health agencies, and residential care communities had licensed social worker employees. In the sectors for which staffing levels could be calculated (adult day services centers, nursing homes, and residential care communities), the average licensed social worker hours per resident or participant day were small (3 minutes to 9 minutes). Although the majority of providers in all sectors offered social work services, therapeutic services, and skilled nursing services, there was some variation across sectors. For example, less than two-thirds of adult day services centers offered social work services, whereas all hospices did so. These differences may be related to different population needs among sectors or to Medicare requirements for hospices to provide medical social services, among other reasons. Compared with the 12.0% of U.S. adults aged 65 and over in 2008 who had clinically depressive symptoms (*Federal Interagency Forum on Aging-Related Statistics, 2012*), depression was common among long-term care services users in all five sectors—ranging from 22.2% of hospice patients to 48.5% of nursing home residents. A higher proportion of hospices and nursing homes offered mental health and counseling services than did residential care communities and adult day services centers.

The adult day services sector was different from other sectors in notable ways. Adult day services centers were more likely to be nonprofit and to operate in less populated areas (i.e., neither metropolitan nor micropolitan). There were also fewer adult day services centers than providers in other sectors (except hospices), and they were less likely than providers in other sectors to offer social work services, mental health or counseling services, therapeutic services, or pharmacy services. Reasons for offering fewer of these services may include financing mechanisms (e.g., Medicare plays little, if any, role in this sector), or differences in the needs of users in different sectors.
Adult day services center participants were more diverse than service users in other sectors with respect to race and ethnicity and age. Compared with the approximately 7.0% of U.S. adults aged 65 and over who were Hispanic and the approximately 9.0% who were non-Hispanic black in 2010 (Federal Interagency Forum on Aging-Related Statistics, 2012), 20.2% of adult day services center participants were Hispanic, and 16.8% were non-Hispanic black. While people of all ages may need long-term care services, NSLTCP findings corroborate previous research showing that the majority of users of paid, long-term care services are older adults (Kaye et al.; O’Shaughnessy, 2013). However, among adult day services center participants, there was a lower proportion of persons aged 85 and over compared with users in other sectors.

In fact, over one-third of adult day services center participants were younger than age 65. The NSLTCP findings in this report provide a current national picture of providers and users of five major sectors of paid, regulated, long-term care services in the United States. Findings on differences and similarities in supply and use, and the characteristics of providers and users of long-term care services offer useful information to policymakers, providers, and researchers as they plan to meet the needs of an aging population. These findings also establish a baseline for monitoring trends and examining the effects of policy changes within and across the major sectors of long-term care services.

4. Coping with Aging and Depression: Treatment Considerations

Coping and well-being
Many variables impact coping and well being in the elderly. Social support, religion and spirituality, active engagement with life and having an internal locus of control have been proposed as being beneficial in helping elderly people to cope with stressful life events. Social support and personal control are possibly the two most important factors that predict well-being, morbidity and mortality in adults. Other factors that may link to well-being and quality of life in the elderly include social relationships (possibly relationships with pets as well as humans), and health (Fentleman, D.L., Smith, J. & Peterson, J, Successful aging in a postretirement society. In P.B. Baltes and M.M. Baltes Eds. Successful aging: Perspectives from the Behavioral Sciences).
Individuals in different wings in the same retirement home have demonstrated a lower risk of mortality and higher alertness and self-rated health in the wing where residents had greater control over their environment, though personal control may have less impact on specific measures of health. Social control, perceptions of how much influence one has over one's social relationships, shows support as a moderator variable for the relationship between social support and perceived health in the elderly, and may positively influence coping in the elderly (Fentleman, D.L., Smith, J. & Peterson, J., Successful aging in a postretirement society. In P.B. Baltes and M.M. Baltes Eds. Successful aging: Perspectives from the Behavioral Sciences).

**Religion**
Religion has been an important factor used by the elderly in coping with the demands of later life, and appears more often than other forms of coping later in life. Religious commitment may also be associated with reduced mortality, though religiosity is a multidimensional variable; while participation in religious activities in the sense of participation in formal and organized rituals may decline, it may become a more informal, but still important aspect of life such as through personal or private prayer (Fentleman, D.L., Smith, J. & Peterson, J., Successful aging in a postretirement society. In P.B. Baltes and M.M. Baltes Eds. Successful aging: Perspectives from the Behavioral Sciences).

**Self-rated health**
Self-ratings of health, the beliefs in one's own health as excellent, fair or poor, has been correlated with well-being and mortality in the elderly; positive ratings are linked to high well-being and reduced mortality. Various reasons have been proposed for this association; people who are objectively healthy may naturally rate their health better than that of their ill counterparts, though this link has been observed even in studies which have controlled for socioeconomic status, psychological functioning and health status. This finding is generally stronger for men than women, though the pattern between genders is not universal across all studies, and some results suggest sex-based differences only appear in certain age groups, for certain causes of mortality and within a specific sub-set of self-ratings of health (Fentleman, D.L., Smith, J. & Peterson, J., Successful aging in a postretirement society. In P.B. Baltes and M.M. Baltes Eds. Successful aging: Perspectives from the Behavioral Sciences).
Emotional Improvement
Given the physical and cognitive declines seen in aging, a surprising finding
is that emotional experience improves with age. Older adults are better at
regulating their emotions and experience negative affect less frequently than
younger adults and show a positivity effect in their attention and memory.
The emotional improvements show up in longitudinal studies as well as in
cross-sectional studies and so cannot be entirely due to only the happier
individuals surviving (Mather, M., & Carstensen, L. L., 2005. Aging and
motivated cognition: The positivity effect in attention and memory. Trends in
Cognitive Sciences).

The concept of successful aging can be traced back to the 1950s, and
popularized in the 1980s. Previous research into aging exaggerated the
extent to which health disabilities, such as diabetes or osteoporosis, could be
attributed exclusively to age, and research in gerontology exaggerated the
homogeneity of samples of elderly people.

Successful aging consists of three components:

1. Low probability of disease or disability;
2. High cognitive and physical function capacity;
3. Active engagement with life.

(Mather, M., & Carstensen, L. L.. Aging and motivated cognition: The
positivity effect in attention and memory. Trends in Cognitive Sciences)

A greater number of people self-report successful aging than those that
strictly meet these criteria. Successful aging may be viewed an
interdisciplinary concept, spanning both psychology and sociology, where it
is seen as the transaction between society and individuals across the life span
with specific focus on the later years of life. The terms "healthy aging"
"optimal aging" have been proposed as alternatives to successful aging
(Mather, M., & Carstensen, L. L. Aging and motivated cognition: The
positivity effect in attention and memory. Trends in Cognitive Sciences)

Six suggested dimensions of successful aging include:

1. No physical disability over the age of 75 as rated by a physician;
2. Good subjective health assessment (i.e. good self-ratings of one's
   health);
3. Length of undisabled life;
4. Good mental health;
5. Objective social support;
6. Self-rated life satisfaction in eight domains, namely marriage, income-related work, children, friendship and social contacts, hobbies, community service activities, religion and recreation/sports.

Throughout history, humans have been dealing with the aging process. Aging has been viewed differently historically by different societies. In Asia and South America, family members of advanced age are respected for their vast experience and included into the immediate family group. In the United States, which emphasizes youth and energy over age and wisdom, family members of advancing years are placed in nursing homes where they can live comfortably out of sight. However, as the baby-boomer generation rapidly advances in age, Americans will have to rethink their attitudes towards aging. In a rapidly aging society, the bias towards youth will have to be replaced by an added level of respect for the elderly and the values that are important to the aging demographic.

Growing older is an experience we all share and many of us worry about. As we age, we face many changes and many sources of stress - we are not as strong as we used to be, illness is more of a problem, children move away from home, people we love die, we may become lonely, and eventually we must give up our jobs and retire.

Coping with all these changes is difficult, but it can be done. The keys to coping include your long-term lifestyle, your ability to expect and plan for change, the strength of your relationships with surviving family and friends, and your willingness to stay interested in and involved with life.

It is, therefore, very important to think carefully about what will happen to you as you age and how you are going to deal with the changes that will happen.

**Dealing with physical changes**

As you grow older, your body will naturally change. You may tire more easily than you used to. You may become ill more often. You may not see or hear as well as you did when you were younger.

Here are some things you can do to cope with these physical changes:

- Accept reality. Denying these changes will only make life less enjoyable for you and the people around you. Get the things that will help you - eyeglasses or hearing aids for example.

- Keep a positive attitude. Remember that slowing down does not mean you have to come to a complete stop. Chances are you will still be able to do almost all the things you used to; you may just need to take a little more time and learn to pace yourself.
• See your family doctor regularly. He/she can, then, deal with any changes or symptoms that require medical attention.
• Be careful about your medications. As you get older, they may begin to interact differently with other drugs and to affect you differently than before. Make sure your doctor knows about all your medications, even those prescribed by another doctor.
• Take responsibility for your own health. Do not hesitate to ask your doctor questions; some do not offer explanations unless asked.
• Change your eating habits. Adopt a balanced diet with fewer fatty foods, and try not to over-eat.
• Drink less alcohol. Your body will have more difficulty coping with it as you grow older.

**Dealing with bereavement**
As you get older, you will likely experience the loss of loved ones more often. It is important to remember the following ways of coping with your grief:

• Do not deny your feelings. Losing someone to death is like being wounded, and you need to heal. If you do not allow yourself to go through the grieving process, you are only storing up problems for a delayed reaction later on.
• Accept the range of emotions you will feel. Tears, anger and guilt are all normal reactions.
• Remember and talk about the deceased person. He/she was an important part of your life. Although your grief will pass, your memories will always stay with you.
• Look to your family and friends for support. They can help you through the grieving period and help you establish a new life afterwards.
• Be supportive of those you know who have suffered a loss. They need the warmth and caring that friendship can bring, just as you will when it happens to you.

**Dealing with loneliness**
Everyone needs some time alone, but being alone against your will is very painful. You risk losing your sense of purpose and self-worth, and becoming depressed. As family members and friends die and children become more involved in their own lives, it is important for you to find ways to cope with loneliness. You may want to consider some of the following suggestions:
• Stay active, and look for new social contacts. Most communities have a number of programs which can help replace the support that used to be provided by family and life-long friends. These programs provide older people with the chance to try new activities and make new friends.

• Very young children can brighten up your life. Try to make friends with people of different ages. You may be pleasantly surprised to find how much you have in common with someone 15 or 20 years younger than you.

• Spend time with grandchildren and great-nieces and nephews. Volunteer to help part-time in a local school or day-care centre. Very young children can brighten up your life with their enthusiasm and energy.

• Learn to recognize and deal with the signs of depression. Loss of appetite and weight, inability to sleep, loss of energy and motivation, and thoughts of suicide are all signs of depression. Your family doctor can refer you to a mental health professional for treatment.

Dealing With Retirement

Your retirement can be a major source of stress because your job is usually a very important part of your life. This stress may be even greater if you have been forced to retire because of your employer’s retirement policies. You may lose your sense of identity and feel less worthwhile. You will probably miss the daily contact with friends from work. However, retirement can be one of the best times of your life, and there are things you can do to meet the challenges facing you, such as:

• Make a list of your abilities and skills. The skills and experience you have gamed from a lifetime of work may help you succeed in a small business or do valuable volunteer work for a favorite charity.

• Enrich your life by renewing contacts with neglected family members and old friends. All too often, our work gets in the way of our relationships and those we care about.

• Renew your interest in the hobbies and activities you enjoy. You now have time to play - enjoy!

• If you can afford it, travel. There are probably places you have wanted to see all your life. The early years of your retirement can be the ideal time to become a nomad for a while.

Between 8 to 20 percent of older adults in the community and up to 37 percent in primary care settings suffer from depressive symptoms. These
symptoms can range from depressive illness (major depressive disorder, dysthymic disorder, or bipolar disorder) to depressive symptoms that fall short of meeting full diagnostic criteria for a disorder and is associated with an increased risk of developing major depression (subsyndromal depression). In any of these forms, however, depressive symptoms are not a normal part of aging. In contrast to the normal emotional experiences of sadness, grief, loss, or passing mood states, they tend to be persistent and to interfere significantly with an individual's ability to function. Depression often co-occurs with other serious illnesses such as heart disease, diabetes, or cancer. Because of these co-occurring conditions health care professionals may mistakenly conclude that depression is a normal consequence of these problems—an attitude often shared by patients themselves. These factors together contribute to the underdiagnosis and undertreatment of depressive disorders in older people. Depression can and should be treated when it occurs and many effective therapies are available. If left untreated, depression impairs one’s enjoyment of life and may increase disability. It can also delay recovery from or worsen the outcome of other co-occurring chronic illnesses.

Cognitive Health
Cognitive health or brain health, is an important part of healthy aging. Cognitive health refers to maintaining and improving mental skills such as learning, memory, decision-making, and planning. Many older adults mistakenly believe becoming “senile” or forgetting is a normal part of aging. Although one in four older adults experiences these events (known collectively as cognitive decline), they are not a normal part of healthy aging. There are certain changes in cognitive health that occur as you age. Normal changes usually mean a slower pace of learning and the need for new information to be repeated. While the majority of older adults will experience these normal changes in cognition, some older adults will experience cognitive decline. Older adults with cognitive decline have a higher risk of developing dementia later in life. Among Americans 65 years and older, approximately 6–10% have dementia, and two-thirds of people with dementia have Alzheimer’s disease. Although research has not found a way to prevent dementia or Alzheimer’s disease, cognitive decline may be preventable. Recent research suggests that being physically active, controlling your hypertension, and engaging in social activities may help you maintain and improve your cognitive health (Source: CDC Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System).
Later in life, the reasons for becoming depressed appear to be obvious and common. The things which we expect to make us feel depressed do become more common as we grow older such as retirement, less income, and perhaps the start of physical problems. There are also the emotional losses such as the death of a partner, family member, friends, or a pet. Surprisingly, less than one elderly person in six feels so depressed that they or others notice. Fewer than one in thirty are so depressed that doctors would diagnose an illness or diagnose a depressive disorder \((\text{Strawbridge, W.J., Wallhagen, M.I. & Cohen, R.D.. Successful aging and well-being: Self-rated compared with Rowe and Kahn. The Gerontologist})\).

Symptoms of physical illnesses may be similar to those of Depression. For example, loss of appetite or disturbed sleep may also be caused by physical illnesses, like thyroid problems, heart disease or arthritis.

**The Geriatric Depression Scale (GDS)**  
Depression is common in late life, affecting nearly 5 million of the 31 million Americans aged 65 and older with clinically significant depressive symptoms reaching 13% in older adults aged 80 and older \((\text{Blazer})\). Major depression is reported in 8-16% of community dwelling older adults, 5-10% of older medical outpatients seeing a primary care provider, 10-12% of medical-surgical hospitalized older adults with 23% more experiencing significant depressive symptoms \((\text{Blazer})\). Recognition in long-term care facilities is poor and not consistent amongst studies \((\text{Blazer})\). Depression is not a natural part of aging. Depression is often reversible with prompt recognition and appropriate treatment. However, if left untreated, depression may result in the onset of physical, cognitive, functional, and social impairment, as well as decreased quality of life, delayed recovery from medical illness and surgery, increased health care utilization, and suicide.

While there are many instruments available to measure depression, the Geriatric Depression Scale (GDS), first created by \text{Yesavage, et al.}, has been tested and used extensively with the older population. The GDS Long Form is a brief, 30-item questionnaire in which participants are asked to respond by answering yes or no in reference to how they felt over the past week. Questions from the Long Form GDS which had the highest correlation with depressive symptoms in validation studies were selected for the short version. Of the 15 items, 10 indicated the presence of depression when answered positively, while the rest (question numbers 1, 5, 7, 11, 13)
indicated depression when answered negatively. Scores of 0-4 are considered normal, depending on age, education, and complaints; 5-8 indicate mild depression; 9-11 indicate moderate depression; and 12-15 indicate severe depression. The Short Form is more easily used by physically ill and mildly to moderately demented patients who have short attention spans and/or feel easily fatigued.

The GDS may be used with healthy, medically ill and mild to moderately cognitively impaired older adults. It has been extensively used in community, acute and long-term care settings.

The GDS was found to have a 92% sensitivity and a 89% specificity when evaluated against diagnostic criteria. The validity and reliability of the tool have been supported through both clinical practice and research. In a validation study comparing the Long and Short Forms of the GDS for self-rating of symptoms of depression, both were successful in differentiating depressed from non-depressed adults with a high correlation (r = .84, p < .001) (Sheikh & Yesavage).

The GDS is not a substitute for a diagnostic interview by mental health professionals. It is a useful screening tool in the clinical setting to facilitate assessment of depression in older adults especially when baseline measurements are compared to subsequent scores. It does not assess for suicidality.

The presence of depression warrants prompt intervention and treatment. The GDS may be used to monitor depression over time in all clinical settings. Any positive score above 5 on the GDS Short Form should prompt an in-depth psychological assessment and evaluation for suicidality.

**Geriatric Depression Scale: Short Form**

Choose the best answer for how you have felt over the past week:
1. Are you basically satisfied with your life? YES / NO
2. Have you dropped many of your activities and interests? YES/ NO
3. Do you feel that your life is empty? YES/ NO
4. Do you often get bored? YES/ NO
5. Are you in good spirits most of the time? YES / NO
6. Are you afraid that something bad is going to happen to you? YES/ NO
7. Do you feel happy most of the time? YES /NO
8. Do you often feel helpless? YES/ NO
9. Do you prefer to stay at home, rather than going out and doing new things? YES/ NO

10. Do you feel you have more problems with memory than most? YES/ NO

11. Do you think it is wonderful to be alive now? YES / NO

12. Do you feel pretty worthless the way you are now? YES/ NO

13. Do you feel full of energy? YES / NO

14. Do you feel that your situation is hopeless? YES/ NO

15. Do you think that most people are better off than you are? YES/ NO

Answers in bold indicate depression. Score 1 point for each bolded answer.

❖ A score > 5 points is suggestive of depression.
❖ A score ≥ 10 points is almost always indicative of depression.
❖ A score > 5 points should warrant a follow-up comprehensive assessment

What are Evidence-Based Practices (EBPs) for Depression in Older Adults?

Depression is one of the leading causes of world-wide disability. Untreated depression can lead to unnecessary suffering, poor health outcomes, high health care costs, and suicide. Effective treatments can reduce the severity of depression in up to 80 percent of older adults. EBPs for treating depression in older adults include: psychotherapy interventions, antidepressant medications, multidisciplinary geriatric mental health outreach services, and collaborative and integrated mental and physical health care. EBPs are interventions that have strong scientific proof that they produce positive outcomes for certain types of disorders. Other interventions—sometimes labeled promising practices—may also produce good outcomes, but research has not been conducted at a level to say that there is strong evidence for those practices. EBPs for older adults with depression are important because their use can:

✓ reduce symptoms of depression
✓ improve health
✓ improve functioning

The selection of an EBP depends on the older adult’s problems, the outcomes desired, and his or her treatment preferences. For example, both antidepressant medications and psychotherapy interventions are effective in the treatment of depression in older adults. The choice of one of these interventions over the other may vary with respect to the nature and severity of depression, prior history of effective treatments, the presence
of other health conditions or medications, tolerability of side effects or required effort, and the preferences and personal values of the older adult regarding these treatment characteristics.

**EBPs for Older Adults with Depression**
Four types of EBPs for treating older adults with depression have been systematically evaluated using randomized controlled trials.

- **Psychotherapy Interventions:** Psychotherapy is a general term for a method of treating mental disorders by talking about mental health problems and related issues with a mental health practitioner. It’s also known as talk therapy, counseling, psychosocial therapy or, simply, therapy or counseling. This KIT describes six psychotherapy EBPs, including cognitive behavioral therapy, behavioral therapy, problem solving treatment, interpersonal psychotherapy, reminiscence therapy, and cognitive bibliotherapy.

- **Antidepressant Medications:** Antidepressant medications are used to treat the symptoms of depression. Antidepressant medications act on chemical substances found in the brain, called neurotransmitters, which are deficient or out of balance in persons with depression.

- **Multidisciplinary Geriatric Mental Health Outreach Services:** Outreach services provide depression treatment in the homes of older adults or in the locations where older adults frequently spend time, instead of a clinic or office. These services often involve practitioners with different training and skill sets, such as psychiatrists, psychologists, social workers, nurses, or professional counselors. This KIT highlights two models of outreach services, including Psychogeriatric Assessment and Treatment in City Housing (PATCH) and the Program to Encourage Active, Rewarding Lives for Seniors (PEARLS).

- **Collaborative and Integrated Mental and Physical Health Care Services:** These programs provide mental health care in the primary health care setting. Programs include collaboration between mental health and physical health care practitioners. This document highlights two models of collaborative care, including Improving Mood, Promoting Access to Collaborative Treatment (IMPACT) and
When selecting which EBPs to add to the array of services in your community or agency, the first set of factors to consider includes:

- the severity of depression of the older adults in your target population
- outcomes affected
- service delivery settings
- timeframe of service delivery
- practitioner qualifications and requirements.

Table 1 summarizes these key features of specific EBPs for older adults with depression. You can use this information to help select the most appropriate EBP for your setting.
Health Status
It is common for older adults to have physical and mental health problems that co-occur with depression. Co-occurring physical health, mental health, and substance abuse problems can affect access and likelihood of response to treatment, as well as treatment preferences and outcomes. Many studies that test the effectiveness of a treatment place restrictions on the older adult participants. Studies may exclude older adults with cognitive impairment or substance abuse problems. Some studies also exclude older adults with co-occurring physical health or mental health disorders. A treatment might work equally well for people with and without co-occurring health problems; however, you will want to carefully monitor the outcomes to ensure that the program works for both groups of people.
The effectiveness of psychotherapy interventions for older adults with depression has been systematically reviewed by several groups of scientists. The following table lists comprehensive reviews of the different EBPs.

### Table 3: Recent Comprehensive Reviews that Evaluate the Evidence for the Psychotherapy EBPs

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<th>Study</th>
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**Cognitive Behavioral Therapy (CBT) for Older Adults**

CBT can be provided by professional mental health practitioners, including psychiatrists, psychologists, social workers, psychiatrically trained nurses, and licensed marriage and family counselors.

**Diagnoses or Disorders Addressed**

- Major Depression
- Minor Depression
- Dysthymia
- Depressive symptoms, as indicated by 10 or greater on the Hamilton Rating Scale for Depression, 10 or greater on the Beck Depression Inventory, or 11 or greater on the Geriatric Depression Scale
- Moderate to severe symptoms of depression, as indicated by 69 or greater on the Zung Self-rated Depression Scale.
➢ Subclinical symptoms of depression CBT also has been tested in older adults with anxiety disorders and schizophrenia

**Manual Availability**

CBT was developed by *Beck and colleagues* and has been adapted for use with older adults.

- Gallagher-Thompson, D., Steffen, A.M., & Thompson, L.W. (Eds.). *Handbook of behavioral and cognitive therapies with older adults*. New York: Springer. This volume reviews the evidence base for CBT with common mental health problems of later life (e.g., depression, generalized anxiety disorder, substance abuse) and with less common problems (e.g., schizophrenia, bipolar disorder, suicide ideation). Chapters also discuss the application of CBT to pain management, insomnia, personality disorders, dementia, and grief reactions.

- Laidlaw, K., Thompson, L., Dick-Siskin, L., & Gallagher-Thompson, D. *Cognitive behavior therapy with older people*. United Kingdom: John Wiley & Sons Ltd.


Therapist and accompanying patient manuals for older adults are available through the Stanford School of Medicine’s Older Adult and Family Center website: [http://oafc.stanford.edu](http://oafc.stanford.edu)

CBT has been implemented in many locations across the country by practitioners who are trained in this practice. CBT also has been combined with case management for low-income older adults, and was found to be more effective than CBT alone (*Areán and colleagues*). The principles of CBT have been used to develop an intervention for Mandarin-speaking Chinese Americans. The intervention is delivered in eight two-hour classes (*Dai and colleagues*). Numerous studies also have been conducted with distressed and/or depressed family caregivers who provide hands-on care to an older relative with Alzheimer’s disease or another form of dementia. The evidence base for the success of the application of CBT with
this population, on, including with ethnic minority caregivers, is found in a comprehensive review by Gallagher-Thompson and Coon (2007). A form of CBT, called Coping With Depression, has been adapted and provided in the Netherlands (Haringsma and colleagues, 2006). The Coping With Depression (CWD) course can be effectively delivered to older adults as an in-person or internet-based program (Spek and colleagues, 2007; 2008).

Behavioral Therapy (BT) for Older Adults
Behavioral Therapy (BT) is a structured, time-limited therapy. It examines the relationship between a person’s behaviors and their mood. BT conceptualizes depression as the result of a lack of pleasant events and an excess of unpleasant events in a person’s life. BT is typically delivered in up to 18 one-hour group or individual sessions that occur in a clinical setting. During sessions of BT, the practitioner teaches older adults to:

➢ monitor their mood
➢ record pleasant and unpleasant events
➢ notice the connection between pleasant events and positive mood, and unpleasant events and negative mood, and
➢ identify and increase participation in pleasant events

Diagnoses or Disorders Addressed
➢ Major Depression
➢ Minor Depression
➢ Depressive symptoms, as indicated by 10 or greater on the Hamilton Rating Scale for Depression, 10 or greater on the Beck Depression Inventory, or 11 or greater on the Geriatric Depression Scale.

Evidence and Outcomes
➢ Five randomized controlled trials have been conducted by multiple researchers.
➢ BT is an established effective treatment for older adults with depression, compared to no treatment or typical care. BT is effective in reducing depression symptoms and in improving the older adult’s life satisfaction and coping strategies.

Problem Solving Treatment (PST) for Older Adults
Problem Solving Treatment (PST) is a psychotherapy that is designed to help older adults develop skills for dealing with stress and feelings of depression. PST can be delivered by a variety of health, mental
health, and social service practitioners in mental health, long-term care, residential, and primary care settings. PST is delivered in 12 or fewer sessions outlined in a manual. Training can be conducted over a relatively short number of training sessions. It is effective in treating depression in older adults.

Problem Solving Treatment (PST) is a short term, intensive intervention where the older adult and the practitioner (often a nurse or social worker) identify problems that the older adult is facing and develop an action plan to solve the problems. PST encourages older adults to identify a particular goal to reduce depression and teaches a systematic and objective approach to working on problems. PST is based on the idea that deficiencies in social problem-solving skills increase the risk for symptoms of depression. PST trains older adults to develop an effective and adaptive approach for solving problems and coping with problems that lead to mental distress. Several concrete steps are associated with PST. These include:

- clarify and define the problem
- set a realistic goal
- generate multiple solutions
- evaluate and compare solutions
- select a feasible solution
- implement the solution
- evaluate the outcomes

PST is typically delivered in 12 or fewer one-hour sessions. PST can be provided by trained practitioners with a bachelor’s degree or higher who work in the health or social service professions. The model has been developed specifically for non-mental health settings, like primary care medicine, so that the intervention could be delivered by a variety of health care professionals, regardless of their mental health background.

Diagnoses or Disorders Addressed

- Major depression
- Minor depression
- Dysthymia
- Severe depression symptoms, as indicated by a CES-D score of 22 or greater, or mild to severe depression symptoms as identified by the Beck Depression Inventory.
Interpersonal Psychotherapy (IPT) for Older Adults

Interpersonal psychotherapy (IPT) is a structured, time-limited therapy. IPT is based on the idea that interpersonally relevant issues often precede depression and that depression can lead to interpersonal problems. IPT focuses on current interpersonal relationships within four areas. Treatment can address one or more of these areas.

➢ Unresolved Grief (complicated bereavement): the practitioner facilitates mourning and helps the older adult find new activities and relationships to compensate for the loss,
➢ Role Transition (major life change): the practitioner helps the older adult deal with change by recognizing the positive and negative aspects of the new and old roles and adapting to the new role,
➢ Interpersonal Role Disputes (conflict with another person): the practitioner helps the older adult understand the relationship, the nature of the dispute, and options to resolve and
➢ Interpersonal Deficits (problems initiating or sustaining relationships): the practitioner helps the older adult identify problematic social skills and improve these skills within the context of the therapeutic frame.

IPT uses several techniques to bring about change. These include elements of exploration, clarification, and encouragement of affect; communication analysis; role playing; extensive psycho education about the biopsychosocial model of depression; and encouragement of alternative coping strategies.

IPT is typically delivered in 16 (and sometimes fewer) individual sessions that are held weekly for 50 to 60 minutes. IPT is divided into three phases.

1) In the first three sessions of IPT, a diagnosis of depression is made and explained, an inventory of social relationships is collected, recent interpersonal problems are identified, and the goals of treatment are set
2) In the intermediate sessions (sessions 4-13), the practitioner works with the older adult to address the interpersonal problem(s).
3) In the termination sessions (sessions 14-16), the course of treatment is reviewed and feelings associated with the end of treatment are discussed. The older adult is encouraged to develop ways to identify and address symptoms of depression if they should arise in the future.

Practitioners IPT can be delivered by mental health care professionals, including psychiatrists, psychologists, social workers, and nurses.
Diagnoses or Disorders Addressed
➢ Major Depression
➢ Minor Depression
➢ Sub-Dysthymic Depression, as defined by depressive symptoms (Geriatric Depression Scale score greater than 10) without meeting diagnostic criteria for major depression or dysthymia.

Cognitive Bibliotherapy (CB) for Older Adults
Cognitive bibliotherapy is a self-directed psychotherapy that is designed to change the thought patterns that cause or maintain depression. It is delivered through self-guided written materials, which are complemented by oversight from a mental health practitioner. No formal treatment manual is available as this is a self-directed intervention. Cognitive bibliotherapy is effective for treating mild or moderate levels of depression in older adults.

Cognitive bibliotherapy involves reading books and completing written exercises in order to learn about depression and ways to reduce its symptoms. Reading materials and written exercises are completed outside of a clinic setting, often at the participant’s home and at the participant’s own pace. Similar to cognitive behavioral therapy (CBT), cognitive bibliotherapy is intended to change the thinking and behaviors that cause or maintain depression. The book Feeling Good, by David Burns, was read by older adults in all studies of cognitive bibliotherapy published to date. After learning to monitor depressive symptoms, readers are introduced to the concept of cognitive distortions and to techniques designed to help them question depressive thoughts and improve their mood. Feeling Good is divided into seven parts entitled:
➢ theory and research
➢ practical applications (i.e., building self-esteem, defeating guilt),
➢ realistic depressions (i.e., depression is not sadness),
➢ prevention and personal growth defeating hopelessness and suicide,
➢ coping with the stresses and strains of daily living, and
➢ the chemistry of mood (i.e., the mind-body connection, antidepressant medications).

Older adults can complete a course of cognitive bibliotherapy over a four-week period. During this time, it is important that practitioners with expertise in depression and CBT have brief, weekly contact
with the older adult. Cognitive bibliotherapy can be an accessible alternative to formal mental health interventions in clinic-based settings. This may be particularly relevant to older adults, who traditionally have underutilized mental health treatment.

Cognitive bibliotherapy is completed by the older adult. For ethical and practical reasons, completely self-administered programs for older adults with depression are not advised (Scogin and colleagues). Practitioners with expertise in depression and CBT should provide at least minimal contact with the older adult.

Diagnoses or Disorders Addressed
➢ Major depression
➢ Minor depression
➢ Dysthymia
➢ Mild to moderate depressive symptoms, as indicated by a score of 10 or greater on the Hamilton Depression Rating Scale, or 11 or greater on the Geriatric Depression Scale.

Reminiscence Therapy (RT) for Older Adults
Reminiscence therapy for older adults is a technique that is designed to help older adults resolve conflicts and accept their successes or failures. It is generally provided in long-term care facilities, senior housing, and senior community centers by trained nurses and therapists. It is effective in treating mild levels of depression. Technical assistance and published protocols are available.

Reminiscence therapy involves the discussion of past activities, events and experiences with another person or group of people. It can be provided in many forms in order to prevent, assess, and intervene with depression and other mental health issues. Structured reminiscence approaches include Life Review and Guided Autobiography.

The concept of Life Review was first published by Robert N. Butler in 1963. The life review process helps older adults resolve conflicts and accept both the successes and failures of their lives. In the life review process, practitioners use weekly topics to guide older adults in recalling memories from different stages of their lives and to stimulate discussion of major life events. These processes are thought to promote feelings of control over past and present life events by counteracting learned helplessness.
Structured reminiscence therapy is typically provided in a group setting, led by a mental health practitioner, and occurs over four to twelve weekly sessions that last 60–90 minutes. There are several potential benefits of reminiscence approaches.

✓ Reminiscence approaches can be used during the assessment process to bolster older adults’ confidence and self-esteem.
✓ Reminiscence can be integrated into a number of treatment approaches, including cognitive behavioral therapy. These approaches are effective in individual, group, marital/family, and milieu therapy modalities.
✓ Practitioners can use reminiscence materials to develop therapeutic resource states that facilitate change.
✓ Reminiscence approaches can help obtain and maintain attention and rapport for those who want to educate older adults about mental health issues.

Reminiscence therapy can be provided by practitioners who have received training in reminiscence therapy. Practitioners can include mental health professionals, nurses, chaplains, and other members of a multi-disciplinary team. Practitioners should integrate their reminiscence approaches within their theoretical approach and treatment plan.

Diagnoses or Disorders Addressed
➢ Major Depression
➢ Depressive symptoms, as indicated by a Geriatric Depression Scale (GDS) score of 14 or greater, or 16 or greater on the CES-D.

Reminiscence therapy has been used to prevent and assess mental health disorders. It has been used in older adults with anxiety and health conditions that cause anxiety; behavioral problems due to dementia, delirium, or other physical health disorders; normal and unresolved grief; and substance abuse. Reminiscence therapy also has been tested in older adults with dementia.

**Antidepressant Medications**
Antidepressant medications are provided by health care practitioners who are licensed to prescribe and monitor medications. They are effective in treating depression in older adults. Antidepressant medications are the most commonly used intervention for the treatment of depression in older adults.
Most antidepressant medications are prescribed by primary care practitioners as the primary treatment for depression. For some older adults, the combination of psychotherapy and antidepressant medications may be more effective than antidepressant medication alone (Thompson and colleagues) and may prevent or delay the recurrence of depression (Reynolds and colleagues). Medication treatment may be the most appropriate treatment for some people with depression. This may include older adults who have depression with psychotic symptoms, severe depression that has responded to antidepressant medications in the past, or severe depression that does not respond to psychotherapy. Medications also may be most appropriate for older adults with depression and dementia or another cognitive impairment that limits their ability to benefit from psychotherapy.

Although many older adults with major depression prefer psychotherapy (Gum and colleagues), there are several reasons why older adults may prefer to receive antidepressant medications. Older adults may prefer medications if they do not wish to attend multiple psychotherapy sessions. For the older adult, multiple psychotherapy sessions may be associated with challenges in transportation, physical mobility, cognition, cost, and stigma perceived in attending appointments with a mental health practitioner. Psychotherapy also may be inaccessible in some locations where older adults receive care. The 50 percent Medicare co-payment for outpatient psychotherapy also may have been a substantial barrier to the use of psychotherapy for some older adults.

Antidepressant medications are administered as pills that are prescribed by a health care practitioner. Antidepressant medications act on chemical substances found in the brain, called neurotransmitters, which are deficient or out of balance in persons with depression. Antidepressants medications may work by improving the levels of neurotransmitters that support the functioning of brain cells. A particular antidepressant medication is selected on the basis of the characteristics of the older adult, the least likelihood of problematic side effects, and any past personal or family history of responding to specific antidepressant medications. The health care practitioner regularly monitors the patient and adjusts the medication dosage accordingly. For example, a partial treatment response may require increasing the dose of the antidepressant, or switching to a different antidepressant. The development of common side effects such as sedation, insomnia, agitation, or nausea may indicate the need to decrease the dose consider a different antidepressant if these side effects do not resolve or if
they worsen over time. Finally, the development of more serious side effects such as confusion, irregular heart rhythm, marked increase or drop in blood pressure, falls, or allergic responses to medication require immediate medical attention. A variety of types of antidepressant medications can reduce symptoms of depression in older adults. For example, selective serotonin reuptake inhibitors (SSRIs) are often effective in treating depression. SSRIs include Celexa (citalopram), Lexapro (escitalopram), Luvox (fluvoxamine), Paxil (paroxetine), Prozac (fluoxetine), and Zoloft (sertraline).

Tricyclic antidepressants (TCAs) are an older and sometimes less expensive type of medicine for depression. These drugs are effective, but may have side effects that can be particularly trouble in older persons such as increased falls due to a drop in blood pressure on standing, irregular heart rate, confusion, or urinary retention.

Monoamine oxidase inhibitors (MAOIs) are another group of older antidepressant medications that are rarely prescribed, and only in situations when other antidepressants have failed. MAOIs are generally contraindicated in older adults as they can be associated with falls due to low blood pressure or dangerous episodes of extremely high blood pressure when taken with particular foods (e.g., aged cheese, Chianti wine) or medications (e.g., SSRIs, stimulants, cough medications, painkillers). Other non-SSRI antidepressants include Cymbalta (duloxetine), Desyrel (trazadone), Effexor (venlafaxine), Serzone (nefazodone), Remeron (mirtazapine), and Wellbutrin (bupropion).
Antidepressant medications are one of the most widely available treatments for older adults with depression. They are available in physical health and mental health care settings that have practitioners who are licensed to prescribe medications.

Antidepressant medications can be provided by health care professionals who are licensed to prescribe medications (e.g., psychiatrists, primary care practitioners, nurse practitioners, and psychologists – psychologists have prescribing privileges in New Mexico and Louisiana). The common occurrence of major physical health conditions, multiple medications, and greater sensitivity to side effects experienced by older adults requires that a medical evaluation and review occur before antidepressants are prescribed, followed by ongoing medical supervision.

Diagnoses or Disorders Addressed
- Major Depression
- Minor Depression
➢ Dysthymia
➢ Antidepressant medications also are effective in older adults with Unipolar Depression and Non-specified Depression.

5. Geriatric Counseling Considerations

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

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

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

The effects of ageism are numerous and potentially debilitating. Ageism can constitute the societal sacrifice of older people for the sake of younger people. In the workplace and in the family unit, older individuals (i.e., those over age 65, which is an admittedly arbitrary cutoff for defining the “elderly”) are often dismissed as unable to make adequate contributions to the group. Ageism also encompasses the assumption, common even among counselors and other caregivers, that older individuals have lost much of the capacity for self-management and self-care that characterizes younger individuals.
Ageism also incorrectly assumes that the process of aging is invariably associated with a decline in mental and physical competencies. It can and does provide a rationalized excuse for forcing older workers to retire. In the United States, federal legislation has been enacted to prevent age discrimination in the workplace, but many older workers still find that they are devalued and passed over for promotions or other benefits simply because of negative assumptions regarding their age and its putative impact upon performance (Butler, et al).

In the context of counseling and therapy, ageism can negatively impact upon the capacity of professional caregivers to work effectively with clients. Attributions of individual traits, behaviors, needs, or other issues addressed in the context of counseling can distort the process itself. For mental health caregivers, serving the older client necessitates coming to terms with one’s own fears and anxieties regarding the aging process (Butler, et al).

**Counter-transference and Transference**

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

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

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

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

Counter-transference may be more difficult in the context of dealing with older clients. Butler, et al pointed out that some aged clients may stimulate therapists’ fears about his or her own old age, arouse the therapist’s conflicts about relationships with parental figures, or suggest to the therapist that intervention is wasted effort because the older client may be nearing death. When therapists working with elderly clients allow negative attitudes to intervene, therapy cannot be successful.

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

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

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

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

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

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

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

**Assessments**

Older clients should be as thoroughly assessed or evaluated as any other particular population. Geriatric assessment is a multidisciplinary evaluation in which the multiple problems of older persons are identified, described, and explained. The resources and strengths of the individual are identified, service needs assessed, and a coordinated care plan developed in order to focus interventions (Butler, et al).
It is important to recognize that the older individual needs a multidisciplinary assessment in which a number of professionals pool their knowledge and expertise to construct as complete a profile of the psychiatric, physical, social, financial, and other problems of the older client as is possible. Such assessments fulfill preventive and screening functions as well as diagnostic functions.

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

**Interventions**

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

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

Process becomes more important than content in this therapist/client relationship. Process may be defined as dealing with or addressing the underlying verbal or nonverbal feelings expressed by the client. Warmth and empathy without condescension are essential aspects of the therapist’s behavior and attitudes. Realistic treatment goals should be set via consultation with the client and other caregivers. Assisting the older person
who has lost a loved one, for example, may involve addressing issues of guilt and atonement as well as the client’s personal fears regarding illness or death. In any event, interventions that are successful with older clients are those that are framed to meet specific needs and result in positive improvements in mood, affect, outlook, and functioning.

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

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

6. Elder Abuse Reporting

Throughout the past three decades, significant progress has been made in increasing awareness of abusive relationships. Nonetheless, child abuse and domestic violence continue to receive more recognition than elder abuse and more attention in both public and medical settings.

Due to the growing number of older Americans, the number of elder abuse cases will increase. The impact of elder abuse as a public health issue will likely grow in the future. Abuse victims have twice as many physician visits compared with the general US population. This of course allows opportunities for detection. Since many elders are isolated, an unexpected visit to the emergency department may be the only opportunity for detection. Emergency physicians are in a unique position to affect diagnosis and management of this vulnerable population.

Elder abuse encompasses a range of behaviors, events, and circumstances. Elder abuse usually consists of repetitive incidences including any act of commission or omission that result in harm or threatened harm to the health and welfare of an older adult.
The *US National Academy of Sciences* defines elder abuse as follows:

- "Intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended), to a vulnerable elder by a caregiver or other person who stands in a trusted relationship to the elder.

- *Failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm*”.

However, terms may vary among professionals and researchers, and usage is not consistent in the laws of different states. For example, the age at which a person is considered elderly, usually 60 or 65 years, varies. Seven categories of elder abuse have been described by the *National Center on Elder Abuse (NCEA)* including:

- **Physical abuse** - Any act of violence that causes pain, injury, impairment, or disease, including striking, pushing, force-feeding, and improper use of physical restraints or medication

- **Emotional or psychological abuse** - Conduct that causes mental anguish including threats, verbal or nonverbal insults, isolation, and humiliation. Some legal definitions require identification of at least 10 episodes of this type of behavior within a single year to constitute abuse.

- **Financial or material exploitation** - Misuse of an elderly person's money or assets for personal gain. Acts such as stealing (money, social security checks, possessions) or coercion (changing a will, assuming power of attorney) constitute financial abuse.

- **Neglect** - Failure of a caretaker to provide for the patient's basic needs. As in the previous examples of abuse, neglect can be physical, emotional, or financial. Physical neglect is failure to provide eyeglasses or dentures, preventive health care, safety precautions, or hygiene. Emotional neglect includes failure to provide social stimulation (leaving an older person alone for extended periods). Financial neglect involves failure to use the resources available to restore or maintain the well-being of the aging adult.

- **Sexual abuse** - Nonconsensual intimate contact or exposure or any similar activity when the patient is incapable of giving consent. Family members, friends, institutional employees, and fellow patients can commit sexual abuse.
• **Self-neglect** - Behavior in which seniors compromise their own health and safety, as when an aging adult refuses needed help with various daily activities. When the patient is deemed competent, many ethical questions arise regarding the patient's right of autonomy and the physician's oath of beneficence.

• **Abandonment** - The desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder.”

*Source: National Center on Elder Abuse (NCEA)*

**Occurrence**

A report from the *National Research Council* suggests that 1-2 million Americans age 65 years or older have been injured, exploited, or otherwise mistreated. Other studies suggest that 3-10% of elders are abused or neglected. Several variables contribute to the underestimation of abused elders including fear, shame, guilt, and/or lack of information. A variety of professionals underreport elder abuse due to lack of recognition and awareness of reporting requirements. A significant amount of research excludes specific demographics such as persons unable to respond to a survey, speakers of languages other than English, and persons with mental illness. Studies have shown that only 1 in 6 victims are likely to self-report mistreatment to the appropriate legal authorities.

Elder physical abuse victims, caregiver neglect, or self-neglect have triple the mortality of those never abused. Proactive detection and intervention by professionals could potentially lead to decreased mortality. Healthcare provider proactivity is essential.

**Race**

Elder abuse exists throughout all racial, socioeconomic, and religious backgrounds. The *NCEA* found the following racial and ethnic distribution among older persons who had been abused:

- White, non-Hispanic – 66.4%
- Black – 18.7%
- Hispanic – 10%
- Other – 4.9%

**Gender**

Women are believed to be the most common victims of abuse, perhaps because they report abuse at higher rates or because the severity of injury in
women typically is greater than in men. Numerous studies, however, have found no differences based on sex.

**Age**

By definition, elder abuse occurs in the elderly, although there is no universally accepted definition of when old age begins. Typically, 60 or 65 years is considered the threshold of old age.

The American Medical Association has recommended that health care professionals regularly ask elderly patients about abuse, even when there are no visible signs/symptoms. There is not yet a consensus on what constitutes an appropriate screen or assessment instrument for detecting elder abuse.

Risk factors of elder abuse include:

- Shared living situation with abuser, likely due to an increased opportunity for contact
- Dementia
- Social isolation
- Pathologic characteristics of perpetrators such as mental illness and alcohol misuse

It would be helpful for providers to consider these "red flags" while providing services for the elderly. The presence of red flags is an indicator that a more in-depth history and/or assessment are necessary. While evaluating a client for possible elder abuse, the provider may want to consider simple and direct questions which are posed in a nonjudgmental or nonthreatening manner. It is also helpful to interview the patient and caregiver both together and separately to detect disparities offering clues to the diagnosis of abuse. Accurate and objective documentation of the interview is important partially because findings may be entered as evidence in criminal trials or in guardianship hearings. Documentation must be complete, thorough, and legible. It is helpful to quote direct statements made by the client.

**Physical**

In a systematic summary of the published work on forensic markers of elder abuse with respect to physical findings, there is a paucity of primary data. Most research on clinical findings purported to be common in elder abuse derives from anecdotes, case reports, or small case series.
Although not guided strongly by evidence, a number of clinical findings and observations make elder abuse a strong possibility, including the following:

- Several injuries in various stages of evolution
- Unexplained injuries
- Delay in seeking treatment
- Injuries inconsistent with history
- Contradictory explanations given by the patient and caregiver
- Laboratory findings indicating under dosage or over dosage of medications
- Bruises, welts, lacerations, rope marks, burns
- Venereal disease or genital infections
- Dehydration, malnutrition, decubitus ulcers, poor hygiene
- Signs of withdrawal, depression, agitation, or infantile behavior

**Causes**

Many theories have been developed to explain abusive behavior toward elderly people. Clearly, no single answer exists to explain behavior in an abusive relationship. A number of psychosocial and cultural factors are involved.

Theories of the origin of mistreatment of elders have been divided into 4 major categories, as follows: physical and mental impairment of the patient, caregiver stress, trans-generational violence, and psychopathology in the abuser.

- **Physical and mental impairment of the patient**
  - Recent studies have failed to show direct correlation between patient frailty and abuse, even though it had been assumed that frailty itself was a risk factor for abuse.
  - Physical and mental impairment nevertheless appear to play an indirect role in elder abuse, decreasing seniors' ability to defend themselves or to escape, thus increasing vulnerability.

- **Caregiver stress**
  - This theory suggests that elder abuse is caused by the stress associated with caring for an elderly patient, compounded by stresses from the outside world.
The effect of stress factors (e.g., alcohol or drug abuse, potential for injury from falls, incontinence, elderly persons' violent verbal behavior, employment problems, low income on the part of the abuser) may all culminate in caregivers' expressions of anger or antagonism toward the elderly person, resulting in violence.

This theory, however, does not explain how individuals in identically stressful situations manage without abusing seniors in their care. Stress should be seen more as a trigger for abuse than as a cause.

- **Trans-generational violence**: This theory asserts that family violence is a learned behavior that is passed down from generation to generation. Thus, the child who was once abused by the parent continues the cycle of violence when both are older.

- **Psychopathology in the abuser**: This theory focuses on a psychological deficiency in the development of the abuser. Drug and alcohol addiction, personality disorders, mental retardation, dementia, and other conditions can increase the likelihood of elder abuse. In fact, family members with such conditions are most likely to be primary caretakers for elderly relatives because they are the individuals typically at home due to lack of employment.

- **Other risk factors** in abuse are (1) shared living arrangements between the elder person and the abuser, (2) dependence of the abuser on the victim, and (3) social isolation of the elder person.

A mandated reporter must report a known or suspected instance of elder or dependent adult abuse when, in his or her professional capacity, or within the scope of his or her employment, he or she (1) has observed or has knowledge of an incident that reasonably appears to be physical abuse, neglect, financial abuse, abandonment, abduction, or isolation; (2) is told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, neglect, financial abuse, abandonment, abduction, or isolation; or (3) reasonably suspects abuse.

**Optional Reports**: Mandated reporters may report a known or suspected instance of elder or dependent adult abuse when they have knowledge of or reasonably suspect that a form of elder or dependent adult abuse for which a report is not mandated has been inflicted upon an elder or dependent adult or that the elder or dependent adult's emotional well-being is threatened in any other way.
**Definition of Elder**: An “elder” is a person who is age 65 years or older.

**Definition of Dependent Adult**: A dependent adult is a person, between the ages of 18 years and 64 years, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights.

Mandated reporters, including therapists, are now required to report the following: Known and reasonably suspected physical abuse of an elder or dependent adult. Instances of known and reasonably suspected neglect, financial abuse, abandonment, abduction, and/or isolation of an elder or dependent adult, and any other treatment that results in physical harm, pain, or mental suffering.

As a mandated reporter, a psychotherapist is required to make a report of known or suspected elder or dependent adult abuse when, in his or her professional capacity, or within the scope of his or her employment, he or she has observed or has knowledge of an incident that reasonably appears to be abuse, is told by an elder or dependent adult that he or she has experienced behavior constituting abuse; and/or reasonably suspects abuse.

Abuse of an elder or dependent adult includes the following categories: Physical abuse, neglect, financial abuse, abandonment, abduction, isolation, and any other form of treatment that results in physical harm, pain, or mental suffering. Mental suffering may consist of fear, confusion, severe depression, agitation, or other serious emotional distress caused by threats, harassment, or other forms of intimidating behavior.

Physical Abuse includes assault, assault with a deadly weapon or with force likely to cause great bodily injury; battery; sexual assault, unreasonable physical restraint; prolonged or continual deprivation of water or food; and the use of physical or chemical restraint for punishment, for a period of time beyond that for which the medication was ordered through instructions from a licensed physician or surgeon caring for the elder or dependent adult, and/or for any purpose not authorized by the elder or dependent adult's physician or surgeon.

Neglect refers to the negligent failure of any person having the care or custody of an elder or dependent adult to exercise that degree of care that a reasonable person in a similar position would provide. Neglect also includes self-neglect, the negligent failure of an elder or dependent adult to provide a reasonable degree of care to himself or herself.
Specific examples of neglect include the failure to assist in personal hygiene or in the provision of food, clothing, or shelter as well as the failure to provide medical care for physical or mental health needs and the failure to prevent malnutrition or dehydration.

Financial Abuse means concealing, taking, or appropriating an elder or dependent adult's property or money to any wrongful use or with the intent to defraud.

Abandonment, desertion or willful abandonment by a person having the care or custody of the elder or dependent adult person under circumstances in which a reasonable person would continue to provide care and custody.

Isolation, deliberately preventing an elder or dependent adult from receiving his or her mail or phone calls, false imprisonment; and/or the physical restraint of an elder or dependent adult for the purpose of preventing him or her from meeting with his or her visitors.

Reports of known or reasonably suspected elder or dependent adult abuse must be filed by telephone immediately or as soon as practically possible. A written report must then be sent within two working days.

Reporters should generally make reports to their county's adult protective agency or a local law enforcement agency. There are two exceptions to this, however: First, if the abuse occurred in a state mental health hospital or state developmental center, the report should be made to designated investigators of the State Department of Mental Health or the State Department of Developmental Services or to the local law enforcement agency. Second, if the abuse occurred in a long-term care facility (other than a state mental hospital or a state developmental center), reports should be made to the local ombudsman or to the local law enforcement agency.

Any person legally required to report elder or dependent adult abuse who knowingly fails to report can be found guilty of a misdemeanor that is punishable by not more than six months in the county jail or a fine not to exceed $1,000 or both imprisonment and a fine. A therapist who fails to make a timely mandated elder or dependent adult abuse report may also face disciplinary action by their governing board and civil action for damages.

The law provides that no person required making a report of elder or dependent adult abuse shall be criminally or civilly liable for such a report, as long as it cannot be proven that the report was made falsely.
7. Older Adults, Substance Abuse, and Mental Health

Treatment Improvement Protocols (TIPs) are best practice guidelines for the treatment of substance abuse, provided as a service of the Substance Abuse and Mental Health Service Administration's Center for Substance Abuse Treatment (CSAT). This TIP brings together the literature on substance abuse and gerontology to recommend best practices for identifying, screening, assessing, and treating alcohol and prescription drug abuse among people age 60 and older.

Alcohol Abuse
Physiological changes, as well as changes in the kinds of responsibilities and activities pursued by older adults, make established criteria for classifying alcohol problems often inadequate for this population.

Abuse of Prescription Drugs
People 65 and older consume more prescribed and over-the-counter medications than any other age group in the United States. Prescription drug misuse and abuse is prevalent among older adults not only because more drugs are prescribed to them but also because, as with alcohol, aging makes the body more vulnerable to drugs' effects.

Figure 3-6: Drug-Alcohol Interactions and Adverse Effects

<table>
<thead>
<tr>
<th>Drug</th>
<th>Adverse Effect With Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen</td>
<td>Severe hepatotoxicity with therapeutic doses of acetaminophen in chronic alcoholics</td>
</tr>
<tr>
<td>Anticoagulants, oral</td>
<td>Decreased anticoagulant effect with chronic alcohol abuse</td>
</tr>
<tr>
<td>Antidepressants, tricyclic</td>
<td>Combined central nervous system depression decreases psychomotor performance, especially in the first week of treatment</td>
</tr>
</tbody>
</table>
Aspirin and other nonsteroidal anti-inflammatory drugs
Increased the possibility of gastritis and gastrointestinal hemorrhage

Barbiturates
Increased central nervous system depression (additive effects)

Benzodiazepines
Increased central nervous system depression (additive effects)

Beta-adrenergic blockers
Masked signs of delirium tremens

Bromocriptine
Combined use increases gastrointestinal side effects

Caffeine
Possible further decreased reaction time

Cephalosporins and Chloramphenicol
Disulfiram-like reaction with some cephalosporins and chloramphenicol

Chloral hydrate
Prolonged hypnotic effect and adverse cardiovascular effects

Cimetidine
Increased central nervous system depressant effect of alcohol

Cycloserine
Increased alcohol effect or convulsions

Digoxin
Decreased digitalis effect

Disulfiram
Abdominal cramps, flushing, vomiting, hypotension, confusion, blurred vision, and psychosis

Guanadrel
Increased sedative effect and orthostatic hypotension

Glutethimide
Additive central nervous system depressant effect

Heparin
Increased bleeding

Hypoglycemics, sulfonylurea
Acutely ingested, alcohol can increase the hypoglycemic effect of sulfonylurea drugs; chronically ingested, it can decrease hypoglycemic effect of these drugs

<table>
<thead>
<tr>
<th>Figure 3-6 Drug-Alcohol Interactions and Adverse Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aspirin and other nonsteroidal anti-inflammatory drugs</strong></td>
</tr>
<tr>
<td><strong>Barbiturates</strong></td>
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<tr>
<td><strong>Benzodiazepines</strong></td>
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<tr>
<td><strong>Beta-adrenergic blockers</strong></td>
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<tr>
<td><strong>Bromocriptine</strong></td>
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<tr>
<td><strong>Caffeine</strong></td>
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<tr>
<td><strong>Cephalosporins and Chloramphenicol</strong></td>
</tr>
<tr>
<td><strong>Chloral hydrate</strong></td>
</tr>
<tr>
<td><strong>Cimetidine</strong></td>
</tr>
<tr>
<td><strong>Cycloserine</strong></td>
</tr>
<tr>
<td><strong>Digoxin</strong></td>
</tr>
<tr>
<td><strong>Disulfiram</strong></td>
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<tr>
<td><strong>Guanadrel</strong></td>
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<tr>
<td><strong>Glutethimide</strong></td>
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<tr>
<td><strong>Heparin</strong></td>
</tr>
<tr>
<td><strong>Hypoglycemics, sulfonylurea</strong></td>
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</tbody>
</table>
Any use of drugs in combination with alcohol carries risk; abuse of these substances raises that risk, and multiple drug abuse raises it even further. For example, chronic alcoholics who use even therapeutic doses of acetaminophen may experience severe hepatoxicity. Alcohol can increase lithium toxicity and enhance central nervous system depression in persons taking tricyclic antidepressants. High doses of benzodiazepines used in conjunction with alcohol or barbiturates can be lethal. The many possible unfavorable reactions between prescription drugs and alcohol are summarized in Figure 3-6.

**Sedative/Hypnotics**

Aging changes sleep architecture, decreasing the amount of time spent in the deeper levels of sleep (stages three and four) and increasing the number and

<table>
<thead>
<tr>
<th>Drug</th>
<th>Adverse Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tolbutamide, chlorpropamide</td>
<td>Disulfiram-like reaction</td>
</tr>
<tr>
<td>Isoniazid</td>
<td>Increased liver toxicity</td>
</tr>
<tr>
<td>Ketoconazole, griseofulvin</td>
<td>Disulfiram-like reaction</td>
</tr>
<tr>
<td>Lithium</td>
<td>Increased lithium toxicity</td>
</tr>
<tr>
<td>Meprobamate</td>
<td>Synergistic central nervous system depression</td>
</tr>
<tr>
<td>Methotrexate</td>
<td>Increased hepatic damage in chronic alcoholics</td>
</tr>
<tr>
<td>Metronidazole</td>
<td>Disulfiram-like reaction</td>
</tr>
<tr>
<td>Nitroglycerin</td>
<td>Possible hypotension</td>
</tr>
<tr>
<td>Phenformin</td>
<td>Lactic acidosis (synergism)</td>
</tr>
<tr>
<td>Phenothiazines</td>
<td>Additive central nervous system depressant activity</td>
</tr>
<tr>
<td>Phenytoin</td>
<td>Acutely ingested, alcohol can increase the toxicity of phenytoin; chronically ingested, it can decrease the anticonvulsant effect of phenytoin</td>
</tr>
<tr>
<td>Quinacrine</td>
<td>Disulfiram-like reaction</td>
</tr>
<tr>
<td>Tetracyclines</td>
<td>Decreased effect of doxycycline</td>
</tr>
</tbody>
</table>

*Source: Korrapati and Vestal*
duration of awakenings during the night. However, these new sleep patterns
do not appear to bother most medically healthy older adults who recognize
and accept that their sleep will not be as sound or as regular as when they
were young. Although benzodiazepines and other sedative/hypnotics can be
useful for short-term amelioration of temporary sleep problems, no studies
demonstrate their long-term effectiveness beyond 30 continuous nights, and
tolerance and dependence develop rapidly.

**Identification, Screening, and Assessment**

The Consensus Panel recommends that every 60-year-old should be
screened for alcohol and prescription drug abuse as part of his or her regular
physical examination. However, problems can develop after the screening
has been conducted, and concurrent illnesses and other chronic conditions
may mask abuse. Although no hard-and-fast rules govern the timing of
screening, the Panel recommends screening or rescreening if certain physical
symptoms are present or if the older person is undergoing major life changes
or transitions. Do not use stigmatizing terms like alcoholic or drug abuser
during these encounters.

**Instruments**

The Panel recommends use of the CAGE Questionnaire and the Michigan
Alcohol Screening Test-Geriatric Version (MAST-G) to screen for alcohol
use among older adults. The Alcohol Use Disorders Identification Test
(AUDIT) is recommended for identifying alcohol problems among older
members of ethnic minority groups.

**Treatment**

The Consensus Panel recommends that the least intensive treatment options
be explored first with older substance abusers. These initial approaches,
which can function either as pretreatment strategy or treatment itself, are
brief intervention, intervention, and motivational counseling. They may be
sufficient to address the problem; if not, they can help move a patient toward
specialized treatment. The Consensus Panel recommends that every
reasonable effort be made to ensure that older substance abusers, including
problem drinkers, enter treatment. Brief intervention is the recommended
first step, supplemented or followed by intervention and motivational
interviewing. Because many older problem drinkers are ashamed about their
drinking, intervention strategies need to be non-confrontational and
supportive.
Conducting Brief Interventions

A brief intervention is one or more counseling sessions, which may include motivation for change strategies, patient education, assessment and direct feedback, contracting and goal setting, behavioral modification techniques, and the use of written materials such as self-help manuals. An older adult-specific brief intervention should include the following steps:

1. Customized feedback on screening questions relating to drinking patterns and other health habits such as smoking and nutrition.
2. Discussion of types of drinkers in the United States and where the patient's drinking patterns fit into the population norms for his or her age group.
3. Reasons for drinking. This is particularly important because the practitioner needs to understand the role of alcohol in the context of the older patient's life, including coping with loss and loneliness.
4. Consequences of heavier drinking. Some older patients may experience problems in physical, psychological, or social functioning even though they are drinking below cutoff levels.
5. Reasons to cut down or quit drinking. Maintaining independence, physical health, financial security, and mental capacity can be key motivators in this age group.
6. Sensible drinking limits and strategies for cutting down or quitting. Strategies that are useful in this age group include developing social opportunities that do not involve alcohol, getting reacquainted with hobbies and interests from earlier in life, and pursuing volunteer activities, if possible.
7. Drinking agreement in the form of a prescription. Agreed-upon drinking limits that are signed by the patient and the practitioner are particularly effective in changing drinking patterns.
8. Coping with risky situations. Social isolation, boredom, and negative family interactions can present special problems in this age group.
9. Summary of the session.

If the client does not respond to the brief intervention, two other approaches should be considered; Intervention and motivational interviewing.

Intervention

The Panel recommends the following modifications to interventions for older patients. No more than one or two relatives or close associates should
be involved along with the health care provider; having too many people present may be emotionally overwhelming or confusing for the older person. Inclusion of grandchildren is discouraged, because many older alcoholics resent their problems being aired in the presence of much younger relatives.

**Treatment Approaches**
The Panel recommends incorporating the following six features into treatment of the older alcohol dependent:

- ✓ Age-specific group treatment that is supportive and non-confrontational and aims to build or rebuild the patient's self-esteem
- ✓ A focus on coping with depression, loneliness, and loss (e.g., death of a spouse, retirement)
- ✓ A focus on rebuilding the client's social support network
- ✓ A pace and content of treatment appropriate for the older person
- ✓ Staff members who are interested and experienced in working with older adults
- ✓ Linkages with medical services, services for the aging, and institutional settings for referral into and out of treatment, as well as case management.

Building from these six features, the Consensus Panel recommends that treatment programs adhere to the following principles:
- ➢ Treat older people in age-specific settings where feasible
- ➢ Create a culture of respect for older clients
- ➢ Take a broad, holistic approach to treatment that emphasizes age-specific psychological, social, and health problems
- ➢ Keep the treatment program flexible
- ➢ Adapt treatment as needed in response to clients' gender.

To help ensure optimal benefits for older adults, the Consensus Panel recommends that treatment plans weave age-related factors into the contextual framework of the American Society of Addiction Medicine (ASAM) criteria. The Consensus Panel recommends the following general approaches for effective treatment of older adult substance abusers:

- ❖ Cognitive-behavioral approaches
- ❖ Group-based approaches
- ❖ Individual counseling
- ❖ Medical/psychiatric approaches
- ❖ Marital and family involvement/family therapy
- ❖ Case management/community-linked services and outreach.
The Panel recommends that cognitive-behavioral treatment focus on teaching skills necessary for rebuilding the social support network; self-management approaches for overcoming depression, grief, or loneliness; and general problem solving.

**Barriers to Identifying and Treating Older Adults with Substance Abuse Problems**

The sheer number and the interconnectedness of older adults' physical and mental health problems make diagnosis and treatment of their substance abuse more complex than for other populations. That complexity contributes, directly or indirectly, to the following barriers to effective treatment:

- Ageism
- Lack of awareness
- Clinician behavior
- Co-morbidity

**Screening for Alcohol and Prescription Drug Abuse**

**Barriers to Screening**

False assumptions, failure to recognize symptoms, and lack of knowledge about screening are among the barriers that inhibit family members, service providers, and others concerned about older adults from raising the issue of alcohol and prescription drug abuse. Although these are the two primary substances of abuse now, providers are likely to see more marijuana and other drug use among adults over 60 in the coming years. Health care providers sometimes share the ageist attitudes. They may not be trained to recognize signs of substance abuse and furthermore may be unwilling to listen attentively to older patients. The latter type of provider often dismisses older patients' observations about their own symptoms and attempts at self-diagnosis and attributes all complaints or changes in health status to the aging process.

Family members also can impede problem recognition. Biases persist against perceiving older adults as alcoholics or recognizing that drinking or prescription drugs, rather than age or disease, may be a cause or chief contributor to sleep problems, mood changes, or memory deficits (*Finlayson*). Another assumption inhibiting identification is the belief that older adults do not respond to treatment, a misperception flatly contradicted
by studies showing that older adults are more likely to complete treatment (Linn; Cartensen et. al) and have outcomes that are as good as or better than those of younger patients when treated as outpatients (Atkinson).

Who and When to Screen
It is preferable to use standardized screening questionnaires, but friendly visitors, Meals-On-Wheels volunteers, caretakers, and health care providers also can interject screening questions into their normal conversations with older, homebound adults. Comfort with this line of questioning will depend on the person's relationship with the older person and the responses given; however, anyone who is concerned about an older adult's drinking practices can try asking direct questions, such as

➢ "Do you ever drink alcohol?"
➢ "How much do you drink when you do drink?"
➢ "Do you ever drink more than four drinks on one occasion?"
➢ "Do you ever drink and drive?"
➢ "Do you ever drink when you're lonely or upset?"
➢ "Does drinking help you feel better [or get to sleep more easily, etc.]? How do you feel the day after you have stopped drinking?"
➢ "Have you ever wondered whether your drinking interferes with your health or any other aspects of your life in any way?"
➢ "Where and with whom do you typically drink?" (Drinking at home alone signals at-risk or potentially abusive drinking.)
➢ "How do you typically feel just before your first drink on a drinking day?"
➢ "Typically, what is it that you expect when you think about having a drink?" (Note: Positive expectations or consequences of alcohol use in the presence of negative affect and inadequate coping skills have been associated with problem drinking.)

If less direct questioning seems appropriate, other useful questions for identifying problematic alcohol or prescription drug use include

➢ "Are you having any medical or health problems? What symptoms do you have? What do you think these mean? Have you felt this way before?"
➢ "Do you see a doctor or other health care provider regularly? When was the last time? Do you see more than one? Why? Have you switched doctors recently? Why?"
➢ "Have you experienced any negative or unwanted events that altered the way you lived (in the last 5 years)? Any since we last met? How
much of an impact did the event have on the way you lived or felt? What feelings or beliefs did it cause or change? Do you believe that you are coping with the changes in a healthy fashion? How (specifically) do you manage (control) the circumstances (consequences) of the problem(s) or event(s)?

➢ "What prescription drugs are you taking? Are you having any problems with them? May I see them?" (This question will need to be followed by an examination of the actual containers to ascertain the drug name, prescribed dose, expiration date, prescribing physician, and pharmacy that filled each prescription. Note whether there are any psychoactive medications. Ask the patient to bring the drugs in their original containers.)

➢ "Where do you get prescriptions filled? Do you go to more than one pharmacy? Do you receive and follow instructions from your doctor or pharmacist for taking the prescriptions? May I see them? Do you know whether any of these medicines can interact with alcohol or your other prescriptions to cause problems?"

➢ "Do you use any over-the-counter drugs (nonprescription medications)? If so, what, why, how much, how often, and how long have you been taking them?"

**Figure 4-3: The CAGE Questionnaire**

<table>
<thead>
<tr>
<th><strong>Figure 4-3 The CAGE Questionnaire</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever felt you should <strong>cut down</strong> on your drinking?</td>
</tr>
<tr>
<td>2. Have people <strong>annoyed</strong> you by criticizing your drinking?</td>
</tr>
<tr>
<td>3. Have you ever felt bad or <strong>guilty</strong> about your drinking?</td>
</tr>
<tr>
<td>4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (<strong>eye opener</strong>)?</td>
</tr>
</tbody>
</table>

*Scoring:* Item responses on the CAGE are scored 0 for "no" and 1 for "yes" answers, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant. *Source: Ewing*

Non-medical caretakers, volunteers, and aides may opt to ask only the four CAGE questions, reproduced in Figure 4-3 and discussed in the Screening Instruments section. If the older adult answers yes to any of the four, refer to a clinician for evaluation. If the questioner suspects that prescription drug abuse may be occurring and the older adult is defensive about his or her use,
confused about various prescription drugs, seeing more than one doctor, or using more than one pharmacy, a clinician should probably be notified to probe further. Other warning signs that may emerge in conversation and should prompt a more in-depth screen or an assessment include

- Excessively worrying about whether prescription psychoactive drugs are "really working" to alleviate numerous physical complaints; complaints that the drug prescribed has lost its effectiveness over time (evidence of tolerance)
- Displaying detailed knowledge about a specific psychoactive drug and attaching great significance to its efficacy and personal impact
- Worrying about having enough pills or whether it is time to take them to the extent that other activities revolve around the dosage schedule
- Continuing to use and to request refills when the physical or psychological condition for which the drug was originally prescribed has or should have improved (e.g., prescription of sleeping pills after the death of a loved one); resisting cessation or decreasing doses of a prescribed psychoactive drug
- Complaining about doctors who refuse to write prescriptions for preferred drugs, who taper dosages, or who don't take symptoms seriously
- Self-medicating by increasing doses of prescribed psychoactive drugs that aren't "helping anymore" or supplementing prescribed drugs with over-the-counter medications of a similar type
- Rating social events by the amount of alcohol dispensed
- Eating only at restaurants that serve alcoholic beverages (and wanting to know whether they do in advance)
- Withdrawing from family, friends, and neighbors
- Withdrawing from normal and life-long social practices
- Cigarette smoking
- Involvement in minor traffic accidents (police do not typically suspect older adults of alcohol abuse and may not subject them to Breathalyzer and other tests for sobriety)
- Sleeping during the day
- Bruises, burns, fractures, or other trauma, particularly if the individual does not remember how and when they were acquired
- Drinking before going to a social event to "get started"; gulping drinks, guarding the supply of alcoholic beverages, or insisting on mixing own drinks
- Changes in personal grooming and hygiene
- Expulsion from housing
Empty liquor, wine, or beer bottles or cans in the garbage or concealed under the bed, in the closet, or in other locations.

**Asking Screening Questions**

Screening questions should be asked in a confidential setting and in a nonthreatening, nonjudgmental manner. Many older adults are acutely sensitive to the stigma associated with alcohol and drug abuse and are far more willing to accept a "medical" as opposed to a "psychological" or "mental health" diagnosis as an explanation for their problems. Prefacing questions with a link to a medical condition can make them more palatable. For example, "I'm wondering if alcohol may be the reason why your diabetes isn't responding as it should," or, "Sometimes one prescription drug can affect how well another medication is working. Let's go over the drugs you're taking and see if we can figure this problem out." It is vitally important to avoid using stigmatizing terms like *alcoholic* or *drug abuser* during these encounters.

Another technique that may help when talking with older adults is active listening. The four components of active listening are (1) observing and reading the person's nonverbal behavior - posture, facial expressions, movement, and tone of voice; (2) listening to and understanding the person's verbal communication; (3) listening in context, that is, to the whole person in the context of the social settings of his or her life; and (4) listening to sour notes, that is, things the person says that may have to be challenged. Motivational interviewing techniques also can be applied when screening older adults. Essentially this approach assumes that the patient is both capable of and responsible for initiating needed changes. Motivational interviewing is non-confrontational, egalitarian, and supportive.

When screening anyone, especially older adults, empathy is crucial. However, in attempting to be non-confrontational and circumspect, it is also important to avoid using euphemisms that minimize the problem. Older adults with alcohol and prescription drug problems are just as likely to engage in denial and rationalization as younger adults; those who are inadvertently misusing a prescription drug or who are unaware that their customary drink before dinner may now be causing problems are unlikely to be defensive about acknowledging the need to change.
Figure 4-4: Michigan Alcoholism Screening Test - Geriatric Version (MAST-G)

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. After drinking have you ever noticed an increase in your heart rate or beating in your chest?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. When talking with others, do you ever underestimate how much you actually drink?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Does alcohol make you sleepy so that you often fall asleep in your chair?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Does having a few drinks help decrease your shakiness or tremors?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Does alcohol sometimes make it hard for you to remember parts of the day or night?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Do you have rules for yourself that you won't drink before a certain time of the day?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Have you lost interest in hobbies or activities you used to enjoy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. When you wake up in the morning, do you ever have trouble remembering part of the night before?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Does having a drink help you sleep?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Do you hide your alcohol bottles from family members?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. After a social gathering, have you ever felt embarrassed because you drank too much?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Have you ever been concerned that drinking might be harmful to your health?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Do you like to end an evening with a nightcap?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Did you find your drinking increased after someone close to you died?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The MAST-G was developed specifically for older adults (see Figure 4-4) and has high sensitivity and specificity among older adults recruited from a wide range of settings, including primary care clinics, nursing homes, and older adult congregate housing locations.

Before discussing results with an older adult, clinicians must be prepared with information about community resources available to assist in coping with this problem (e.g., meeting dates, times, and locations of Alcoholics Anonymous and other self-help recovery groups whose membership is largely 55 and older; contact and eligibility information for treatment programs that respond to the special needs of older adults); the older adult's available supports (e.g., Is transportation available? Is the recommended program affordable or covered by insurance?); and the older adult's special needs (e.g., Is the program bilingual or wheelchair accessible?). In addition, a strategy for responding to denial or refusal to follow through with a plan of action should be in place. With the agreement of an older adult involved in a

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. In general, would you prefer to have a few drinks at home rather than go out to social events?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Are you drinking more now than in the past?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Do you usually take a drink to relax or calm your nerves?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Do you drink to take your mind off your problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Have you ever increased your drinking after experiencing a loss in your life?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Do you sometimes drive when you have had too much to drink?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Has a doctor or nurse ever said they were worried or concerned about your drinking?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Have you ever made rules to manage your drinking?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. When you feel lonely, does having a drink help?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Scoring: Five or more "yes" responses are indicative of an alcohol problem. For further information, contact Frederic C. Blow, Ph.D., at University of Michigan Alcohol Research Center, 400 E. Eisenhower Parkway, Suite A, Ann Arbor, MI 48108; (734) 998-7952. Source: Blow, F.C.; Brower, K.J.; Schulenberg, J.E.; Demo-Dananberg, L.M.;

The MAST-G was developed specifically for older adults (see Figure 4-4) and has high sensitivity and specificity among older adults recruited from a wide range of settings, including primary care clinics, nursing homes, and older adult congregate housing locations.
self-help group or treatment program, clinicians can broker an introduction to a peer "who's been there." Frequently, these "veterans" will accompany prospective members to meetings and mentor them through the treatment process.

For some older adults coming to grips with an alcohol or prescription drug problem, repeated contacts will be necessary before they are willing to cooperate with a referral. Clinicians have observed that this process is akin to planting and nurturing a seed. Bringing the seed to fruition, however, ultimately depends on the older adult. Scoring: Five or more "yes" responses are indicative of an alcohol problem.

Assessing Co-morbid Disorders

The relationship between alcohol use and a coexisting physical or mental disorder can take many different forms. At one extreme, medical and psychiatric problems can coexist with alcohol use with no specific relationship to drinking. Alternatively, those problems may be precipitating or maintenance factors for drinking. The use of alcohol to anesthetize pain is an example of a maintenance factor; alcohol use can then become its own problem or cause drug interaction problems with prescribed pain medications. Medical or psychiatric problems such as alcoholic cirrhosis or cognitive deficits are other possible consequences of drinking. Even when the link is not so direct, alcohol use can worsen other conditions such as hypertension or congestive heart failure.

The existence of co-morbid medical and psychiatric disorders will influence treatment choice and priorities and will affect treatment outcome. Frail or medically compromised alcohol abusers, for example, may require more intensive monitoring during the detoxification period of treatment than their more robust peers. When disorders such as uncontrolled hypertension or depression are detected, reducing alcohol consumption becomes a priority; until drinking is curbed, medication prescribed for those conditions will not work effectively. In contrast, for older adults suffering from chronic pain, the priority would be to identify an effective painkiller, then taper the amount of alcohol consumed.
Psychiatric co-morbidities
Data from the Epidemiologic Catchment Area (ECA) study have strengthened support for a possible link between alcohol use and abuse and the development of other psychiatric illnesses (Regier et al.). Adults with a lifetime diagnosis of alcohol abuse or dependence had nearly three times the risk of being diagnosed with another mental disorder. Co-morbid disorders associated with alcohol use include anxiety disorders, affective illness, cognitive impairment, schizophrenia, and antisocial personality disorder. According to one study, older alcohol abusers are more likely to have triple diagnoses alcohol, depression, and personality disorders - whereas younger substance abusers are more likely to have diagnoses of schizophrenia (Speer and Bates).

Cognitive Impairments

<table>
<thead>
<tr>
<th>Figure 4-5 Comparison of Dementia and Delirium: Characteristics and Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dementia</strong></td>
</tr>
</tbody>
</table>

### Figure 4-5 Comparison of Dementia and Delirium: Characteristics and Causes

<table>
<thead>
<tr>
<th>Impairments in short- and long-term memory, abstract thinking, and judgment</th>
<th>Inability to appreciate and respond normally to the environment, often with altered awareness, disorientation, inability to process visual and auditory stimuli, and other signs of cognitive dysfunction</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Aphasia (language disorder)</td>
<td>✓ Potentially life-threatening</td>
</tr>
<tr>
<td>✓ Apraxia (inability to carry out motor activities despite intact comprehension and motor function)</td>
<td>✓ Acute onset</td>
</tr>
<tr>
<td>✓ Agnosia (inability to recognize or identify items despite intact sensory function)</td>
<td>✓ Clouding of consciousness</td>
</tr>
<tr>
<td>✓ Constructional difficulty (inability to copy three-dimensional figures, assemble blocks, or arrange sticks in specific designs)</td>
<td>✓ Reduced wakefulness</td>
</tr>
<tr>
<td>✓ Personality change or alteration and accentuation of premorbid traits</td>
<td>✓ Disorientation to time and space</td>
</tr>
<tr>
<td>✓ Mood disturbances</td>
<td>✓ Increased motor activity (e.g., restlessness, plucking, picking)</td>
</tr>
<tr>
<td>✓ Loss of self-care abilities</td>
<td>✓ Impaired attention and concentration</td>
</tr>
<tr>
<td></td>
<td>✓ Impaired memory</td>
</tr>
<tr>
<td></td>
<td>✓ Anxiety, suspicion, and agitation</td>
</tr>
<tr>
<td></td>
<td>✓ Variability of symptoms over time</td>
</tr>
<tr>
<td></td>
<td>✓ Misinterpretation, illusions, or hallucinations</td>
</tr>
<tr>
<td></td>
<td>✓ Disrupted thinking, delusions, speech abnormalities</td>
</tr>
</tbody>
</table>
**Figure 4-5 Comparison of Dementia and Delirium: Characteristics and Causes**

<table>
<thead>
<tr>
<th>Most Common Causes</th>
<th>Common Intracranial Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Alzheimer's disease</td>
<td>➢ Infections (e.g., meningitis,</td>
</tr>
<tr>
<td>➢ Vascular dementia</td>
<td>encephalitis)</td>
</tr>
<tr>
<td>➢ Alcohol-related dementia</td>
<td>➢ Seizures</td>
</tr>
<tr>
<td></td>
<td>➢ Stroke</td>
</tr>
<tr>
<td></td>
<td>➢ Subdural hematomas</td>
</tr>
<tr>
<td></td>
<td>➢ Tumors</td>
</tr>
<tr>
<td><strong>Common Metabolic/Toxic Causes</strong></td>
<td><strong>Common Extracranial Causes</strong></td>
</tr>
<tr>
<td>➢ Chronic drug-alcohol-nutritional</td>
<td>➢ Anesthesia</td>
</tr>
<tr>
<td>abuse (e.g., Wernicke-Korsakoff</td>
<td>➢ Drug-drug or alcohol-drug interactions</td>
</tr>
<tr>
<td>syndrome)</td>
<td>➢ Intoxication and/or withdrawal</td>
</tr>
<tr>
<td>➢ Organ system failure</td>
<td>from alcohol or drugs (particularly</td>
</tr>
<tr>
<td>➢ Anoxia</td>
<td>psychoactive drugs)</td>
</tr>
<tr>
<td>➢ Folic acid deficiency</td>
<td>➢ Toxic effects of prescribed or</td>
</tr>
<tr>
<td></td>
<td>over-the-counter drugs</td>
</tr>
<tr>
<td>➢ Hypothyroidism</td>
<td>➢ Giant cell arteritis (a chronic</td>
</tr>
<tr>
<td></td>
<td>inflammatory process involving</td>
</tr>
<tr>
<td></td>
<td>the extracranial arteries)</td>
</tr>
<tr>
<td>➢ Bromide intoxication</td>
<td>➢ Hip fracture</td>
</tr>
<tr>
<td>➢ Hypoglycemia</td>
<td>➢ Hydrocephalus (increased fluid in the</td>
</tr>
<tr>
<td></td>
<td>brain)</td>
</tr>
<tr>
<td></td>
<td>➢ Hypercapnia (reduced ventilation</td>
</tr>
<tr>
<td></td>
<td>often associated with chronic</td>
</tr>
<tr>
<td></td>
<td>obstructive pulmonary disease)</td>
</tr>
<tr>
<td><strong>Common Infectious Causes</strong></td>
<td>➢ Infections</td>
</tr>
<tr>
<td>➢ Neurosyphilis paresis (a syphilitic</td>
<td>➢ Dehydration</td>
</tr>
<tr>
<td>infection manifested as dementia,</td>
<td>➢ Malnutrition</td>
</tr>
<tr>
<td>seizures, and problems walking</td>
<td>➢ Metabolic disturbances (e.g., liver</td>
</tr>
<tr>
<td>and standing)</td>
<td></td>
</tr>
<tr>
<td>➢ AIDS/HIV-related disorders</td>
<td></td>
</tr>
<tr>
<td>➢ Meningitis</td>
<td></td>
</tr>
<tr>
<td>➢ Encephalitis</td>
<td></td>
</tr>
<tr>
<td><strong>Other Common Causes</strong></td>
<td></td>
</tr>
<tr>
<td>➢ Huntington's Chorea</td>
<td></td>
</tr>
<tr>
<td>➢ Parkinson's disease</td>
<td></td>
</tr>
</tbody>
</table>
Affective disorders
Affective disorders, common in older patients, also influence treatment choices. For example, a patient with an affective disorder who takes psychotropic drugs requires a treatment program with a staff familiar with these medications. Suicidal patients require intensive inpatient programs and an immediate intervention. Significant depressive symptoms, which are a common reaction after detoxification, can be worse in older adults than in younger patients and may require prescribed medicines to alleviate the depression before the abuse or addiction therapy is resumed.

Other psychiatric disorders
There are other psychiatric disorders (e.g., schizophrenia, obsessive and compulsive behaviors) that complicate the treatment of abuse and addiction. In these instances, treatment options must be evaluated on a case-by-case basis, although all programs considered for referral should include medical and mental health personnel skilled in responding to those disorders. Although suicide is not a specific psychiatric disorder, the Panel believes that there is a significant relationship among aging, alcohol use, and suicide. People older than 65 account for 25 percent of the national suicide rate (Conwell). Patients who attempt suicide require immediate and intensive inpatient therapy for as long as the illness persists. Providers must be alert to the possibility of major depression, which is common in older adults, evolving into suicidal tendencies. It helps if family and significant others, clergy, social workers, and home health care providers are knowledgeable about the warning signs for suicide, because these symptoms are more frequently manifested in nonclinical settings.

Moving the older adult into treatment
After determining that an older adult may benefit from a reduction in or complete abstention from alcohol use, the clinician must next assess the patient's understanding of this benefit. Many older adults may not know that their alcohol use is affecting their health. Because patient understanding and cooperation are essential both in eliciting accurate information and following through on the treatment plan prescribed, clinicians should use the assessment process as an opportunity to educate the older adult and to motivate him or her to accept treatment.
Interacting with older adults

Many health care professionals rarely interact with older adults. To facilitate the assessment process with this population, the Consensus Panel recommends that clinicians adhere to the following guiding principles:

❖ Areas of concern most likely to motivate older substance abusers are their physical health, the loss of independence and function, financial security, and maintenance of independence.

❖ Assessment and treatment decisions must include the patient in order to be successful. This is particularly relevant for older adults, who may be very uncomfortable in formalized addiction treatment programs that do not include many of their peers or address their specific developmental and health needs.

❖ Depending on an individual's particular situation, it may be important to include family members in treatment or intervention discussions (understanding that children may vacillate between a desire to help and denial and that patient confidentiality must always be respected).

❖ Addiction is a chronic illness that ebbs and flows. Thus, patients' needs will change over time and will require different types and intensities of treatment.

❖ Because many older adults have several health care providers (e.g., visiting nurses, social workers, adult day care staff, religious personnel), it is important to include this network as a resource in assessment and in providing treatment.

❖ Given the complex health needs of older adults, health care providers may need assistance from experienced nonmedical personnel to adequately assess the totality of treatment issues and choices. Providers should be aware of their limitations both in providing addiction treatment and in assessing and treating mental or physical health needs.

❖ All treatment strategies must be culturally competent and, to the extent possible, incorporate appropriate ethnic considerations (e.g., rituals).

❖ Overarching continuity of care issues and considerations should be identified and addressed, especially in rural and minority communities where emergency room staff function as primary care providers.

Referral and treatment approaches

Once screening and assessment have identified a problem, the clinician and patient must choose the most appropriate treatment. The Consensus Panel recommends that the least intensive treatment options be explored first: brief
intervention, intervention, and motivational counseling. Although these three approaches can be sufficient to address the problem for some older patients, for others they will function as pretreatment strategies. These less intensive options will not resolve the latter type of patients' alcohol or other drug problems but can move them into specialized treatment by helping them overcome resistance to and ambivalence about changing their drinking behavior.

Like treatment itself, pretreatment activities in some cases may be conducted best in the client's home and can be coupled with other personal or social services (Fredriksen, Graham et al.) or with home-based detoxification services (Cooper). This approach is ideal for the large number of at-risk older individuals who are homebound; it can be conducted by visiting nurses, housing authorities, and social workers. Community health services often have staff designated to make visits to older adults in their homes, and some in-home treatment programs have a visiting nurse who identifies and treats substance abuse in the home.

**Least intensive options**

**Brief intervention for at-risk drinkers**
Research has shown that 10 to 30 percent of nondependent problem drinkers reduce their drinking to moderate levels following a brief intervention by a physician or other clinician. A brief intervention is one or more counseling sessions, which may include motivation-for-change strategies, patient education, assessment and direct feedback, contracting and goal setting, behavioral modification techniques, and the use of written materials such as self-help manuals (Fleming et al.). Brief intervention techniques have been used to reduce alcohol use in adolescents, in adults under age 65 who are nondependent problem drinkers, and most recently, in older adults (Blow, in press; Fleming et al.). All of these activities can be conducted by trained clinicians, home health care workers, psychologists, social workers, and professional counselors (e.g., physicians, nurses, physicians' assistants).

Brief intervention strategies range from relatively unstructured counseling and feedback to more formal structured therapy and rely heavily on concepts and techniques from the motivational psychology and behavioral self-control training literature (Miller and Taylor; Miller and Hester; Miller and Munoz, Miller and Rollnick). The goal is to motivate the problem drinker to change his behavior, not to assign blame. Drinking goals accordingly should be
flexible, allowing the individual to choose drinking in moderation or abstinence.

**Conducting brief interventions with older adults**

Older adults present unique challenges to those applying brief intervention strategies for reducing alcohol consumption. Because many older at-risk and problem drinkers are ashamed about their drinking, intervention strategies need to be especially non-confrontational and supportive. In addition, the consumption level that constitutes at-risk drinking is lower than that for younger individuals (*Chermack et al.*), so even low levels can be dangerous. Chronic medical conditions may make it more difficult for clinicians to recognize the role of alcohol in decreases in functioning and quality of life. These issues must be kept in mind during brief interventions with this vulnerable population.

One approach devised to facilitate brief interventions is known by the acronym *FRAMES*. This approach emphasizes

- ✓ **Feedback** of personal risk or impairment as derived from the assessment
- ✓ Personal **responsibility** for change
- ✓ Clear **advice** to change
- ✓ A **menu** of change options to increase the likelihood that an individual will find a responsive treatment (although multiple attempts may be necessary)
- ✓ An **empathic** counseling style
- ✓ Enhanced client **self-efficacy** and ongoing follow up (*Miller and Sanchez*).

Panel members agree that when older adults are motivated to take action on their own behalf, the prognosis for positive change is extremely favorable. Key to inspiring motivation is the clinician's caring style, willingness to view the older adult as a full partner in his or her recovery, and capacity to provide hope and encouragement as the older adult progresses through the referral, treatment, and recovery process.

**Intervention and motivational counseling**

If the older problem drinker does not respond to the brief intervention, two other approaches, intervention and motivational counseling, should be considered.
Intervention
In an intervention, which occurs under the guidance of a skilled counselor, several significant people in the client’s life confront the individual with their firsthand experiences of his or her drinking or drug use (Johnson, Twerski). The formalized process begins before the intervention and includes a progressive interaction between the counselor and the family or friends for at least 2 days before meeting with the patient. During this time, the counselor not only helps plan the intervention but also educates the family about substance abuse and its prevention (Johnson). Participants are coached about offering information in an emotionally neutral, factual manner while maintaining a supportive, non-accusatory tone, thus presenting incontrovertible evidence to the loved one that a problem exists. When using this approach with older adults, Panel members recommend some modifications. No more than one or two relatives or close associates should be involved along with the counselor; having too many people present may be emotionally overwhelming or confusing for the older person. The most influential person to include in interventions or any other pretreatment activity may be a spouse, cohabitant, care giving son or daughter, clergy member, or visiting nurse or caseworker, depending on the particular social network of the client. Inclusion of grandchildren is discouraged: Panel members report that many older alcoholics describe long-lasting resentment and shame about the airing of their problems in the presence of much younger relatives.

Because denial is as much a part of psychoactive prescription drug dependence as it is of alcoholism and addiction to illicit drugs, an intervention may help move psychoactive drug abusers toward detoxification or other formal treatment, although extra caution is advisable. Both the diagnosis of abuse or dependence and the need for treatment are particularly difficult for older patients to accept because their initial use of psychoactive prescription drugs was, in almost all cases, originally sanctioned by a health care provider and prescribed as a remedy for a legitimate medical problem or complaint. As a group, older adults tend to have even greater disdain for "drug addicts" than the general population: Any implied linkage with the criminalized population of illicit drug users is unnecessarily stigmatizing and appropriately resented. Such labels as addict, alcoholic, and drunkard should be avoided.

Figure 5-1: ASAM-PPC-2 Assessment Dimensions
<table>
<thead>
<tr>
<th>Dimension 1 - Acute Intoxication and/or Withdrawal Potential</th>
</tr>
</thead>
<tbody>
<tr>
<td>What risk is associated with the patient's current level of acute intoxication? Is there significant risk of severe withdrawal symptoms or seizures, based on the patient's previous withdrawal history, amount, frequency, and recency of discontinuation or significant reduction of alcohol or other drug use? Are there current signs of withdrawal? Does the patient have supports to assist in ambulatory detoxification, if medically safe?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dimension 2 - Biomedical Conditions and Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there current physical illnesses, other than withdrawal, that need to be addressed or that may complicate treatment? Are there chronic conditions that affect treatment?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dimension 3 - Emotional/Behavioral Conditions and Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there current psychiatric illnesses or psychological, behavioral, or emotional problems that need to be addressed or which complicate treatment? Are there chronic conditions that affect treatment? Do any emotional/behavioral problems appear to be an expected part of addiction illness, or do they appear to be autonomous? Even if connected to the addiction, are they severe enough to warrant specific mental health treatment?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dimension 4 - Treatment Acceptance/Resistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the patient actively objecting to treatment? Does the patient feel coerced into treatment? How ready is the patient to change? If willing to accept treatment, how strongly does the patient disagree with others' perceptions that he or she has an addiction problem? Does the patient appear to be compliant only to avoid a negative consequence, or does he or she appear to be internally distressed in a self-motivated way about his or her alcohol/other drug use problems?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dimension 5 - Relapse/Continued Use Potential</th>
</tr>
</thead>
</table>
The answers to these questions should help the provider assess the severity of the problem and the intensity of the services required. For older adults, the triage process is often greatly influenced by factors other than the severity of a drinking or prescription drug problem. For example, physical accessibility of facilities will influence treatment choices for wheelchair-bound patients; hearing-impaired patients will need programs with individual therapy and/or modified small group therapy. Language barriers, illiteracy, and different cultural views of and customs surrounding substance abuse add to the complex of factors required to assess functional abilities in older adult patients. To help ensure optimal benefits for older adults, the Consensus Panel recommends that treatment plans weave age-related factors into the contextual framework of the ASAM criteria.

**Levels of Treatment Services**
The following section provides an overview of treatment services from the most to the least intensive, with examples demonstrating how various circumstances may affect the level of care at which a service is offered.

**Inpatient/outpatient detoxification treatment**

One of the first issues to consider for an older patient with a substance dependence diagnosis is whether detoxification management is necessary and, if so, whether it should be undertaken in an inpatient hospital-based setting or managed on an outpatient basis. No studies or reports specifically assess the potential risks or benefits of outpatient detoxification among older adults, but detoxification is generally seen as medically riskier for an older person. Until more research is available, best clinical judgment must guide such decisions. For more information on detoxification, see TIP 19, Detoxification from Alcohol and Other Drugs (CSAT). Medical safety and potential access to the abused drugs are primary considerations when deciding whether an older patient's withdrawal from prescription drugs requires supervision in a hospital. Factors indicating the need for inpatient detoxification include:

- ✓ A high potential for developing dangerous abstinence symptoms such as a seizure or delirium because (1) the dosage of alcohol or drug has been particularly high or prolonged and has been discontinued abruptly or (2) the patient has experienced these serious symptoms at any time previously
- ✓ Suicidal ideation or threats
- ✓ The presence of other major psychopathology
- ✓ Unstable or uncontrolled co-morbid medical conditions requiring 24-hour care or parenterally administered medications (e.g., renal disease, diabetes)
- ✓ Mixed addictions, (e.g., alcohol, sedative/hypnotic drugs)
- ✓ A lack of social supports at home or living alone with continued access to the abused substance(s)
- ✓ A failure to respond to outpatient treatment.

**Treatment Approaches**

The Consensus Panel recommends the following general approaches for effective treatment of older adult substance abusers:

- ❖ Cognitive-behavioral approaches
- ❖ Group-based approaches
- ❖ Individual counseling
- ❖ Medical/psychiatric approaches
- ❖ Marital and family involvement/family therapy
Case management/community-linked services and outreach.

Not every approach will be necessary for every client. Instead, the program leaders can individualize treatment by choosing from this menu to meet the needs of the particular client. Planning information comes from interviews; mental status examinations; physical examinations; laboratory, radiological, and psychometric tests; and social network assessments, among others.

**Figure 5-3: Treatment Objectives and Approaches**

<table>
<thead>
<tr>
<th>General Objectives/ Examples</th>
<th>General Approaches/Examples</th>
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</thead>
<tbody>
<tr>
<td>Eliminate or reduce substance abuse</td>
<td>Cognitive-behavioral (group or individual)</td>
</tr>
<tr>
<td></td>
<td>✓ Alcohol (drug) effects</td>
</tr>
<tr>
<td></td>
<td>✓ Relapse prevention</td>
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<td></td>
<td>✓ Stress management</td>
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<td></td>
<td>Group approaches</td>
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<tr>
<td></td>
<td>✓ Alcohol (drug) effects education</td>
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<td></td>
<td>Medical</td>
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<tr>
<td></td>
<td>✓ Naltrexone, acamprosate (alcohol)</td>
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<tr>
<td>Safely manage intoxication episodes during treatment</td>
<td>Medical</td>
</tr>
<tr>
<td></td>
<td>✓ Remove patient from activities and observe</td>
</tr>
<tr>
<td></td>
<td>✓ Link and refer to detoxification program</td>
</tr>
<tr>
<td>Enhance relationships</td>
<td>Promote health</td>
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<tr>
<td><strong>Cognitive-behavioral (group or individual)</strong></td>
<td><strong>Medical</strong></td>
</tr>
<tr>
<td>✓ Social skills and network building</td>
<td>✓ Provide primary medical care</td>
</tr>
<tr>
<td><strong>Group approaches</strong></td>
<td><strong>Cognitive-behavioral (group or individual)</strong></td>
</tr>
<tr>
<td>✓ Social support</td>
<td>✓ Self-management skills training</td>
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<tr>
<td>✓ Socialization skill education</td>
<td><strong>Group approaches</strong></td>
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<tr>
<td>✓ Gender-specific issues</td>
<td>✓ Health education</td>
</tr>
<tr>
<td><strong>Marital and family approaches</strong></td>
<td>✓ Education on nutrition, diet, cooking, shopping</td>
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<tr>
<td>✓ Spouse counseling</td>
<td>✓ Sleep hygiene</td>
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<tr>
<td>✓ Marital therapy</td>
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<td>✓ Family therapy</td>
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<td><strong>Case management</strong></td>
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<tr>
<td>✓ Linkage to community social programs</td>
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<td>✓ Home visitation</td>
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<td><strong>Individual counseling</strong></td>
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<tr>
<td>✓ Focus on psychodynamic issues in relationships</td>
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<td><strong>Case management</strong></td>
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<td>✓ Linkage to community social programs</td>
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<td>✓ Focus on psychodynamic issues in relationships</td>
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**Figure 5-3 Treatment Objectives and Approaches**
Cognitive-Behavioral Approaches
There are three broad categories of cognitive-behavioral approaches: behavior modification/therapy, self-management techniques, and cognitive-behavioral therapies. Behavior modification applies learning and conditioning principles to modifying overt behaviors - those behaviors obvious to everyone around the client (Powers and Osborne, Spiegler and Guevremont). Self-management refers to teaching the client to modify his or her overt behaviors as well as internal or covert patterns. Cognitive-behavior modification involves altering covert patterns or behaviors that only the client can observe. Cognitive-behavioral techniques teach clients to identify and modify self-defeating thoughts and beliefs (Dobson, Scott et al.). The cognitive-behavioral model offers an especially powerful method for targeting problems or treatment objectives that affect drinking behavior. Together, provider and client analyze the behavior itself, constructing a "drinking behavior chain." The chain is composed of the antecedent situations, thoughts, feelings, drinking cues, and urges that precede and initiate alcohol or drug use; the drinking or substance-abusing behavior (e.g., pattern, style); and the positive and negative consequences of use for a given individual. When exploring the latter, it is particularly important to note the positive consequences of use: those that maintain abusive behavior.

Researchers have developed an instrument that can elicit by interview the individual's drinking or drug use behavior chain (Dupree and Schonfeld).
Immediate antecedents to drinking include feelings such as anger, frustration, tension, anxiety, loneliness, boredom, sadness, and depression. Circumstances and high-risk situations triggering these feelings might include marital or family conflict, physical distress, or unsafe housing arrangements, among others. Many older adults drink excessively in response to perceived losses and changes associated with aging and their affective and behavioral response to those losses. Alcohol use is often a form of "self-medication," a means to soften the impact of unwanted change and feelings. For the patient, new knowledge of his or her drinking chain often clarifies for the first time the relationship between thoughts and feelings and drinking behavior, a discovery one Panel member calls "taking the mystery out of drunkenness." This method provides insight into individual problems, demonstrates the links between psychosocial and health problems and drinking, and provides the data for a rational treatment plan and an explicit individualized prevention strategy.

Breaking drinking behavior into the links of a drinking chain serves treatment in other ways, too. It suggests elements of the community service network that may be helpful in establishing an integrated case management plan to resolve antecedent conditions (e.g., housing, financial, medical problems) that necessitate involvement from the community beyond the treatment program.

Behavioral treatment can be used with older adults individually or in groups, with the group process particularly suited to older adults. Equipped with the knowledge of the individual's drinking or drug abuse behavior chain, the group leader begins to teach the client the skills necessary to cope with high-risk thoughts or feelings. The leader teaches the older person to initiate alternative behaviors to drinking, then reinforces such attempts. The leader may demonstrate through role-playing alternative ways to manage high-risk situations, permitting the client to select coping behaviors that he or she feels willing and able to acquire. The leader may also ask for feedback from the group and use that feedback to work gradually toward a workable behavioral response specific to the individual. The behaviors are rehearsed within the treatment program until a level of skill is acquired. The patient is then asked to try out the behaviors in the real world as "homework." For example, a client who has been practicing ways to overcome loneliness or social isolation may receive a community-based assignment in which to carry out the suggested behaviors. The individual reports back to the group, then the therapist and group members provide feedback and reinforce the individual's
attempt at self-management (whether the outcome was a success or not). This process continues until the individual develops coping skills and brings the antecedents for abuse under self-control or self-management. Typically, as patients learn to manage the conditions (thoughts, feelings, situations, cues, urges) that prompt alcohol abuse, abstinence can be maintained. Defining drinking behavior antecedents is also useful for determining when a client is ready for discharge. When the individual has acquired and can successfully use coping behaviors specific to his or her antecedents for drinking, the treatment team might begin to assist the person in gradually phasing out of the program. Discharge that takes place before the client has acquired specific coping behaviors is almost certain to result in relapse - probably very soon after discharge.

One older adult-specific treatment program that has used these cognitive-behavioral and self-management approaches is the Gerontology Alcohol Project (GAP) (Dupree et al.). The program assessed antecedents on a typical day of drinking for each person entering treatment. Group treatment involved skill acquisition in order to cope with problems such as anger and frustration, depression and grief, tension and anxiety, lack of social support, passivity, and an unstructured life. GAP staff were encouraged to teach skills at a slower pace than might be used with younger adults and to limit the amount of information taught per session by following written curriculum manuals. These teaching guides provided age-specific examples and maintained consistency in teaching. Confrontation was not permitted. This facilitated more open discussion between staff and clients, encouraging clients to report instances when they slipped. This information was used in the group to help both the person who slipped and other clients. Each slip was diagrammed in terms of that person's drinking behavior chain, with the antecedent conditions and consequences, in order to teach group members how to avoid or manage their own high-risk situations. The group engaged in exercises or rehearsals of the necessary actions and cognitions to prevent one drink (a slip) from becoming a full relapse. A 1-year follow up of clients completing GAP indicated a high rate of success. Seventy-five percent of clients maintained their drinking reduction goals and increased the size of their social support networks (Dupree et al.). Later studies comparing early and late-onset older problem drinkers showed great similarity between these two groups' antecedents to drinking and treatment outcomes (Schonfeld and Dupree). Another study described a behavioral regimen that included psychoeducation, self-management skills training, and marital therapy. A follow up study of 16 male inpatients, ages 65 to 70, undertaken 2 to 4 years after
discharge, indicated that half were abstaining, two had reduced their drinking, and the remaining patients' drinking was destructive (Carstensen et al.). These studies recommend (and the Panel concurs) that treatment focus on teaching skills necessary for rebuilding the social support network; self-management approaches for overcoming depression, grief, or loneliness; and general problem solving (Schonfeld and Dupree).

**Alcoholics Anonymous and other self-help groups**
Many treatment programs refer patients to Alcoholics Anonymous (AA) and other self-help groups as part of aftercare. Providers should warn older patients that these groups might seem confrontational and alienating. The referring program should tell patients exactly what to expect - that the group discussions may well include profanity and younger members' accounts of their antisocial behavior. To orient clients to these groups, the treatment program may ask that local AA groups provide an institutional meeting as a regular part of the treatment program. Other options are to help clients develop their own self-help groups or even to facilitate the development of independent AA groups for older adults in the area.

**Individual counseling or short-term psychotherapy**
Individual counseling is especially helpful to the older substance abuser in treatment's beginning stages, but the counselor often must overcome clients' worries about privacy. Subjects that many older adults are loath to discuss include their relationships to their spouses, family matters and interactions, sexual function, and economic worries. It is essential to assure the client that the sessions are confidential and to conduct the sessions in a comfortable, self-contained room where the client can be certain the conversation will not be overheard.

Older clients often respond best to counselors who behave in a nonterrorizing, supportive manner and whose demeanor indicates that they will honor the confidentiality of the sessions. Clients frequently describe the successful relationship in familial terms: "It is like talking to my son," or, "It is as though she were my sister." Older clients value spontaneity in relationships with the counselor and other staff members; a counselor's appropriate self-disclosure often enhances or facilitates a beneficial relationship with the patient.

Because receiving counseling may be a new experience for the client, the provider should explain the basics of counseling and clearly present the
responsibilities of the counselor and the client. Summarizing at the beginning of each session helps to keep the session moving in the appropriate direction. Summarizing at the end of a session and providing tasks to be thought about or completed before the next session help reinforce any knowledge or insights gained and contribute to the older client's feeling that she is making progress.

In individual sessions, counselors can help clients prepare to participate in a therapy group, building their understanding of how the group works and what they are expected to do. Private sessions can also be used to clarify issues when the individual is confused or is too embarrassed to raise a question in the group. As the client becomes more comfortable in the group setting, the counselor may decide to taper the number of individual counseling sessions. Likewise, the client may prepare for discharge by reducing the frequency or length of sessions, secure in the knowledge that more time is available if needed.

8. Aging and Mental Health

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

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

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

One large, ongoing longitudinal study found high cognitive performance to be dependent on four factors, ranked here in decreasing order of importance:
education, strenuous activity in the home, peak pulmonary flow rate, and “self-efficacy,” which is a personality measure defined by the ability to organize and execute actions required to deal with situations likely to happen in the future (Albert et al.).

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

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

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

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

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

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

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

Loss
Many older adults experience loss with aging—loss of social status and self-esteem, loss of physical capacities, and death of friends and loved ones. But in the face of loss, many older people have the capacity to develop new adaptive strategies, even creative expression (Cohen). Those experiencing loss may be able to move in a positive direction, either on their own, with the benefit of informal support from family and friends, or with formal support from mental health professionals. The life and work of William Carlos Williams are illustrative. Williams was a great poet as well as a respected physician. In his 60s, he suffered a stroke that prevented him from practicing medicine. The stroke did not affect his intellectual abilities, but he became so severely depressed that he needed psychiatric hospitalization. Nonetheless, Williams, with the help of treatment for a year, surmounted the depression and for the next 10 years wrote luminous poetry, including the Pulitzer Prize-winning *Pictures From Bruegel*, which
was published when he was 79. In his later life, Williams wrote about “old age that adds as it takes away.” What Williams and his poetry epitomize is that age can be the catalyst for tapping into creative potential (Cohen).

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

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

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

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

Assessment and diagnosis of late-life mental disorders are especially challenging by virtue of several distinctive characteristics of older adults. First, the clinical presentation of older adults with mental disorders may be different from that of other adults, making detection of treatable illness more difficult. For example, many older individuals present with somatic complaints and experience symptoms of depression and anxiety that do not meet the full criteria for depressive or anxiety disorders. The consequences of these subsyndromal conditions may be just as deleterious as the syndromes themselves. Failure to detect individuals who truly have treatable mental disorders represents a serious public health problem (National Institutes of Health [NIH] Consensus Development Panel on Depression in Late Life).

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

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

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

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

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

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

Depression is strikingly prevalent among older people. As noted below, at least 8 to 20 percent of older adults in the community and up to 37 percent in primary care settings experience symptoms of depression. One approach to preventing depression is through grief counseling for widows and widowers. For example, participation in self-help groups appears to ameliorate depression, improve social adjustment, and reduce the use of alcohol and other drugs of abuse in widows (Constantino, Lieberman & Videka-Sherman). The efficacy of self-help groups approximates that of brief psychodynamic psychotherapy in older bereaved individuals without significant prior psychopathology (Marmar et al.). The
battery of psychosocial and pharmacological treatments to prevent recurrences of depression (i.e., secondary prevention) is discussed later in this chapter under the section on depression. Depression is a foremost risk factor for suicide in older adults (Conwell, Conwell et al.). Older people have the highest rates of suicide in the U.S. population: suicide rates increase with age, with older white men having a rate of suicide up to six times that of the general population (Kachur et al., Hoyert et al.). Despite the prevalence of depression and the risk it confers for suicide, depression is neither well recognized nor treated in primary care settings, where most older adults seek and receive health care (Unutzer et al.). Studies described in the depression section of this chapter have found that undiagnosed and untreated depression in the primary care setting plays a significant role in suicide (Caine et al.). This awareness has prompted the development of suicide prevention strategies expressly for primary care. One of the first published suicide prevention studies, an uncontrolled experiment conducted in Sweden, suggested that a depression training program for general practitioners reduces suicide (Rihmer et al.). Suicide interventions, especially in the primary care setting, have become a priority of the U.S. Public Health Service, with lead responsibility assumed by the Office of the Surgeon General and the National Institute of Mental Health. Depression and suicide prevention strategies also are important for nursing home residents. About half of patients newly relocated to nursing homes are at heightened risk for depression (Parmelee et al.).

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

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

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

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

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

The liver undergoes changes in blood flow and volume with age. Phase I metabolism (oxidation, reduction, hydrolysis) may diminish or remain
unchanged, while phase II metabolism (conjugation with an endogenous substrate) does not change with aging. Renal blood flow, glomerular surface area, tubular function, and reabsorption mechanisms all have been shown to diminish with age. Diminished renal excretion may lead to a prolonged half-life and the necessity for a lower dose or longer dosing intervals. Pharmacodynamics, which refers to the drug’s effect on its target organ, also can be altered in older individuals. An example of aging-associated pharmacodynamic change is diminished central cholinergic function contributing to increased sensitivity to the anticholinergic effects of many neuroleptics and antidepressants in older adults (Molchan et al.). Because of the pharmacokinetic and pharmacodynamic concerns presented above, it is often recommended that clinicians “start low and go slow” when prescribing new psychoactive medications for older adults. In other words, efficacy is greatest and side effects are minimized when initial doses are small and the rate of increase is slow. Nevertheless, the medication should generally be titrated to the regular adult dose in order to obtain the full benefit. The potential pitfall is that, because of slower titration and the concomitant need for more frequent medical visits, there is less likelihood of older adults receiving an adequate dose and course of medication.

Older people encounter an increased risk of side effects, most likely the result of taking multiple drugs or having higher blood levels of a given drug. The increased risk of side effects is especially true for neuroleptic agents, which are widely prescribed as treatment for psychotic symptoms, agitation, and behavioral symptoms. Neuroleptic side effects include sedation, anticholinergic toxicity (which can result in urinary retention, constipation, dry mouth, glaucoma, and confusion), extrapyramidal symptoms (e.g., parkinsonism, akathisia, and dystonia), and tardive dyskinesia. Tardive dyskinesia is a frequent and persistent side effect that occurs months to years after initiation of neuroleptics. In older adults, tardive dyskinesia typically entails abnormal movements of the tongue, lips, and face. In a recent study of older outpatients treated with conventional neuroleptics the incidence of tardive dyskinesia after 12 months of neuroleptic treatment was 29 percent of the patients. At 24 and 36 months, the mean cumulative incidence was 50.1 percent and 63.1 percent, respectively (Jeste et al.). This study demonstrates the high risk of tardive dyskinesia in older patients even with low doses of conventional neuroleptics. Studies of younger adult patients reveal an annual cumulative incidence of tardive dyskinesia at 4 to 5 percent (Kane et al.).
Unlike conventional neuroleptics, the newer atypical ones, such as clozapine, risperidone, olanzapine, and quetiapine, apparently confer several advantages with respect to both efficacy and safety. These drugs are associated with a lower incidence of extrapyramidal symptoms than conventional neuroleptics are. For clozapine, the low risk of tardive dyskinesia is well established (Kane et al.). The incidence of tardive dyskinesia with other atypical antipsychotics is also likely to be lower than that with conventional neuroleptics because extrapyramidal symptoms have been found to be a risk factor for tardive dyskinesia in older adults (Saltz et al., Jeste et al.). The determination of exact risk of tardive dyskinesia with these newer drugs needs long-term studies.

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

Compliance with the treatment regimen also is a special concern in older adults, especially in those with moderate or severe cognitive deficits. Physical problems, such as impaired vision, make it likely that instructions may be misread or that one medicine may be mistaken for another. Cognitive impairment may also make it difficult for patients to remember whether or not they have taken their medication. Although in general, older patients are more compliant about taking psychoactive medications than other types of drugs (Cooper et al.), when noncompliance does occur, it may be less easily detected, more serious, less easily resolved, mistaken for symptoms of a new disease, or even falsely labeled as “old-age” symptomatology. Accordingly, greater emphasis must be placed on strict compliance by patients in this age group (Lamy et al.). Medication noncompliance takes different forms in older adults, that is, overuse and abuse, forgetting, and alteration of schedules and doses. The most
common type of deliberate noncompliance among older adults may be the underuse of the prescribed drug, mainly because of side effects and cost considerations. Factors that contribute to medication noncompliance in older patients include inadequate information given to them regarding the necessity for drug treatment, unclear prescribing directions, suboptimal doctor-patient relationship, the large number of times per day drugs must be taken, and the large number of drugs that are taken at the same time (Lamy et al.). Better compliance may be achieved by giving simple instructions and by asking specific questions to make sure that the patient understands directions.

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

New approaches to service delivery are being designed to realize the benefits of established psychosocial interventions. Many older people are not comfortable with traditional mental health settings, partially as a result of stigma (Waters). In fact, many older people prefer to receive treatment for mental disorders by their primary care physicians, and most older people do receive such care in the primary care setting (Brody et al., Unutzer et al.).
Since older people show willingness to accept psychosocial interventions in the primary care setting, new models are striving to integrate into the primary care setting the delivery of specialty mental health services. The section of this chapter on service delivery discusses new models in greater detail.

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

**Other Mental Disorders in Older Adults**

**Anxiety Disorders**

Anxiety symptoms and syndromes are important but understudied conditions in older adults. Overall, community-based prevalence estimates indicate that about 11.4 percent of adults aged 55 years and older meet criteria for an anxiety disorder in 1 year (Flint). Phobic anxiety disorders are among the most common mental disturbances in late life according to the ECA study (Table 5-1). Prevalence studies of panic disorder (0.5 percent) and obsessive-compulsive disorder (1.5 percent) in older samples reveal low rates (Table 5-1) (Copeland et al., Copeland et al., Bland et al., Lindesay et al.). Although the National Comorbidity Survey did not cover this age range, and the ECA did not include this disorder, other studies showed a prevalence of generalized anxiety disorder in older adults ranging from 1.1 percent to 17.3 percent higher than that reported for panic disorder or obsessive-compulsive disorder (Copeland et al., Skoog). Worry or “nervous tension,” rather than specific anxiety syndromes may be more important in older people. Anxiety symptoms that do not fulfill the criteria for specific syndromes are reported in up to 17 percent of older men and 21 percent of older women (Himmelfarb & Murrell). In addition, some disorders that have received less study in older adults may become more important in the
near future. For example, post-traumatic stress disorder (PTSD) is expected to assume increasing importance as Vietnam veterans age. At 19 years after combat exposure, this cohort of veterans has been found to have a PTSD prevalence of 15 percent (*cited in McFarlane & Yehuda*). As affected patients age, there is a continuing need for services. In addition, research has shown that PTSD can manifest for the first time long after the traumatic event (*Aarts & Op den Velde*), raising the specter that even more patients will be identified in the future.

The effectiveness of benzodiazepines in reducing *acute* anxiety has been demonstrated in younger and older patients, and no differences in the effectiveness have been documented among the various benzodiazepines. Some research suggests that benzodiazepines are marginally effective at best in treating *chronic* anxiety in older patients (*Smith et al.*). The half-life of certain benzodiazepines and their metabolites may be significantly extended in older patients (particularly for the compounds with long half-life). If taken over extended periods, even short-acting benzodiazepines tend to accumulate in older individuals. Thus, it is generally recommended that any use of benzodiazepines be limited to discrete periods (less than 6 months) and that long-acting compounds be avoided in this population. On the other hand, use of short-acting compounds may predispose older patients to withdrawal symptoms (*Salzman*). Side effects of benzodiazepines may include drowsiness, fatigue, psychomotor impairment, memory or other cognitive impairment, confusion, paradoxical reactions, depression, respiratory problems, abuse or dependence problems, and withdrawal reactions. Benzodiazepine toxicity in older patients includes sedation, cerebellar impairment (manifested by ataxia, dysarthria, incoordination, or unsteadiness), cognitive impairment, and psychomotor impairment (*Salzman*). Psychomotor impairment from benzodiazepines can have severe consequences, leading to impaired driver skills and motor vehicle crashes (*Barbone et al.*) and falls (*Caramel et al.*). Buspirone is an anxiolytic (antianxiety) agent that is chemically and pharmacologically distinct from benzodiazepines. Controlled studies with younger patients suggest that the efficacy of buspirone is comparable to that of the benzodiazepines. It also has proven effective in studies of older patients. On the other hand, buspirone may require up to 4 weeks to take effect, so initial augmentation with another antianxiety medication may be necessary for some acutely anxious patients (*Sheikh*). Significant adverse reactions to buspirone are found in 20 to 30 percent of anxious older patients (*Napoliello, Robinson et al.*). The most frequent side effects include gastrointestinal symptoms,
dizziness, headache, sleep disturbance, nausea/vomiting, uneasiness, fatigue, and diarrhea. Still, buspirone may be less sedating than benzodiazepines (Salzman, Seidel et al.).

Although the efficacy of antidepressants for the treatment of anxiety disorders in late life has not been studied, current patterns of practice are informed by the efficacy literature in adults in midlife.

Although schizophrenia is commonly thought of as an illness of young adulthood, it can both extend into and first appear in later life. Diagnostic criteria for schizophrenia are the same across the life span. Symptoms include delusions, hallucinations, disorganized speech, disorganized or catatonic behavior (the so-called “positive” symptoms), as well as affective flattening, alogia, or avolition5 (the so-called “negative” symptoms). Symptoms must cause significant social or occupational dysfunction, must not be accompanied by prominent mood symptoms, and must not be uniquely associated with substance use.

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

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

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

A cross-sectional study that compared middle-aged with older patients, all of whom lived in community settings, found some similarities and differences (Eyler-Zorrilla et al.). The older patients experienced less severe symptoms overall and were on lower daily doses of neuroleptics than middle middleaged patients who were similar in demographic, clinical, functional, and broad cognitive measures. In addition, positive symptoms were less prominent (or equivalent) in the older group, depending on the measure used. Negative symptoms were more prominent (or equivalent) in the older group, and older patients scored more poorly on severity of dyskinesia. Older patients were impaired relative to middle-aged ones on two measures of global cognitive function. This finding, however, appeared to reflect a normal degree of decline from an impaired baseline, as the degree of change in cognitive function with age in the patient group was equivalent to that seen in the comparison group. A recent study used the Direct Assessment of Functional Status scale (DAFS) (Loewenstein et al.) to compare the everyday living skills of middle-aged and older adults with schizophrenia with those of people without schizophrenia of similar ages (Klapow et al.). The patients exhibited significantly more functional limitations than the controls did across most DAFS subscales. In another recent study that used a measure of overall disease impact, the Quality of Well-Being Scale, older outpatients with schizophrenia manifested significantly lower quality of well-being than did comparison subjects, and
their scores were slightly worse than those of ambulatory AIDS patients (Patterson et al.). Thus, while schizophrenia may be less universally deteriorating than previously has been assumed, older patients with the disorder continue nonetheless to exhibit functional deficits that warrant research and clinical attention.

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

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

Pharmacological treatment of schizophrenia in late life presents some unique challenges. Conventional neuroleptic agents, such as haloperidol, have proven effective in managing the “positive symptoms” (such as delusions and hallucinations) of many older patients, but these medications have a high risk of potentially disabling and persistent side effects, such as tardive dyskinesia (*Jeste et al.*, in press). The cumulative annual incidence of tardive dyskinesia among older outpatients (29 percent) treated with relatively low daily doses of conventional antipsychotic medications is higher than that reported in younger adults (*Jeste et al.*, in press). Recent years have witnessed promising advances in the management of schizophrenia. Studies with mostly younger schizophrenia patients suggest that the newer “atypical” antipsychotics, such as clozapine, risperidone, olanzapine, and quetiapine, may be effective in treating those patients previously unresponsive to traditional neuroleptics. They also are associated with a lower risk of extrapyramidal symptoms and tardive dyskinesia (*Jeste et al.*, in press). Moreover, the newer medications may be more effective in treating negative symptoms and may even yield partial improvement in certain neurocognitive deficits associated with this disorder (*Green et al.*). The foremost barriers to the widespread use of atypical antipsychotic medications in older adults are (1) the lack of large-scale studies to demonstrate the effectiveness and safety of these medications in older patients with multiple medical conditions, and (2) the higher cost of these medications relative to traditional neuroleptics (Thomas & Lewis).

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

As the Baby Boom generation born between 1946 and 1964 ages, it is likely more victims of late life violence and abuse will seek out or be referred to the specialized services provided by IPV programs. This potential calls for increased collaboration between aging and domestic violence networks to assure maximum support and safety for victims and survivors of abuse in later life. The national aging network of State Units on Aging, Area Agencies on Aging, Tribal and Native organizations, and direct service providers—especially long term care ombudsman programs, adult protective services, legal services, and information and referral/assistance—has a key role to play in speaking out for older victims.

IPV later life occurs when older individuals are physically, sexually, or emotionally abused, exploited, or neglected by someone [with whom] they have an ongoing relationship. . . . Abusers intentionally use coercive tactics, such as isolation, threats, intimidation, manipulation, and violence to gain and maintain control over the victim. — National Clearinghouse on Abuse in Later Life No matter what the victim's age, abusers' tactics are remarkably similar. Abusers frequently look for someone they can dominate, people believed to be weak, people unlikely or unable to retaliate. With respect specifically to abuse in later life, the aggressors include spouses and former spouses, partners, adult children, extended family, and in some cases caregivers. As victims' advocates know well, abusive behaviors such as punishing, isolating, or depriving are at root about a desire for power and control. Power is used to control where the victim goes, who the victim sees, what the victim can or cannot do; decision-making is curtailed; property and financial resources are exploited. A sense of entitlement often underlies the abusive behavior. The problem of abuse in later life occurs in all communities and affects people of all ethnic, cultural, racial, economic, and religious backgrounds. Although most victims are female, older men can be harmed, too. IPV in later life and elder abuse often go hand in hand, and the consequences on lives are very similar. Elder abuse, broadly speaking, includes physical, emotional, sexual abuse, financial exploitation, neglect, self-neglect, and abandonment of older persons — terms defined by law in state adult protective services (APS) statutes. APS laws in most states address the needs of vulnerable adults over the age of 18 who are living alone or with family and who are at risk of abuse, neglect, or exploitation. The network on aging is charged with the responsibility under federal law to serve as a visible advocate for older Americans age 60 and over.
About the Aging Network

The national aging network, established by Congress under the Older Americans Act (OAA), is composed of 56 State Units on Aging, over 600 Area Agencies on Aging, and thousands of public and private local service providers across the country. The U.S. Administration on Aging, an office within the Department of Health and Human Services, administers most OAA programs at the federal level. The aging network serves as a main gateway to OAA programs and to the many services supported by other federal, state and private sources. As a focal point, the network coordinates access, community long-term care, and supportive services for older Americans and their families. The array of services offered through the aging network varies from state to state and county to county; however, the basic structure of the aging service system is consistent throughout the country.

State Units on Aging (SUAs) are agencies of state and territorial governments designated by governors and state legislatures to administer, manage, design and advocate for benefits, programs, and services for the elderly and their families and, in many states, for adults with physical disabilities. In addition to overseeing Older Americans Act-funded programs, SUAs have significant policy, planning and advocacy roles in leveraging other federal, state, local, public, and private funds to support programs on aging. Two-thirds of the SUAs administer their state’s Medicaid waiver program (often called a home and community-based service waiver), a program which aims to help people in need of significant daily activity support and health services to receive care at home. In over half the states, the SUA administers adult protective services. Some SUAs are members of state domestic violence councils. Some convene or participate in intergovernmental working groups focused on older victims. Each SUA has a staff member who has been designated the elder abuse contact at the state level. State elder abuse contacts can provide consultation on the development of aging network partnerships and collaborations. To locate the SUA in your state, visit www.nasua.org/SUA_members.cfm.

Area Agencies on Aging (AAAs) play a pivotal role in communities across the country in planning and developing services to respond to local needs. The AAAs support a range of services in the community including legal assistance, in-home services, information and referral/assistance, client assessment and care management, senior centers, adult day care services, transportation, caregiver support, congregate meals, meals on wheels, chore and homemaker services, telephone reassurance, and friendly visiting. In some states, AAAs are responsible for the delivery of adult protective services. These services include receiving and investigating
reports of elder abuse. Most AAAs conduct elder abuse prevention activities such as public education campaigns, training for mandated reporters and educational conferences. Guardianship and money management programs, supported by AAAs in some areas, are examples of services intended to protect those most at risk of abuse.

The AAA is the principal contact point for domestic violence programs interested in local collaboration. Visit www.n4a.org/aboutaaas.cfm to learn more. Use the National Eldercare Locator 1 800–677-1116 or visit www.eldercare.gov to identify the AAA for your area. The Locator is a national, toll-free telephone referral service connecting callers with state and local agencies on aging and community services.

Aging Network Services at a Glance
The services available through the aging network offering support to victims of late life domestic violence and elder abuse fall under four broad categories:
1. Access services
2. Elder rights
3. Services in the community
4. In-home services

Information and Referral Assistance (I&R/A)
Millions of older people and their families around the country receive assistance each year from a network of more than 3,000 aging I&R/A programs and services. Many state agencies on aging have toll-free 800 aging I&R help lines—and in some areas state and local Long Term Care Ombudsman programs share a common intake line with the aging I&R/A. Individuals can also call the AAA for information on services and resources available locally. Most aging I&R/A databases provide information on a wide variety of critical health and human services. Increasingly, these databases are readily available to the public online. Find out if the aging I&R/A in your area has information about domestic violence services. If not, request to have local contact information included.

State Health Insurance Counseling and Assistance Programs
The State Health Insurance Counseling and Assistance Program, or SHIP, has trained volunteer counselors in every state and several territories who are available to provide free one on-one help with Medicare questions or problems. To locate a program in your area, visit www.medicare.gov/
contacts/static/allStateContacts.asp SHIP services can be especially helpful for late life domestic violence victims—in particular adults with disabilities under age 60 who have experienced problems with Medicare, and those not yet enrolled.

**Elder rights/Legal Assistance**
Legal services help those who could not otherwise afford an attorney to obtain advice, information, and limited representation in civil law matters such as financial abuse and exploitation, consumer problems, advanced directives, and guardianship. These services are primarily provided by local legal services entities in the community funded by AAAs. At the state level, every SUA has a State Legal Service Developer on staff to coordinate the provision of legal assistance. State and area agencies on aging work to expand legal service availability through coordination with state/local bar committees, the development of pro bono or reduced-fee panels and through coordination with grantees of the Legal Services Corporation. Many states also operate statewide legal hotlines. Older Americans Act-funded legal services are free; however, the demand for services far exceeds the dollars available. To meet the needs in the community, many programs establish case intake priorities. The AAA can provide more information about legal resources for older persons in the area.

The following are examples of possible legal remedies for victims of late life violence or elder abuse:

- Assisting a victim to enter into a new power of attorney arrangement and/or revoke authority of an existing attorney in fact (the individual who holds a power of attorney).
- Terminating the powers of a guardian who has abused his or her role.
- Providing defense for a proposed ward in a guardianship proceeding if an abuser is attempting to gain control without looking out for the ward's best interests.
- Returning title to a victim's name for property, vehicles, certificates of deposit, or bank accounts that were taken by a perpetrator.
- Filing an action to recover property or money wrongfully taken.
- Obtaining a restraining order or injunction to stop a perpetrator.
- Establishing a trust to protect the resources of a victim.
- Changing a will back to a testator's/victim's wishes from the changes made by a perpetrator.
- Appealing a denial of public benefits, Social Security, or disability decision.
• Filing for a name change.
• Filing an order for removal of a perpetrator from a victim's property.
The American Bar Association’s Law & Aging Guide can help you find a senior legal services program in your area. You can search by state online at www.abanet.org/aging/statemap.html. For a listing of State Legal Services Developers see www.tcs.org/lsd_01.pdf.

**Long Term Care Ombudsman Program**
Long term care ombudsmen at both the state and local levels advocate for and protect the rights of residents in nursing and care homes. Ombudsmen investigate and work toward resolution of complaints about care voiced by residents or their family members. Federal law requires all states to have a Long Term Care Ombudsman Program. A contact directory of state ombudsman offices is available on the National Long Term Care Ombudsman Resource Center Web site www.ltcombudsman.org. Domestic violence doesn’t necessarily stop when a victim enters a nursing, assisted living, or care home. In many instances, the ombudsman can identify and respond to these situations. The ombudsman can also be a resource to a victim of domestic violence who has a family member in a nursing home. Similar to domestic violence intervention, the ombudsman focus is to clarify and carry out the wishes of the resident. All communications between the resident and the Ombudsman are confidential. Ombudsmen and domestic violence programs will likely benefit from joint training to promote greater understanding and collaboration.

**Elder Abuse Prevention and Coalitions**
Community and state advocates all around the country are working to educate the public and increase understanding about elder abuse. In addition to offering various resources on elder abuse such as brochures, wallet cards with reporting numbers, posters, and service directories, state and area agencies on aging help sponsor and organize multidisciplinary conferences, training, and outreach presentations for community leaders, advocates, allied professionals, and concerned citizens. Aging network agencies also lead, coordinate, and participate in state and local elder abuse coalitions. Membership in these coalitions includes law enforcement; prosecutors; adult protective services; representatives from the health care sector; emergency medical services; and other key partners. Often the coalitions develop
community projects to increase understanding and outreach to elder abuse victims. Elder abuse prevention activities are mandated by the Older Americans Act. Domestic violence programs, if not already involved in a state or local elder abuse coalition, are encouraged to inquire about becoming a member. Similarly, to promote collaboration and exchange, invite participation of elder abuse partners in state and local domestic violence task forces and coordinating councils.

**Adult Protective Services**
Adult protective services are authorized under state law. Support is provided to both older and at-risk vulnerable adults who are in danger of being abused or neglected, or who are unable to protect themselves and have no one to assist them. Services include but are not limited to receiving and investigating reports of abuse, neglect or exploitation, legal advocacy, and providing or arranging for community services such as emergency shelter. Service plans are developed for victims who agree to receive help. If the victim is unable to make decisions because of mental illness or dementia and is at risk of continuing harm, adult protective services may provide emergency services and/or petition the court for the appointment of a guardian advocate. The AAA in some areas of the country is the local provider of adult protective services; in most states, however, the county social service agency is assigned responsibility. Domestic violence programs seeking to improve services for victims of late life violence and abuse are encouraged to coordinate with both sectors. Ideally, opportunities would be offered for advocates in the aging, domestic violence, and adult protective services sectors to participate in joint training so that each better understands the other’s mandates, philosophies, challenges, and professional cultures. To learn more, visit the National Center on Elder Abuse Web site www.elderabusecenter.org.

**Services in the community**

**Senior Employment and Volunteer Opportunities**
Senior employment services are designed to link mature job seekers 55 and over with job opportunities. Income eligible persons are recruited, trained, and referred to job openings with local employers. Funding for the Senior Community Service Employment Program, or SCSEP, comes from the U.S. Department of Labor. SCSEP is operated by national, state, and local agency sponsors. The ultimate goal is to place mature and older workers in permanent, non-subsidized employment. Volunteer opportunities abound in
the aging network. Examples include friendly visiting to shut-ins, volunteer ombudsmen service, home meal delivery, benefits counseling, and senior companion services for developmentally disabled children and adults.

SCSEP may be a source of help for older domestic violence victims who need job coaching and a gradual, supportive entry into the world of work. According to AARP, more than one quarter of SCSEP positions are filled by job seekers 55–59. Volunteer opportunities in service to older persons may be particularly important for domestic violence victims who feel isolated and for whom such experience would enhance a sense of independence and self-worth. Volunteer opportunities can be explored through contact with the AAA information and referral/assistance service.

In-Home Supportive and Personal Care Services
A wide range of supporting in home, homemaker, and chore services are available to assist older adults who need help with everyday activities. These services are non-medical and may include such things as light housekeeping, laundry, personal care, shopping and cooking, transportation, friendly visiting and telephone reassurance, respite, repair or yard work, and case management. The AAA provides information and assistance in accessing these services. In-home supportive services help prevent social isolation and may help to reduce the likelihood of elder abuse, neglect, and exploitation by family members.

Senior Centers
There are now thousands of senior community centers around the country. These community gathering places serve a variety of purposes, including functioning as meal sites, screening clinics, recreational centers, social service agency branch offices, mental health counseling clinics, older worker employment agencies, volunteer coordinating centers, and community meeting halls. Senior centers are key locations for reaching victims, or potential victims, of late life domestic violence. They offer a convenient meeting place for community education and discussion/support groups on domestic violence/elder abuse. They can also be a resource for finding community volunteers. Local senior centers offer different types of programs and services based on population needs and resource availability. For more information, contact your local AAA. Working with the Aging Network As with other human service systems, the national aging network is diverse. At the same time, however, members of the network share a common set of
values and a single vision: to protect the inherent dignity, security, and equal rights of all older Americans. The key unifying values are these:

➢ Self-determination. The value of self-determination is based on a belief that all older Americans, including residents of nursing and care homes, are entitled to plan and manage their own daily lives: where they live, how they spend their money, what services they receive, and other important daily decisions. Respect, active listening, and open communication are essential tools for empowering choice and independence. If a person loses decision-making capacity due to dementia or other mental health need, a legal guardian or surrogate decision-maker may be appointed (by the individual or court) to make decisions in his or her behalf.

➢ Advocacy. Uniquely in federal law, Older Americans Act authorizing legislation requires state and area agencies on aging to be "visible and active advocates" for older persons. In their role as "systems advocates" they speak out on policy issues; testify at federal/state/local hearings; and identify unmet needs and gaps in services. In parallel step, elder rights programs such as long-term care ombudsman and legal assistance serve an individual advocacy role, speaking out for those who are without voice. There may be distinctions in how the aging network and the domestic violence programs view their advocacy roles. This may be a fruitful place to start identifying similarities and distinctions. Elder rights. The term “elder rights” reflects the aging network’s belief that older people have a right to the many benefits, services, and protections promised in law—not just aging statutes, but statutes covering the population at large. Older persons’ needs are often ignored and access to important services denied. By providing stepped-up information about benefits to help cut through red tape, legal representation to solve problems, and protective services for those who are most vulnerable, the aging network plays a key role in promoting elder rights. Typically, the states’ elder rights systems focus on the coordination of adult protective, long term care ombudsman, legal assistance services. Community-based long term care. This term encompasses the effort within the aging network to offer elders with long term care needs health and supportive services in their own homes and community. Homemaker, home-health aide, day care, and personal attendant care are among the services provided. Medicaid waivers fund a large proportion of these services. Caregiver support services (such as
respite care) are provided to help families maintain the elder in non-institutional settings.

Eligibility and fees. Other than age, there are no eligibility criteria restricting services under the Older Americans Act. Other senior services, especially those funded by special state appropriations and federal Medicaid waivers, may have financial criteria for eligibility, require cost sharing, or be offered on a sliding fee schedule. For many in-home services (home-delivered meals, homemaker and chore services, for example) individual needs assessments establish service priorities. There are waiting lists for many services. Under the Older Americans Act, priority in home and community service delivery is given to those who are determined to be in greatest need.

About the Older Victim: Common Indicators of Domestic Violence in Later Life
New collaborations benefit from dialogue and common understanding. Not surprisingly, the behavioral indicators of late life domestic violence parallel victim/abuser scenarios found in other forms of domestic violence and are likely well known by domestic violence staff. The chart on the next page, developed by experts in elder abuse, is included here to underline the importance of recognizing potential victim and abuser actions.
Responding to and Working with Older Victims

Ending a relationship is always difficult, particularly when it is a loved one. Most victims of abuse in later life prefer to maintain some type of relationship with their spouse/partner, family member, or caregiver – they simply want the abuse to end. Some older victims will choose to stay with an abuser, often for religious, cultural, generational, or financial reasons. These victims can benefit from support, information, safety planning and strategies to break isolation. Personal values formed by an individual’s background, experience, and beliefs also play a role. It is important to respect the victim’s
values, decisions, and cultural heritage. Some cultural groups may be more willing to report abuse or talk to professionals about family problems than others. Race, culture, or ethnicity may influence body language, eye contact, and expressions of emotion. Generational values are also involved. Many older persons may be uncomfortable talking about personal, private matters with strangers. They may fear younger professionals imposing their own generational values about divorce or women’s roles onto them and judging their decisions.

Some tips for establishing rapport are:

• **The setting.** Establish comfort. Choose a quiet place and face the person directly. Pay attention to lighting; reduce glare from outside sources.

• **The conversation.** Use respectful and formal terms of address: Mrs., Mr., and so on. Introduce yourself clearly. To help reduce stress, start with a non-threatening topic. Speak calmly and clearly in a normal tone. Avoid jargon.

• **Active listening.** Show from the start that you accept the person and understand. Listen for meaning. Restate, “Let’s see if I’m clear about this." Reflect, “This seems to be really difficult for you.” Validate, “I appreciate your willingness to talk about such a difficult issue.”

• **The plan.** Engage the victim in deciding what the next steps should be. “Let’s explore the options.” Reinforce steps that have been taken so far. Recognize that decisions may take time. Don’t rush. Slow down to give the victim time to sort out what he or she has heard.

**Domestic Violence/Aging Network Collaborations**

The aging network and domestic violence programs are natural allies in the fight against violence in all its forms. Examples of collaboration include participation on multidisciplinary teams, involvement in coalitions, joint training, joint referral protocols, public education, and policy development. The National Center on Elder Abuse Promising Practices Database [www.elderabusecenter.org/default.cfm?p=toolsresources.cfm](http://www.elderabusecenter.org/default.cfm?p=toolsresources.cfm) contains a listing of several projects around the country that provide services in collaboration with domestic violence programs. These projects may serve as examples for aging network staff seeking to form new partnerships. The Wisconsin Coalition Against Domestic Violence, National Clearinghouse on Abuse in Later Life also has compiled profiles of several elder specific services that are provided by domestic violence programs. A summary can be viewed at [www.ncall.us/docs/NCALL_Directory.pdf](http://www.ncall.us/docs/NCALL_Directory.pdf)
State and National Resources on Late Life Violence

➢ **National Domestic Violence Hotline** 1-800-799-SAFE (7233) or 1-800-787-3224 (TTY) [www.ndvh.org](http://www.ndvh.org/) Help is available to callers 24 hours a day, 365 days a year. Assistance is available in English and Spanish with access to more than 140 languages through interpreter services.

➢ **Domestic Violence and Sexual Assault State Coalitions** work with statewide systems and agencies on behalf of the needs and interests of victims of abuse/assault. Coalitions are membership organizations comprised of local domestic violence and sexual assault agencies and other organizations and individuals dedicated to the elimination of abuse. Most do not provide direct services to victims of abuse. Areas where they can help include: public awareness, professional training, community education, information and referral, resource and materials development, technical assistance, and consultation. Coalitions also monitor state and national legislation and lobby to support the creation of laws that increase victim safety and support and hold perpetrators accountable. A contact directory of state domestic violence coalitions is available on the U.S. Department of Justice, Office of Violence Against Women Web site at [www.usdoj.gov/ovw/state.htm](http://www.usdoj.gov/ovw/state.htm). To locate your state sexual assault coalition, see [www.usdoj.gov/ovw/saresources.htm](http://www.usdoj.gov/ovw/saresources.htm)

➢ **National Center on Elder Abuse**, funded by the U.S. Administration on Aging, is a gateway to a wealth of information on subjects ranging from elder abuse and neglect to financial exploitation, nursing home abuse, and domestic violence in later life. Examples of publications are *Domestic Violence: Older Women Can Be Victims Too* and *Multidisciplinary Elder Abuse Prevention Teams: A New Generation*. For more information, call (202) 898-2578, e-mail ncea@nasua.org, or visit the NCEA Web site at [www.elderabusecenter.org](http://www.elderabusecenter.org)

➢ **National Clearinghouse on Abuse in Later Life**, a project of the Wisconsin Coalition Against Domestic Violence, has numerous publications and resources concerning older battered women and sexual assault including. Examples include *Golden Voices: Support Groups for Older Abused Women* and *A National Domestic Abuse in Later Life Resource Directory*. For more information, call (608)
255-0539, e-mail wcadv@wcadv.org, or visit the Clearinghouse's Web site at www.ncall.org

➢ American Bar Association Commission on Law and Aging has produced a Resource Packet on Domestic Violence and Sexual Abuse in Later Life with funding from the Office on Violence Against Women at the U.S. Department of Justice. For more information, call (202) 662-8690 or e-mail abanet@abanet.org, or visit www.abanet.org/aging/resourcepack.pdf

➢ Clearinghouse on Abuse and Neglect of the Elderly is the nation’s largest computerized collection of scholarly references and other resources relating to elder abuse, neglect, and exploitation. To search for literature, visit the CANE Web site at http://db.rdms.udel.edu:8080/CANE/index.jsp. To narrow the search, key in ‘domestic violence’ or ‘older battered women.’ For more information, call (302) 831-3525 or e-mail CANE-Ud@udel.edu

➢ National Resource Center on Domestic Violence, a project of the Pennsylvania Coalition Against Domestic Violence, provides technical assistance, training and information on domestic violence and related issues. For more information, call 1-800-537-2238, or visit the Center's Web site at www.vawnet.org/index.php

➢ National Coalition Against Domestic Violence is a national organization of grassroots shelter and service programs for battered women. It serves as a national information and referral center on domestic violence. For information, technical support, or referral, call (303) 839-1852, e-mail mainoffice@ncadv.org, or visit the Coalition's Web site at www.ncadv.org/

➢ Asian & Pacific Islander Institute on Domestic Violence serves as a forum for, and clearinghouse on information, research, resources, and critical issues about violence against women in Asian and Pacific Islander communities. For more information, call (415) 954-9988, e-mail apidвинstitute@apiahf.org, or visit the Institute's Web site at www.apiahf.org/apidvinstitute/default.htm

➢ Sacred Circle, National Resource Center to End Violence Against Native Women provides training, consultation, and technical
assistance to Indian Nations, tribal organizations, law enforcement agencies, prosecutors, and courts to address the safety needs of Native women who are battered, raped and stalked. It is a project of Cangleska, Inc., which operates a shelter on the Pine Ridge reservation in southwestern South Dakota. For more information, call (605) 341-2050, e-mail scircle@sacred-circle.com, or visit the Sacred Circle Web site at www.sacred-circle.com/

➢ **Alianza – National Latino Alliance for the Elimination of Domestic Violence** is part of a national effort to address the domestic violence needs and concerns of under-served populations in Latino communities. For more information, call (800) 342-9908 or 1-800-342-9908, e-mail inquiry@dvalianza.org, or visit the Alianza Web site at www.dvalianza.org

➢ **Institute on Domestic Violence in the African American Community** is focused on setting an agenda to reduce/eliminate domestic violence in the African American community. For more information, call (612) 624-5357, e-mail nidvaac@che.umn.edu, or visit the DV Institute Web site at www.dvinstitute.org

➢ **Institute on Aging, San Francisco Elder Abuse Prevention Program** has worked with local and national organizations to create several publications on late life domestic violence. Titles include: *Domestic Violence and the Elderly: A Cross-Training Curriculum in Elder Abuse and Domestic Violence; Serving the Older Battered Woman: A Conference Planning Guide*; and *Older Battered Women: Integrating Aging and Domestic Violence Services*. For more information, call (715) 750-4188, e-mail elderabuseprevention@ioaging.org, or visit the IOA Web site at www.ioaging.org/programs/eap/eap.html

➢ **American College of Obstetricians and Gynecologists, Division of Women’s Health Issues** has produced a variety of materials about domestic violence and older battered women. For more information, call (202) 863-2487, or visit the ACOG Web site at www.acog.org/departments/dept_web.cfm?recno=17

➢ **Area Agency on Aging, Region One, Phoenix** has produced an educational video, *The Dance*, available in English and Spanish (*Nuestro Baile*), depicting the life of an older battered woman. For
more information or to order a copy of the video, call (602) 264-2255 or 1-888-783-7500. Or visit the agency's Web site at www.aaaphx.org/main/domesticViolence.asp

➢ **American Medical Association** has developed diagnostic and treatment guidelines for physicians on topics of domestic violence and elder abuse. For more information, call (312) 464-5066, or visit the AMA Web site at www.amaassn.org/ama/pub/category/3242.html

➢ **Family Violence Prevention Fund** has a number of helpful publications on domestic violence. For more information, visit the FVPF Web site at http://endabuse.org/

### 10. Sex and Aging

The topic of Love, Intimacy and Sexuality in the area of healthy aging is of major importance today for several reasons. "A happy sex life is part of the enjoyment of good health. Enjoyable sex refreshes both the mind and body" (*Source: Gillie & Mercer*). The elderly population is increasing annually at the same time that a youth-culture mentality is flourishing. A commonly held societal view is that older people ought not, or do not want to engage in sexual activity. Studies and research data, however, indicate that there is no automatic cut-off age for sexual activity. The loss of desire and need for love and intimacy are not dependent on the calendar. While there are significant changes in the physical and psychological aspects of sex with age, in the absence of illness or psychological factors, such changes do not lessen the capacity to engage in and enjoy sex in older adults.

As early as 1979 data indicated that "many old people continue to enjoy sex in their eighties and there is often no reason why sex life should not continue at this age. The exercise is good for the heart and lungs, quite apart from the pleasure which sex itself brings" (*Gillie & Mercer, p. 186*). More recent data on sex and aging confirms the earlier findings. *The Sexual Health Info Center* (2001) reports that "most older people experience some interest in sexual intimacy. Many people are sexually intimate well into their 80s and beyond. We do not all of a sudden become asexual beings; our capacity for sexual intimacy will be with us our entire lives."

Another factor for decreased sexual relations is that many older adults are
not familiar with the physical changes that are a normal part of aging, and may come to believe that they are sexually inadequate; this, in turn, can lower their self-esteem, raise their anxiety level, and ultimately prevent them from attempting to engage in intimate relationships. This may hold true for couples in a marital relationship as well as for single, divorced or widowed older adults (Deacon, Minichiello, Plummer).

As people age, they are usually faced with the elimination of two very satisfying and nurturing parts of life; these are careers and co-workers, and in many cases grown children who are on their own and do not live nearby. In addition, as people age, many relatives, partners, mates and close friends have passed on. The loss of these intimate relationships and work can leave a vacuum in the day to day lives of many older people. For healthy aging to occur, new personal relationships must be formed. The need for intimacy does not diminish with age. In fact, as The Sexual Health Info Center points out, personal relationships become even more important. Although many older people may still have spouses or life partners, the loss of children and career intensifies the need for love, intimacy and sex "as a way of solidifying our relationship with our partner and taking refuge from the sometimes harsh reality of the world. Sex is a way to affirm the love of life....It expresses the closeness of our deepest relationships and is an important measure of the quality of life." (Source: Social Gerontology: Sex and the Elderly).

Healthy aging is, of course, inevitably tied to the quality of life. The quality of life can be maintained in old age if one is lucky enough to be relatively healthy, to have a network of friends, to have hobbies or some kind of work in which creativity can be expressed -- whether it is volunteering at a free health clinic, or a local school, gardening, painting, sports or any other activity that fills time in a meaningful way. In addition, the role of love, intimacy and sex in healthy aging cannot be underestimated (Source: Social Gerontology: Sex and the Elderly).

HIV and the Elderly

While much of the public’s attention is focused on young people contracting almost half of all new HIV and AIDS cases, there’s a growing HIV/AIDS problem developing among the elderly, a problem that will only grow worse as baby boomers reach retirement.

In 2005, persons aged 50 and over accounted for
• 15% of new HIV/AIDS diagnoses
• 24% of persons living with HIV/AIDS (increased from 17% in 2001)
• 19% of all AIDS diagnoses
• 29% of persons living with AIDS
• 35% of all deaths of persons with AIDS

The rates of HIV/AIDS among persons 50 and older were 12 times as high among blacks (51.7/100,000) and 5 times as high among Hispanics (21.4/100,000) compared with whites (4.2/100,000). Persons over the age of 50 may have many of the same risk factors for HIV infection that younger persons have. Prevention challenges among persons 50 and older include:

• Many older persons are sexually active but may not be practicing safer sex to reduce their risk for HIV infection.

• Older women may be especially at risk because age-related vaginal thinning and dryness can cause tears in the vaginal area.

• Some older persons inject drugs or smoke crack cocaine, which can put them at risk for HIV infection. HIV transmission through injection drug use accounts for more than 16% of AIDS cases among persons aged 50 and older.

• Some older persons, compared with those who are younger, may be less knowledgeable about HIV/AIDS and therefore less likely to protect themselves. Many do not perceive themselves as at risk for HIV, do not use condoms, and do not get tested for HIV.

• Older persons of minority races/ethnicities may face discrimination and stigma that can lead to later testing, diagnosis, and reluctance to seek services.

(Source: CDC)

People of color are still disproportionately affected. Fifty-two percent of older Americans living with HIV/AIDS are either Black or Hispanic, reports the CDC. Among men over 50 living with HIV and AIDS, 49 percent are of color. Among women, 70 percent are of color.
The continued increase in HIV among those over 50 can also be attributed to their living longer, thanks to advanced HIV therapy. According to Bill Rydwels, a 73-year-old man who has been living with HIV for 20 years, who works with the Chicago Forum on HIV and Aging, the perception that people over 50 aren’t sexually active is one of the leading causes of high rates of HIV and AIDS among this group, “People over 50 come from a generation where the discussion of sex was an under-the-table thing,” he said. “Nobody wants to discuss the sexual habits of older people. It’s the concept that older people stop having sex, and it’s just not a reality.”

According to a study by the University of Chicago, 60 percent of men and 37 percent of women 50 years old and above report engaging in sexual intercourse a few times per month. Rita Strombeck, a physician with Healthcare Education Associates, a group that has recently developed a continuing medical education program for doctors and nurses to recognize HIV/AIDS as a problem among older people, agrees, “It has to do with the fact that they [older people] don’t consider themselves at risk and they are. One of the problems with doctors and primary care providers is they don’t recognize it’s a problem with older adults, either”.

According to Patricia Hawkins, associate executive director of the D.C.-based Whitman-Walker Clinic, the popularity of medications such as Viagra has also contributed to the surge of HIV and AIDS among this group, “Viagra has contributed a lot to this because there is so much more sexual activity among seniors and yet they are not often using contraception because they aren’t worried about pregnancy,” she said. “I don’t think that our medical community has caught up to the impact of Viagra.”

Because of a general lack of awareness in older adults, they have been omitted from research, trials, prevention and intervention efforts. Nonetheless, because of their age, they may be more at risk than young people. For older women, the use of condoms becomes unimportant after menopause.

Not only are older people at risk, the symptoms of HIV are hard to detect because of aging. Sometimes it’s difficult for physicians to determine if a person has the flu or is infected with the virus. Many of the early symptoms such as night sweats, chronic fatigue, weight loss, dementia and swollen lymph nodes mimic the natural aging process.

The National Association on HIV Over Fifty (NAHOF) says that there are specific ways to target older people, “Specific programs must be implemented for older adults who need to be informed about the
transmission and prevention of HIV, more research is needed to study seniors’ sexual and drug-using behaviors to determine HIV disease progression and treatments and programs aimed at reaching health care and service providers should cover misdiagnoses, treatments, support groups and more.”

11. Resources

Guidelines, Reports, Training Manuals, and On-Line Resources
Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults (2012) American Geriatrics Society http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/2012 Potentially inappropriate medications (PIMs) continue to be prescribed and used as first-line treatment for the most vulnerable of older adults, despite evidence of poor outcomes from their use. The Beers Criteria were updated using a comprehensive, systematic review and grading of the evidence on drug-related problems and adverse drug events in older adults. Thoughtful application of the Criteria will allow for closer monitoring of drug use, application of real-time e-prescribing and interventions to decrease adverse drug events in older adults, and better patient outcomes.

Consensus statement on improving the quality of mental health care in U.S. nursing homes: management of depression and behavioral symptoms associated with dementia, American Geriatrics Society & Association for Geriatric Psychiatry Journal of the American Geriatrics Society, 51(9), 1287–1298. This consensus statement, developed by an interdisciplinary panel of experts, focuses on the assessment and treatment of depression and dementia-related behavioral symptoms in nursing home residents. Dementia in the Long-term Care Setting Clinical Practice Guideline (2012) American Medical Directors Association http://www.nhqualitycampaign.org/files/Excerpts_from_AMDA_Clinical_Guidelines.pdf The purpose of this clinical practice guideline is to offer practitioners and care providers in LTC facilities a systematic approach to the recognition, assessment, treatment, and monitoring of patients with dementia, including impaired cognition and problematic behavior. It will provide a guide to appropriate management that maximizes function and quality of life, thereby minimizing the likelihood of complications and functional decline. The excerpts will focus on assessment, non-pharmacologic treatment and
monitoring of a resident with dementia, including impaired cognition and problematic behavior.

The guidelines provide information on: the parameters of evaluation and evidence based practices; prevailing diagnostic nomenclature and specific diagnostic criteria; special issues surrounding informed consent in cognitively compromised populations; cultural perspectives and personal and societal biases related to dementia; standardized psychological and neuropsychological tests; and, the importance of providing constructive feedback, support, education, and interventions as part of the evaluation process.

Guidelines for Psychological Practice with Older Adults, American Psychological Association. These guidelines are intended to provide practitioners with a frame of reference for engaging in clinical work with older adults, and basic information and further references in the areas of attitudes, general aspects of aging, clinical issues, assessment, intervention, consultation, professional issues, and continuing education and training relative to work with this group.

The intent of the Blueprint is to provide information on how healthcare professionals, individuals and families can work together to ensure appropriate, effective, and integrated healthcare for the increasing number of older adults. As interdisciplinary health care teams often function differently according to the site, models for different settings, including long-term care settings are discussed.

Advancing Excellence in America’s Nursing Homes (2012) Center for Medicare and Medicaid Services Multiple training programs/materials available for providers, clinicians, consumers and surveyors on the Advancing Excellence website and several association, university websites as well. [http://www.nhqualitycampaign.org]
Behavior Modification: Theory and Approaches, Center for Medicare and Medicaid Services http://surveyortraining.cms.hhs.gov/pubs/VideoInformation.aspx?cid=1087 Surveyor training by Leon Hyer, PhD, examines the role of behavior modification strategies that are commonly employed in the long-term care setting. The video emphasizes non-pharmacological interventions, although a general discussion of pharmacological alternatives and their effectiveness is included. The broadcast focuses on five major theories of behavior modification, with discussion and example scenarios for each.


Non-Pharmacological Interventions for Behavioral Symptoms of Dementia: A Systematic Review of the Evidence, O’Neil, M., Freeman, M., Christensen, V., Telerant, A., A
ddle man, A., & Kansagara, D. VA-ESP Project #05-225, Portland VA Medical Center, Portland, ORThis report reviews systematically the evidence on non-pharmacological treatments for behavioral symptoms of dementia. It is estimated that behavioral symptoms occur in as many as 90 percent of people with Alzheimer’s disease. Moreover, it is the behavioral symptoms that are most often cited by caregivers as the reason for the placement of individuals with dementia into residential care. Psychotropic medications are commonly used to treat the behavioral symptoms of dementia. There is little evidence, however, that such interventions are effective, and their potential side effects are frequent and often hazardous. It has been reported that the use of atypical and typical antipsychotic medication is associated with the increased risk of death. Because of the limited benefits and the potential harms associated with psychotropic medications, non-pharmacological interventions for the
behavioral symptoms associated with dementia may be an attractive alternative to pharmacological treatment.

Journal Articles Effective behavioral interventions for decreasing dementia-specific challenging behavior in nursing homes. Allen-Burge, R., Stevens, A. B., & Burgio, L.D. Journal of Geriatric Psychiatry, 14(3), 213-232. This paper provides a selective review of behavioral intervention research aimed at successfully decreasing dementia-related challenging behaviors in nursing homes. The authors include separate discussions of behavioral excesses (disruptive vocalization, wandering, physical and verbal aggression) and deficits (excess dependency, therapeutic activities, social interaction/communication). Descriptions of interventions used to address each behavior problem are followed by methodological evaluations of the research. Discussions are augmented by inclusion of the authors' ongoing intervention research. The paper concludes with a description of a comprehensive program for teaching behavior management skills to nurse aides and a motivational system for maintaining the performance of these skills over the long-term.

Come talk with me: Improving communication between nursing assistants and nursing home residents during care routines Burgio, L. D., Allen-Burge R., Roth D. L., Bourgeois M. S., Dijkstra K., Gerstle J., et al., The Gerontologist, 41(4), 449-460. The effects of communication skills training and the use of memory books by certified nursing assistants (CNAs) on verbal interactions between CNAs (n = 64) and nursing home residents (n = 67) were examined during care routines. CNAs were taught to use communication skills and memory books during their interactions with residents with moderate cognitive impairments and intact communication abilities. A staff motivational system was used to encourage performance and maintenance of these skills. Formal measures of treatment implementation were included. Results were compared with those for participants on no-treatment control units. Trained CNAs talked more, used positive statements more frequently, and tended to increase the number of specific instructions given to residents. Changes in staff behavior did not result in an increase in total time giving care to residents. Maintenance of CNA behavior change was found 2 months after research staff exited the facility. Although an increase was found in positive verbal interactions between CNAs and residents on intervention units, other changes in resident communication were absent. Nursing staff can be trained to improve and maintain communication skills during care without increasing the amount of time delivering care. Teaching and maintaining behavior management skills
The Gerontologist, 42(4), 487-496. This study examined the efficacy of a comprehensive behavior management skills training program for improving certified nursing assistants' (CNA) skill performance in the nursing home, to assess the effectiveness of a staff motivational system for maintaining newly acquired behavior management skills for a 6-month period, and to evaluate any resulting effects on resident agitation. This study used a randomized clinical trial of 88 residents with behavior disturbances and 106 CNAs who cared for them in two urban nursing homes. After CNAs received 4 weeks of behavior management training, supervisory nursing staff implemented formal staff management (FSM), designed to maintain training effects over time. The supervisory staff used conventional staff management (CSM, usual supervisory routine) on control units. During the immediate post-training phase, both the FSM and CSM groups improved five out of seven communication skills and the ability to delay physical assistance during care routines. Although CNAs showed a reduction in the use of ineffective behavior management strategies, they did not increase their use of effective behavioral strategies. Follow-up assessments suggested that the FSM system was more effective than CSM for maintaining and even improving communication skills over time. Resident agitation was reduced during care interactions and maintained at follow-up. The behavior management skills training program improved CNAs' ability to interact with behaviorally disturbed nursing home residents and produced sustained reductions in agitation. The FSM system was more effective for maintaining communication skills 6 months after training.

Geropsychology Practice: One psychologist’s experience in long-term care Burns, S. Psychological Services, 5(1), 73-84. The rapidly developing field of Clinical Geropsychology was acknowledged as a proficiency in 1998 by the American Psychological Association. This article presents one psychologist's perspective in an account of her 3 1/2 years of clinical experience working with an ethnically diverse, elderly cohort in a small, state-financed nursing home in Hawaii. Some practice setting challenges are presented, along with a portrayal of the benefits of interdisciplinary practice. The experiences described in this article are intended to provide support for the fundamental value and relevance of the Guidelines for Psychological Practice With Older Adults, and to encourage a more eclectic, adaptive, and inclusive practice model of therapy with the elderly that is evidence-based, person centered, and systems-oriented. Use of non-pharmacologic
interventions among nursing home residents with dementia. Camp, C.J., Cohen-Mansfield, J., & Capezuti, E.A. Psychiatric Services, 53(11), 1397-1401. The authors describe domains of non-pharmacologic interventions for residents with dementia who are receiving long-term care. Special emphasis is placed on interventions involving the domains of inappropriate behavior, restraint reduction, and cognition. Illustrations of the salubrious effects of these interventions are presented. For each domain, a review of the available information about non-pharmacologic interventions is provided, and areas in which additional information is needed are discussed. The authors conclude with a summary that emphasizes linkages and similarities among interventions across domains. The authors' major point is that effective non-pharmacologic interventions are available for a variety of behavioral problems that are commonly observed in long-term care settings.

Emergency commitment from nursing homes. Christy, A., & Molinari, V. (2011). Journal of the American Medical Directors Association, 12 (8), 551-553. The purpose of this study was to describe emergency commitment of residents from nursing homes and to discuss relevant policy issues. There were 898 residents of Florida nursing homes with a total of 1032 emergency commitments. Some individuals had more than one emergency commitment from a nursing home during the year, with 9% having between two and five emergency commitments. One-third of the emergency commitments were for residents younger than 65. Some of these individuals also had substantial numbers of emergency commitments in the 7 years from July 2000 through June 2007. Implications: There are facility, client, and regulatory factors that can be addressed to reduce the inappropriate usage of emergency commitments in nursing homes.

Behavioral manifestations of pain in the demented elderly. Cipher, D.J., Clifford, P.A., Roper, K. Journal of American Medical Directors Association, 7(5), 355-365. In long-term care settings, behavioral disturbances are exhibited more often by those residents with some level of cognitive impairment. The extent to which pain influences dysfunctional behaviors, and the extent to which pain manifests itself as dysfunctional behaviors, has not been empirically studied. The purpose of our study was to investigate the relationship between pain and behavioral disturbances among long-term care residents suffering from varying levels of dementia. A cross-sectional study of 277 long-term care residents aged 60 and older was conducted. Results suggest that pain influenced behavioral disturbances among those with severe dementia more often than those with moderate or mild dementia, and
residents with chronic pain who have severe dementia exhibit significantly more dysfunctional behaviors than those with earlier-stage dementia. These findings support the utility of comprehensive behavioral analysis involving clinical ratings of intensity, frequency, and duration of dysfunctional behaviors, with the assessment of the resident's level of dementia. The results imply that pain and other forms of physical suffering must be adequately treated in order to reduce behavioral disturbances and improve quality of life.

Efficacy of geropsychological treatment in improving quality of life in long-term care: pain, depression, behavioral disturbances, ADLS, and health care utilization Cipher, D.J., Clifford, P.A., Roper, K. Clinical Gerontologist, 30(3), 23-40. Geropsychological interventions have become a necessary component of quality long-term care (LTC) designed to address residents' co-morbidities involving emotional, functional, and behavioral difficulties. This two-part study was conducted to investigate the impact of Multimodal Cognitive- Behavioral Therapy (MCBT) for the treatment of pain, depression, behavioral dysfunction, functional disability, and health care utilization in a sample of cognitively impaired LTC residents who were suffering from persistent pain. In Study 1, 44 consecutive new patients received a comprehensive psychological evaluation, eight sessions of cognitive- behavioral therapy, and follow-up psychological evaluation over a five-week period. Analyses indicated that patients exhibited significant reductions in pain, activity interference due to pain, emotional distress due to pain, depression, and significant increases in most activities of daily living. They also exhibited significant reductions in the intensity, frequency, and duration of their behavioral disturbances, but not the number of behavioral disturbances. In Study 2, as a follow-up to Study 1, a retrospective chart review was conducted to compare the treatment group with a matched-control group on post treatment health care utilization. Comparisons between the two groups on Minimum Data Set (MDS) ratings indicated that the treatment group required significantly fewer physician visits and change orders than the control group. Implications of these collective findings are that geropsychological treatment is likely to improve certain aspects of residents' quality of life in LTC. The geriatric multidimensional pain and illness inventory: A new instrument assessing pain and illness in long-term care Clifford, P.A., Cipher, D.J. Clinical Geropsychologist, 28 (3), 45-61. 

The Geriatric Multidimensional Pain and Illness Inventory (GMPI) was developed in order to assess the perceptual, functional, and emotional concomitants of pain and illness in long-term care. The GMPI was
administered to 401 adults aged 60 and older residing in one of 16 long-term care facilities. The GMPI items were analyzed for reliability, content validity, and convergent and discriminant validity. Factor analysis of the GMPI items revealed three subscales, level of pain severity, level of functional limitations associated with pain, and level of emotional distress associated with pain. The GMPI items were significantly correlated with items from the Geriatric Depression scale, the Neurobehavioral Cognitive Status Exam, and the Activities of Daily Living. The GMPI is evidenced to be a reliable and valid assessment tool for assessing pain of residents in long-term care facilities. State policies for the residency of offenders in long-term care facilities: Balancing right to care with safety Cohen, D., Hayes, T., & Molinari, V. (2011). Journal of the American Medical Directors Association, 12(7), 481-486. The presence of residents in long-term care facilities who are registered sex offenders, other predatory offenders, parolees, or inmates transferred by correctional authorities is controversial and has raised concerns about how to care for this potentially dangerous population who may jeopardize the safety of others. Although the present offender population appears to be small, it is likely that demographic and economic pressures will increase its size. Since 2004, 14 states have passed legislation about placement of sex and other offenders in facilities and 5 have implemented non-law policies. Because legislation is relatively recent, it is not possible to evaluate best practices at this time. Research should be a priority to determine best policies and practices to balance the right to care with safety.

Can persons with dementia be engaged with stimuli? Cohen-Mansfield, J., Marx, M. S., Dakheel-Ali, M., Regier, N.G. & Thein, K. (2010). American Journal of Geriatric Psychiatry, 18(4), 351-362. The purpose of this study was to determine which stimuli are most engaging, most often refused by nursing home residents with dementia, and most appropriate for persons who are more difficult to engage with stimuli. Participants were 193 residents of seven Maryland nursing homes with a diagnosis of dementia. Stimulus engagement was assessed by the Observational Measure of Engagement. The most engaging stimuli were one-on-one socializing with a research assistant, a real baby, personalized stimuli based on the person's self-identity, a lifelike doll, a respite video, and envelopes to stamp. Refusal of stimuli was higher among those with higher levels of cognitive function and related to the stimulus' social appropriateness. Women showed more attention and had more positive attitudes for live social stimuli, simulated social stimuli, and artistic tasks than did men. Persons with comparatively higher levels of cognitive functioning were more likely to be engaged in manipulative and
work tasks, whereas those with low levels of cognitive functioning spent relatively more time responding to social stimuli. The most effective stimuli did not differ for those most likely to be engaged and those least likely to be engaged. Nursing homes should consider both having engagement stimuli readily available to residents with dementia, and implementing a socialization schedule so that residents receive one-on-one interaction. Understanding the relationship among type of stimulus, cognitive function, and acceptance, attention, and attitude toward the stimuli can enable caregivers to maximize the desired benefit for persons with dementia.

The impact of past and present preferences on stimulus engagement in nursing home residents with dementia Cohen-Mansfield, J., Marx, M. S., Thein, K., & Dakheel-Ali, M. (2010). Aging and Mental Health, 14(1), 67-73. Engagement with stimuli in 193 nursing home residents with dementia was examined. The expanded version of the self-identity questionnaire [Cohen-Mansfield, J., Golander, H. & Arheim, G.] was used to determine participants’ past/present interests (as reported by relatives) in the following areas: art, music, babies, pets, reading, television, and office work. We utilized the observational measurement of engagement (Cohen-Mansfield, J., Dakheel-Ali, M., & Marx, M.S. Analysis revealed that residents with current interests in music, art, and pets were more engaged by stimuli that reflect these interests than residents without these interests. The findings demonstrate the utility of determining a person's preferences for stimuli in order to predict responsiveness. Lack of prediction for some stimuli may reflect differences between past preferences and activities that are feasible in the present.

Depression identification in the long-term care setting: The GDS vs. the MDS Heiser, D. Clinical Geropsychologist. This study compared depression identification rates and validity of the currently mandated Minimum Data Set (MDS) and the Geriatric Depression Scale Short Form-15 item (GDS) in a sample of nursing home residents. Results indicate the GDS is a better tool for identifying depression than the MDS. The GDS, MDS Section E1, QI, and OSCAR screened 35%, 23%, 3%, and 4% positive for depression, respectively. Mean sensitivity and specificity for SADS-RDC (gold standard) vs. GDS, MDS Section E1, OSCAR, and QI were .91, .79, .83, and .88, respectively. Chi-square analyses indicated the GDS was the only test, in relation to the SADS-RDC to identify depressed residents p = .001.

challenges to both clinicians and researchers. In this review we discuss the variety of forms depression can take among LTC residents and the influence the LTC environment can play on the development and maintenance of depression. We describe instruments that can be used to assess depressive symptoms, along with their strengths and liabilities. Additionally, we summarize treatment approaches, with an emphasis on the relatively limited number of empirically informed interventions. Throughout, we describe modifications that may improve the accuracy of assessment and the effectiveness of psychological treatments. Depression, while common among LTC residents, appears amenable to psychological intervention, although the field is far from identifying empirically supported treatments in the LTC setting.

Group, individual, and staff therapy: An efficient and effective cognitive behavioral therapy in long-term care Hyer, L., Yeager, C. A., Hilton, N., & Sacks, A. American Journal of Alzheimer’s Disease and other Dementias, 23(6), 528-539. Depression is a major problem in long-term care (LTC) as is the lack of related empirically supported psychological treatments. This small study addressed a variant of cognitive behavioral therapy, GIST (group, individual, and staff therapy), against treatment as usual (TAU) in long-term care. 25 residents with depression were randomized to GIST (n = 13) or TAU (n = 12). Outcome measures included geriatric depression scale-short form (GDS-S), life satisfaction index Z (LSI-Z), and subjective ratings of treatment satisfaction. The GIST group participated in 15 group sessions. TAU crossed over to GIST at the end of the treatment trial. There were significant differences between GIST and TAU in favor of GIST on the GDS-S and LSI-Z. The GIST group maintained improvements over another 14 sessions. After crossover to GIST, TAU members showed significant improvement from baseline. 8 Participants also reported high subjective ratings of treatment satisfaction. This trial demonstrated GIST to be more effective for depression in LTC than standard treatments.

Longitudinal investigation of wandering behavior in Department of Veterans Affairs nursing home care units King-Kallimanis, B., Schonfeld, L., Molinari, V., Brown, L., Kearns, W., et al. International Journal of Geriatric Psychiatry, 25, 166-174. The purpose of this study was to explore the extent of and factors associated with male residents who change wandering status post nursing home admission. Admissions over a 4-year period were examined using repeat assessments with the Minimum Data Set (MDS) to formulate a model understanding the development of wandering behavior. 134 Veterans Administration (VA) nursing homes throughout the United
States including 6673 residents were studied. MDS variables (cognitive impairment, mood, behavior problems, activities of daily living and wandering) included ratings recorded at residents' admission to the nursing home and a minimum of two other time points at quarterly intervals. The majority (86%) of the sample was classified as non-wanderers at admission and most of these (94%) remained non-wanderers until discharge or the end of the study. Fifty-one per cent of the wanderers changed status to non-wanderers with 6% of these residents fluctuating in status more than two times. Admission variables associated with an increased risk of changing status from non-wandering to wandering included older age, greater cognitive impairment, more socially inappropriate behavior, resisting care, easier distractibility, and needing less help with personal hygiene. Requiring assistance with locomotion and having three or more medical comorbidities were associated with a decreased chance of changing from non-wandering to wandering status. A resident's change from non-wandering to wandering status may reflect an undetected medical event that affects cognition, but spares mobility.

STAR-Caregivers: A community-based approach for teaching family caregivers to use behavioral strategies to reduce affective disturbances in persons with dementia Logsdon, R.G., McCurry, S.M., & Teri, L. (2005). Alzheimer's Care Quarterly, 6(2), 146-153. The STAR-Caregivers program is a behavioral intervention to decrease depression and anxiety in individuals with Alzheimer's disease and their family caregivers. It consists of 8 weekly in-home sessions followed by 4 monthly telephone calls. Community-based mental health practitioners were trained to conduct the systematic and standardized STAR-Caregivers program, and deliver it to family members who were caring for a relative with dementia at home. This article describes the STAR-Caregivers program and presents illustrative case studies to demonstrate that master's-level practitioners in a community setting can effectively deliver behavioral interventions.

Evidence-based psychological treatments for disruptive behaviors in individuals with dementia Logsdon, R.G., McCurry, S.M., & Teri, L. Psychology and Aging, 22(1), 28-36. In this article, the authors review the literature regarding evidence-based psychological treatments (EBTs) for behavioral disturbances in older adults with dementia, as proposed by the American Psychological Association's Committee on Science and Practice of the Society for Clinical Psychology. Fifty-seven randomized clinical trials were reviewed for inclusion on the basis of titles or abstract information. Forty-three were excluded either because they did not meet EBT
methodological criteria or because they involved environmental or psycho-
educational nursing interventions in which the psychological component
could not be separately evaluated. Fourteen studies were considered for
inclusion as EBTs; of these, 8 showed significant differences between
treatment and control groups. Results of this review indicate that behavioral
problem-solving therapies that identify and modify antecedents and
consequences of problem behaviors and increase pleasant events and
individualized interventions based on progressively lowered stress threshold
models that include problem solving and environmental modification meet
EBT criteria. Additional randomized clinical trials are needed to evaluate the
generalizability and efficacy of these and other promising psychological
interventions in a variety of settings with individuals who have a range of
cognitive, functional, and physical strengths and limitations.

An evidence-based exercise and behavior management program for
dementia care Logsdon, R., & Teri, L. Generations; 34(1), 80-83. The
Reducing Disability in Alzheimer's Disease (RDAD) program is a
systematic, evidence-based approach designed to improve mood and
increase physical activity for community residing individuals with dementia.
RDAD focuses on teaching caregivers behavioral and problem-solving
strategies to implement a regular exercise program and decrease behavioral
disturbances in their care recipients. Results of a randomized, controlled
clinical trial indicate that the RDAD program is both feasible and beneficial
for community-residing individuals with a range of cognitive abilities and
impairments. This article discusses how RDAD may be adopted and applied
in community based agencies and settings.

Use of Montessori-based activities for clients with dementia in adult day
care: Effects on engagement Judge, K.S., Camp, C. J., & Orsulic-Jeras, S.
American Journal of Alzheimer’s Disease and Other Dementias, 15(1),
42-46. Clients with dementia in an adult day care center were observed
taking part in regular activities programming or Montessori-based activities
developed for persons with dementia. During the nine-month study, clients
in Montessori-based activities exhibited greater amounts of constructive
engagement, defined as motor or verbal behavior exhibited in response to
the activity in which the client was taking part, than clients in regular
programming. Montessori-based activities also elicited less passive
engagement, defined as listening and/or looking behavior exhibited in
response to the activity the clients were participating in, than regular
programming. Implications of these results and ways to implement
Montessori-based programming in settings serving persons with dementia are discussed.

Effect of a DVD intervention on therapists’ mental health practices with older adults Lysack, S., Lichtenberg, P., & Schneider, B. (2011). The American Journal of Occupational Therapy, 65(3), 297-305. The effectiveness of an educational intervention in DVD format aimed at strengthening the mental health practices of occupational therapists working with older adults was tested. The DVD intervention was tested in a pretest–posttest design. Occupational therapists (n=30) completed a brief knowledge and attitude questionnaire; a chart review (n=383) of therapists’ (n=20) patients at 3 months before and 3 months after DVD training was also conducted. Questionnaire data showed that the percentage of therapists with correct answers increased 20%–30% for 5 of the 11 knowledge items. Chart review data showed therapists spoke more often with their older patients about mood, depression, and cognitive impairment; screened more often for depression and cognitive impairment; and reported findings more often to the treatment team after training.

BE-ACTIV: A staff-assisted behavioral intervention for depression in nursing homes Meeks, S., Looney, S.W., Van Haitsma, & Teri, L. The Gerontologist, 48(1), 105-114. This article describes a 10-week, behavioral, activities-based intervention for depression that can be implemented in nursing homes collaboratively with nursing home activities staff, and presents data related to its development, feasibility, and preliminary outcomes. BE-ACTIV, which stands for Behavioral Activities Intervention was developed in two pilot study phases: a treatment development phase and a feasibility–outcome phase with a small, randomized trial. The intervention was piloted with five depressed residents in a single nursing home in collaboration with the social services and activities staff. The second phase randomized 20 residents from six nursing homes to receive either the intervention or treatment as usual. The intervention was well received by residents, family, and staff members. Experience with the intervention and input from staff members resulted in modifications to streamline the intervention and improve implementation. Results suggest that BE-ACTIV reduced institutional barriers to participation in pleasant activities, increased resident control over activity participation, increased overall activity participation, and improved depressive symptoms. Despite low power, statistical and graphical comparisons suggest superiority of the intervention over treatment as usual. Because depression among nursing home residents is prevalent, heterogeneous, and often treatment resistant, there is a need for
effective, low cost interventions that are ecologically acceptable and efficient. BE-ACTIV is a promising intervention; it is brief, addresses institutional barriers, involves facility staff in treatment, and is acceptable to residents.

Improving the quality of long-term care Molinari, V. Clinical Geropsychologist, 28 (3), 111-112. Improving the Quality of Long-term Care is a follow-up on the IOM's original report documenting the changes that have occurred in the long-term care industry since OBRA took effect. Its examination of the quality of long-term Care is a follow-up on the IOM's original report documenting the changes that have occurred in the long-term care industry since OBRA took effect. Its examination of the quality of long-term care (LTC) provided by nursing homes and other LTC sites provides a broad over-arching framework for understanding the positives and negatives of current LTC practice and for planning future initiatives. It addresses the need for the provision of additional training for all nursing home staff including medical directors, nursing home administrators, nurses and nursing assistants. The emphasis on consumer choice and preferences is commendable. The IOM bluntly acknowledges that little change will occur without the federal and state governments' recognition that the labor-intensive nature of simple but effective interventions requires reforms in reimbursement procedures.

Special series of articles on professional psychology in long-term care Molinari, V., P. & Hartman-Stein (Eds.). In Clinical Psychology: Science and Practice, 7 (3), 312-344. With the overall aging of the population and the concomitant need for the provision of mental health care for older adults, professional psychology in long-term care has come of age. Psychologists are now increasingly practicing in such traditional long-term care settings as nursing homes and in less traditional ones such as rehabilitation units, day centers, partial hospitalization programs, and hospices. The practice of psychology in long-term care is strongly influenced by public policy issues relating to Medicare, such as conditions of reimbursement, the rise of managed Medicare, and the continued disparity between payment for mental health and medical diagnoses. The articles in this special section on long-term care summarize the research on assessment and interventions for long-term care patients, outline the training opportunities available, and provide a decision-making framework for the common professional ethical/legal issues encountered in long-term care settings.

Serious mental illness in Florida nursing homes: Need for training Molinari, V., Merritt, S., Mills, W., Chiriboga, D., Conboy, A., Hyer, K., & Becker, M.
Gerontology and Geriatrics Education, 29, 66-83. This study examined how the mental health needs of nursing home (NH) residents with serious mental illness (SMI) are addressed. Data were collected from three sources: interviews with 84 SMI stakeholders; surveys of 206 NH staff members; and focus groups at two psychiatry specialty NHs. Four common themes emerged: placement of older adults with SMI was a significant problem for discharge planners and NH admission coordinators; NH staff reported being uneasy with SMI residents and were concerned over aggressive behavior; staff in NHs with psychiatry specialty units appeared more comfortable serving SMI residents; and SMI training was a consistent recommendation of all SMI stakeholders and NH staff. Implications for training are discussed.

Mental health services in nursing homes: A survey of Florida nursing home administrative personnel Molinari, V., Hedegock, D., Branch, L. Brown, L., & Hyer, K. Aging & Mental Health, 13, 477-486. Mental health problems are pervasive in nursing homes (NHs), but little is known regarding the delivery of mental health services in these settings. To fill this gap in knowledge, a survey of NH administrative personnel views on mental health services use was conducted. 146 surveys from NH administrative personnel were analyzed, reflecting 70% of the NHs that sent representatives to training conferences held at four Florida locations. Results showed substantial provision of mental health services (approximately half of the NHs have psychologists, psychiatrists and other MDs consulting on a weekly basis) and high satisfaction with services currently offered. Mental health services are typically provided by outside consultants who most frequently address behavior problems, anxiety/fears and depression. Sub-analyses of mental health service usage by types of NHs were largely non-significant. Almost half of the NHs reported the involuntary hospitalization of at least one resident during the previous year. No barriers to mental health services were rated as serious, and no mental health services were viewed as very difficult to provide. Top perceived barriers to mental health services delivery were resident and family attitudes towards mental health services; administrator and staff attitudes were perceived to be less problematic. Specialty psychotherapeutic services were the most difficult to provide in NHs, with psychopharmacological interventions the least difficult to provide. In conclusion, administrators report a variety of mental health services provided by a diverse group of professionals in NHs, and are generally satisfied with the treatment provided.

We examined the psychopharmacological services provided within 3 months of nursing home (NH) admission to a whole population of newly admitted Florida NH residents 65 years and older (N = 947) for a 1-year period via secondary analyses of selected variables from Medicaid and the Online Survey and Certification and Reporting System. Within 3 months of admission, 12% received non-psychopharmacological mental health care. However, 71% of new residents received at least one psychoactive medication, and more than 15% were taking four or more 11 psychoactive medications. Most of those being treated with psychoactive medication had not received psychopharmacological treatment 6 months prior to admission (64%) and had not received a psychiatric diagnosis 6 months preceding admission (71%). Blacks were less likely to receive medications than non-Hispanic Whites. Results expand on past research by identifying an increase in the amount of psychoactive medications prescribed to NH residents, a lack of prior psychiatric treatment and diagnoses for those currently receiving psychoactive medications, only limited provision of non-psychopharmacological mental health care, and racial or ethnic differences in the use of medications by NHs.

Reasons for psychiatric prescription for new nursing home residents
Molinari, V., Chiriboga, D. A., Branch, L.G., Schinka, J., Schonfeld, L., Kos, L., Mills, W., Krok, J., & Hyer, K. (2011). Aging & Mental Health, 15(7), 904-912. This article focuses on justification of psychoactive medication prescription for NH residents during their first three months post-admission. Data was extracted from 73 charts drawn from a convenience sample of individuals who were residents of seven nursing homes (NHs) for at least three months during 2009. Six focus groups with NH staff were conducted to explore rationales for psychoactive medication usage. Eighty-nine percent of the residents who received psychoactive medications during the first three months of residence had a psychiatric diagnosis, and all residents who received psychoactive medications had a written physician's order. Mental status was monitored by staff, and psychoactive medications were titrated based on changes in mental status. One concern was that no Level II Pre-admission Screening and Annual Resident Review (PASRR) evaluations were completed during the admissions process. Further, while 73% had mental health diagnoses at admission, 85% of the NH residents were on a psychoactive medication three months after admission, and 19% were on four or more psychoactive medications. Although over half of the residents had notes in their charts regarding non-psychopharmacological strategies to address problem behaviors, their number was eclipsed by the number
receiving psychopharmacological treatment. While the results suggest that NHs may be providing more mental health care than in the past, psychopharmacological treatment remains the dominant approach, perhaps because of limited mental health training of staff, and lack of diagnostic precision due to few trained geriatric mental health professionals. A critical review of the role of the PASRR process is suggested.

Commentary on the current status and the future of behavior therapy in long-term care settings Molinari, V., & Edelstein, B. (2011). Behavior Therapy, 42(1), 59-65. The mental health statistics for long-term care facilities are sobering. Nursing homes have been described as psychiatric institutions, but without the trained mental health personnel to provide appropriate psychiatric treatment. The strategies and behavioral techniques utilized in working with frail older adults in long-term care settings have become more sophisticated over the years. The evidence base for psychological treatment for older adults is expanding rapidly, and given the complexity of the problems encountered, geropsychology has been and will remain multimodal in its approaches to assessment and treatment.

Screening for mental disorders in residential aged care facilities Pachana, N. A., Helmes, E., Byrne, G. J., Edelstein, B. A., Konnert, C. A., & Pot, A. M. International Psychogeriatrics, 22(7), 1107-20. The International Psychogeriatric Association Task Force on Mental Health Services in Long-Term Care Facilities seeks to improve care of persons in residential aged care facilities (RACFs). As part of that effort the current authors have contributed an overview and discussion of the uses of brief screening instruments in RACFs. While no current guidelines on the use of screening instruments in nursing homes were found, relevant extant guidelines were consulted. The literature on measurement development, testing standards, psychometric considerations and the nursing home environment were consulted. Cognitive, psychiatric, behavioral, functional and omnibus screening instruments are described at a category level, along with specifics about their use in a RACF environment. Issues surrounding the selection, administration, interpretation and uses of screening instruments in RACFs are discussed. Issues of international interest (such as translation of measures) or clinical concern (e.g. impact of severe cognitive decline on assessment) are addressed. Practical points surrounding who can administer, score and interpret such screens, as well as their psychometric and clinical strengths more broadly are articulated. In conclusion, guidelines for use of screening instruments in the RACF environment are offered, together with broad recommendations concerning the appropriate use of brief screening
instruments in RACFs. Directions for future research and policy directions are outlined, with particular reference to the international context.

Psychotherapy in Long-term Care: I. Practical Considerations and the Link to Policy and Advocacy Powers, D. Professional Psychology, Research and Practice, 39(3), 251-256. This article is the 1st of 2 examining 3 domains that are important to providing high-quality, evidence-based services to long-term care (LTC) residents: policy and advocacy, practical considerations, and outcome research. Older adults who reside in LTC facilities have a very high rate of mental health difficulties. Psychologists have been able to provide services to this population through Medicare since the late 1980s, resulting in an increase in psychologists who are working with LTC residents, either as part of their practice or on a full-time basis. The focus of this article is on practical considerations for therapists in LTC settings from both the published literature and personal observations (including an illustrative case example), the current policy environment, and the importance of advocacy on behalf of clients. Psychotherapy in Long-term Care: II.

Evidence-Based Psychological Treatments and Other Outcome Research Powers, D. Professional Psychology, Research and Practice, 39(3), 257-263. This article is the 2nd of 2 that together examine 3 domains important to providing high-quality, evidence-based services to long-term care (LTC) facility residents: policy and advocacy, practical considerations, and outcome research. Older adults who reside in LTC facilities have a very high rate of mental health difficulties. Psychologists have been able to provide services to this population through Medicare since the late 1980s, and empirical findings on treatment approaches are important in guiding psychotherapists to more helpful intervention. The focus of this article is on practical considerations for therapists in LTC settings from both the published literature and personal observations (including an illustrative case example), the current policy environment, and the importance of advocacy on behalf of clients. Psychotherapy in Long-term Care: II.

NOPPAIN: A nursing assistant – Administered pain assessment instrument for use in dementia Snow, A.L., Breuera, E., Ashton, C., & Kunik, M.E. Dementia and Geriatric Cognitive Disorders, 17 (3), 240-246. The Non-Communicative Patient's Pain Assessment Instrument (NOPPAIN) is a nursing assistant-administered instrument for assessing pain behaviors in patients with dementia. This study investigated the validity of the NOPPAIN. Twenty-one nursing assistants (NAs) with no prior training in
using the NOPPAIN watched six videos, each portraying a bed-bound patient with severe dementia receiving personal care from a nursing assistant and responding with a different level of pain intensity. The NAs completed a NOPPAIN rating for each video. The NAs were also presented with each possible pair of videos and asked to identify the video showing the most pain. Results indicated the NAs were quite accurate in their ratings of the videos, providing excellent preliminary evidence on the use of the NOPPAIN for detecting pain.

State regulations for nursing home residents with Serious Mental Illness Street, D., Molinari V., & Cohen, D. (2012). Community Mental Health Journal. http://link.springer.com/article/10.1007%2Fs10597-012-9527-9 To identify state regulations for nursing home residents with Serious Mental Illness (SMI), we reviewed state regulations for policies relating to nursing home residents with SMI, and conducted interviews with expert stakeholders. A framework for analyzing state regulations was generated by identifying four discrete categories: States with specific mental illness regulations, Alzheimer's or dementia regulations, minor mention of mental illness, and no mention of mental illness. A large majority of the states have little or no mention of mental illness in their nursing home regulations, suggesting limited attention to all forms of mental illness by most state regulatory bodies.

Assessment and management of behavioral disturbances in Alzheimer’s disease Teri, L., & Logsdon, R.G. Comprehensive Therapy, 26(3), 169–175. n nursing home patients with dementia. This article provides an update and review of strategies for assessing and treating behavioral changes in patients with Alzheimer disease. It discusses the impact of behavioral disturbances, on patients, presents guidelines for identifying and monitoring behavioral changes, and presents behavioral treatment approaches.

STAR: A dementia-specific training program for staff in assisted living residences Teri, L., Huda, P., Gibbons, L.E., Young, H., & van Leynseele, J. The Gerontologist, 45(5), 686-693. This article describes, and provides data on, an innovative, comprehensive, dementia-specific training program designed to teach direct care staff in assisted living residences to improve care and reduce problems in residents with dementia. STAR, which stands for Staff Training in Assisted living Residences, provides two 4-hr workshops augmented by four individualized on-site consultations and three leadership sessions. Developed by means of an iterative process of implementation and revision, it was then evaluated in a small randomized controlled trial. A total of 114 staff and 120 residents in 15 residences
participated. STAR was exceptionally well received. Training details are provided with a discussion of unique challenges inherent in implementation. Following training, STAR residents evidenced significantly reduced levels of affective and behavioral distress compared with control residents. Furthermore, STAR residents improved whereas control residents worsened.

Books


Handbook of Health and Behavior: Psychological Treatment Strategies for the Nursing Home Patient Casciani, J. C. San Diego, CA: Concept Healthcare. This Handbook represents an innovative response to the trend toward increased medical complexity in nursing home patients, and to the demand for greater behavioral health collaboration in their treatment plans. It is a portable reference guide for health care professionals who want to understand the recommended cognitive-behavioral approaches for the co-morbid psychological issues impacting medical conditions in nursing facilities, including diabetes, respiratory disease, obesity and chronic pain, and diagnoses requiring rehabilitation, such as stroke and fractures. An array of assessment measures are discussed, and cognitive-behavioral treatment protocols are reviewed for twelve acute and chronic medical conditions. This Handbook will serve as an indispensable tool to help patients mentally manage their disabling medical conditions.

Handbook of Counseling and Psychotherapy with Older Adults Duffy, M. New York, NY: John Wiley & Sons. This book serves as a resource for mental health professionals who provide counseling and psychotherapy to older adults. The editor divides the book into two sections. Part I focuses on treatment modalities including the psychotherapy process, group approaches, family and systemic approaches, and social and community interventions. Part II provides interventions for a series of specific problems.

Handbook of Behavioral and Cognitive Therapies with Older Adults Gallagher-Thompson, D., Steffen, A.M., & Thompson , L.W. (Eds.). New York: Springer. Brings together expert scientist practitioners and the full spectrum of cognitive and behavioral interventions to promote age-appropriate best practice. The book enhances the professional’s understanding of the learning and self-regulating capacities of older adults. Its consistent and easy-access format features empirical reviews, recommended cognitive and behavioral interventions specific to the problem, instructive case studies, and salient diversity issues. In their choice of topics, the editors have assembled the Handbook to fit the unique challenges of both older individuals and the practitioners working
with them. Topics covered include: common conditions, including depression, anxiety, insomnia, and pain syndromes, severe mental illnesses such as bipolar disorder, schizophrenia, dementia; grief and loss, family care giving, suicidality, underserved populations, including ethnically and culturally diverse individuals, emerging areas of mental illness management, and effects of Medicare on practice. This is important information for use by frontline mental health professionals and in graduate and advanced courses. Reflecting a rapidly developing field, this resource will open up new areas of research and inspire the next wave of treatments tailored to this rapidly expanding population.


Assessing and Treating Late-Life Depression: A Casebook and Resource Guide Karel, M. J., Ogland-Hand, S., & Gatz, M. New York, NY: Basic Books. This practice-oriented, research-based casebook draws on extensive clinical and academic data on late-life depression and its treatment as a resource for practitioners and researchers. With a rapidly aging population, depression among the elderly has become a critical issue for the mental health and medical communities. The authors provide an interdisciplinary framework for understanding and treating late-life depressive symptoms and elucidate the problems and principles of late-life depression with fourteen extended case studies. Explicating the range of syndromes and strategies for assessing and treating them, they conclude with a guide to medications, screening tools, innovative models, and supplementary resources.

Neurocognitive Disorders in Aging Kempler, D. Thousand Oaks, CA: Sage Publications. This is a comprehensive, well written introduction to common disorders that yield cognitive and behavioral problems in older adults. Both diagnosis and treatment are discussed.

Psychotherapy with Older Adults (3rd Ed.) Knight, B. G. Thousand Oaks, CA: Sage Publications, Inc. Provides the knowledge, technique, and skills required to be an effective therapist for older adults. Considers essentials of gerontology and the nature of therapy. Case examples are provided. Includes chapters on building rapport with the older client, grief work with older adults, and life review in psychotherapy with older adults.
Adding Value to Long-Term Care: An Administrator’s Guide to Improving Staff Performance, Patient Experience, and Financial Health Lazer, D. San Francisco: Jossey-Bass. Written for health care administrators, medical directors, nursing executives, architects, and facility planners, this book provides the tools needed to improve the clinical environment for residents, staff, and families; strengthen overall business operations; and secure a facility's financial future.

The Guide to Psychological Practice in Geriatric Long-Term Care Lichtenberg, P. A. New York, NY: Haworth Press Inc. Part one provides an integrative model of psychological services in geriatric care. Part two focuses on the most relevant clinical issues, encouraging psychologists to use their theoretical background and clinical training to investigate new long-term care topics.

Caring for people with challenging behaviors: Essential Skills and Successful Strategies in Long-Term Care Long, S. W. Baltimore, MD: Health Professions Press. In this book, the term behavior problem refers to any behavior that causes emotional or physical harm. It can be harmful to either the person engaging in the behavior or to someone else. From this point of view, a resident's hostile behavior aimed at someone else is a behavior problem. If a resident's behavior hurts someone else unintentionally, it is still considered a behavior problem. In addition, behaviors related to depression, anxiety, or fear can be problematic. This book details techniques for successfully addressing such behavior.

Whole Person Dementia Assessment Mast, B. (2011). Baltimore, MD: Health Professions Press. Although we can’t currently offer a cure for Alzheimer's, we can provide better information and advice to people with the disease (and their caregivers) to help improve their ability to live and cope with this challenging disease. This groundbreaking book shows how to start making a difference during the initial evaluation and beyond. Treating every assessment as more than a simple diagnostic process, Whole Person Dementia Assessment sets the stage for more constructive interventions, better care, and a higher quality of life throughout the disease process by providing a richer understanding of the person and the way the disease is affecting him or her. Blending traditional clinical evaluation procedures with more person-centered approaches, Whole Person Dementia Assessment shows how to assess a person’s cognitive deficits while also discovering and emphasizing remaining strengths and abilities. Best practice assessment tools are recommended and provided, including a comprehensive, whole-person interview form. Backed by solid research findings, Dr. Mast
demonstrates that geriatricians, psychiatrists, psychologists, social workers, and long-term care providers who incorporate these methods into their assessment processes, will substantially improve their ability to develop rapport with the person and family members.

Treating Dementia in Context: A Step by Step Guide to Working with Individuals and Families McCurry, S., & Drossel, C. (2011). Washington, DC: APA. In this book, the authors present a clear and practical blueprint for psychologists, physicians, nurses, social workers, and other health care professionals who work with dementia patients and their families. Their evidence-based contextual model of dementia care lays out broad intervention strategies, and encourages readers to use their own creativity and inner resources to develop appropriate solutions for each unique situation and individual. The chapters present a rich variety of vignettes that illustrate common quality-of-life concerns in dementia patients, including medical co-morbidities, patient/caregiver relationships, caregiver burnout, and interactions with health care professionals. Throughout, the authors combine a comprehensive knowledge of the literature with their own extensive clinical experience in advocating a compassionate and open-minded stance that respects the individuality, preferences, and dignity of dementia patients. Health care professionals at all levels of experience, from outpatient to assisted living to residential care settings, will find Treating Dementia in Context an inspirational resource for clinical practice.

Professional Psychology in Long-Term Care: A Comprehensive Guide Molinari, V. (Ed.). New York, NY: Hatherleigh Press. Provides therapists, mental health professionals, professors, students, and laypersons with the tools and skills necessary to administer optimal long-term care to a growing elderly population. The editor divides the book into the following three parts: assessment, treatment, and professional issues. The first section includes articles on psychopathological, neurological, and medical assessment. The following treatment section contains papers on individual therapy in long-term care, behavioral interventions for patients with dementia, and basic psychopharmacology in a nursing home. The last portion deals with professional issues such as ethics, public policy, and clinical research in long-term care.

Psychotherapy with Older Adults (3rd Ed.) Knight, B. G. Thousand Oaks, CA: Sage Publications, Inc. Provides the knowledge, technique, and skills required to be an effective therapist for older adults. Considers essentials of gerontology and the nature of therapy. Case examples are provided. Includes
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Caring for people with challenging behaviors: Essential Skills and Successful Strategies in Long-Term Care Long, S. W. Baltimore, MD: Health Professions Press. In this book, the term behavior problem refers to any behavior that causes emotional or physical harm. It can be harmful to either the person engaging in the behavior or to someone else. From this point of view, a resident's hostile behavior aimed at someone else is a behavior problem. If a resident's behavior hurts someone else unintentionally, it is still considered a behavior problem. In addition, behaviors related to depression, anxiety, or fear can be problematic. This book details techniques for successfully addressing such behavior.

Whole Person Dementia Assessment Mast, B. (2011). Baltimore, MD: Health Professions Press. Although we can’t currently offer a cure for Alzheimer’s, we can provide better information and advice to people with the disease (and their caregivers) to help improve their ability to live and cope with this challenging disease. This groundbreaking book shows how to start making a difference during the initial evaluation and beyond. Treating every assessment as more than a simple diagnostic process, Whole Person Dementia Assessment sets the stage for more constructive interventions, better care, and a higher quality of life throughout the disease process by providing a richer understanding of the person and the way the disease is affecting him or her. Blending traditional clinical evaluation procedures with more person-centered approaches, Whole Person Dementia Assessment shows how to assess a person’s cognitive deficits while also discovering and emphasizing remaining strengths and abilities. Best practice assessment
tools are recommended and provided, including a comprehensive, whole-person interview form. Backed by solid research findings, Dr. Mast demonstrates that geriatricians, psychiatrists, psychologists, social workers, and long-term care providers who incorporate these methods into their assessment processes, will substantially improve their ability to develop rapport with the person and family members.

Treating Dementia in Context: A Step by Step Guide to Working with Individuals and Families McCurry, S., & Drossel, C. (2011). Washington, DC: APA. In this book, the authors present a clear and practical blueprint for psychologists, physicians, nurses, social workers, and other health care professionals who work with dementia patients and their families. Their evidence-based contextual model of dementia care lays out broad intervention strategies, and encourages readers to use their own creativity and inner resources to develop appropriate solutions for each unique situation and individual. The chapters present a rich variety of vignettes that illustrate common quality-of-life concerns in dementia patients, including medical co-morbidities, patient/caregiver relationships, caregiver burnout, and interactions with health care professionals. Throughout, the authors combine a comprehensive knowledge of the literature with their own extensive clinical experience in advocating a compassionate and open-minded stance that respects the individuality, preferences, and dignity of dementia patients. Health care professionals at all levels of experience, from outpatient to assisted living to residential care settings, will find Treating Dementia in Context an inspirational resource for clinical practice.

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Press Inc. This special issue of The Clinical Gerontologist was turned into an edited volume on geropsychology practice in long-term mental health care.

Psychotherapy for Depression in Older Adults Qualls, S.H., & Knight, B.G. [Wiley Series in Clinical Geropsychology]. Hoboken, N.J.: John Wiley & Sons. This book contains chapters written by different authors on assessment and treatment of depression. There are specific chapters on empirically-supported treatments for depression in older adults including cognitive-behavioral therapy, interpersonal psychotherapy, and problem-solving therapy. The book also discusses the social/cultural context of psychotherapy with older adults, issues in providing psychotherapy to depressed older adults in long-term care settings, how to build and manage a geropsychology practice.

Caregiver Family Therapy: Empowering Families to Meet the Challenges of Aging Qualls, S.H., & Williams, A.A. (2012). APA Books. Caring for an older family member with physical or cognitive impairments is a difficult, strenuous process. Caregivers often struggle to balance their own needs with those of the care recipient. Their relationships with family, friends, coworkers, and even the care recipient can suffer as well. As a result, family members often seek professional help to guide them through the caregiving process. This book presents Caregiver Family Therapy (CFT), a systems approach to treating families that care for an aging adult. CFT consists of three core stages: identifying the problem, structuring caregiver roles, and ensuring caregiver self-care. Transition stages bridge one core stage to the next, helping caregivers structure care for the older adult, examine the impact of care giving role structures, and consider broader effects of care giving. As new challenges arise, the stages are repeated and the CFT process begins anew. Full of rich clinical examples, this book will help therapists and other service providers meet the complex, diverse needs of care giving families.

Geropsychology and Long-Term Care: A Practitioner’s Guide Rosowsky, E., Casciani, J., & Arnold, M. New York, NY: Springer. Among the growing population living in nursing homes and assisted-living communities, emotional and behavioral problems are frequently under-diagnosed and under-treated. Psychologists in Long-term Care (PLTC) has been instrumental in establishing standards for appropriate, respectful, and ethical care, and developing education and training resources for professionals. The contributors, all experts affiliated with PLTC, offer information that is up to-date, readily accessible, and eminently useful, whether the reader needs information on bedrock skills, multidisciplinary treatment, privacy issues, or
the way facilities are run. The topics covered include common psychological disorders in long-term care, and their prevalence; federal policy issues affecting care delivery; and, the funding and referral processes in nursing homes. It also covers assessment tools commonly used with elders in 17 long-term care along with treatment plans and process, including the integration of psychiatric medicine into therapy. It later examines types of LTC providers, their training, and their roles in multidisciplinary care. Finally it discusses outcome measurement and Medicare documentation.

Personality Disorders and Older Adults: Diagnosis, Assessment, and Treatment. Segal, D. L., Coolidge, F. L., & Rosowsky, R. Hoboken, NJ: John Wiley & Sons. The older adult population is booming in the United State and across the globe. With this boom comes an increase in the number of older adults who experience psychological disorders. Current estimates suggest that about 20% of older persons are diagnosable with a mental disorder: Personality disorders are among the most poorly understood, challenging, and frustrating of these disorders among older adults. This book is designed to provide scholarly and scientifically-based guidance about the diagnosis, assessment, and treatment of personality disorders to health professionals, mental health professionals, and senior service professionals who encounter personality-disordered or “difficult” older adults.


The Essential Dementia Care Handbook. Stokes. G., & Goudie, F. (Eds.). Oxon, UK: Speechmark Publishing Ltd. This very practical and informative book discusses the diagnosis of dementia and other problems associated with aging. The sections on assessment, functional analysis, and addressing challenging behaviors are particularly useful for long-term care settings.

Mental Disorders in Older Adults: Fundamentals of Assessment and Treatment (2nd Ed.) Zarit, S. H., & Zarit, J. M. New York, NY: Guilford Press. This book provides professionals and students with essential knowledge and skills for effective practice with older adults and their caregivers. Combining their expertise as a researcher and an experienced clinician, the authors offer a unique perspective on how to understand the
challenges facing older adults and help them live more fulfilling, healthy, and independent lives. Illustrated with ample clinical material, the book reviews normal aging processes and presents a framework for assessment and treatment. Frequently encountered clinical problems are examined—including dementias, mood and anxiety disorders, paranoid symptoms, and more—and specific applications of a variety of therapies are described. The authors also address the nuts and bolts of providing family support, consulting in institutional settings, and dealing with ethical issues surrounding confidentiality, informed consent, and end-of-life decision making. Increased attention is given to different forms of dementia and how to distinguish among them. Coverage of psychopharmacology and combined treatments also has been expanded, with a focus on enhancing multidisciplinary collaboration.

Book Chapters

Evidence-based treatments for behavioral disturbances in long-term care Curyto, K. J., Trevino, K. M., Ogland-Hand, S., & Lichtenberg, P. in Making evidenced-based psychological treatments work with older adults F. Scogin & A. Shah (Eds.) (2012) (pp. 167-223). Washington, DC: American Psychological Association. This chapter discusses evidence-based treatments for behavioral disturbances in long-term care. Extensive research on nonpharmacological interventions for disruptive behavior has been conducted. Three theoretical frameworks can be used to organize this research: the learning behavior model (LBM), the person–environment fit model, and the need-driven behavior model. The next section of this chapter discusses each model and its supporting evidence. In practice, these models overlap and often lead to similar interventions, as they all focus on how the environment can be changed (to change antecedents–consequences, to adjust to abilities and disabilities, or to meet needs respectively).

Psychotherapeutic interventions for older persons with dementing disorders Duffy, M., in Strategies for therapy with the elderly Brody, C. New York, NY: Springer Publishing This chapter encompasses three major areas of
work with clients aged 60 years and older: Living in nursing homes, living in assisted living housing while participating in community-oriented activities for the aged, and living independently and being seen in private practice. It comprises a variety of approaches, ranging from eclectic small group formats for nursing home residents, group and individual counseling in assisted living settings, home care for the elderly, to psychoanalytic therapy techniques in private practice. Illustrative case examples used throughout the book bring to life successful strategies and interventions. New areas of focus include: Treatment of stress and mental disorders, Alzheimer's disease, care giving issues at home, and expanded information on Medicare coverage issue.

Psychological assessment in geriatric settings Edelstein, B., Martin, R. & Koven, L., in Handbook of psychology: Volume 10 Graham, J.R., Naglieri, J.A., Weiner, I.B. (Eds.). New York, NY: John Wiley & Sons, Inc. The principal goal of this chapter is to acquaint the reader with assessment issues that are relatively unique to older adults, with particular attention to factors that could influence the process or outcome of clinical assessment. The chapter begins with the discussion of two intra- and interpersonal variables--bias in the form of ageism and cultural competence. Ignorance of the importance and influence of these variables can lead to corruption, contamination, and invalidation of the entire assessment enterprise. The authors then consider biological and medical issues that are more common among older adults that can play a significant role in the interplay between biological and environmental factors. Next, the chapter shifts to two conceptual issues, beginning with the assessment paradigms within which the clinician performs the assessment. The authors then address diagnostic issues and question the prudence of utilizing traditional diagnostic taxonomies with older adults. The complexities of carrying out clinical assessments are then addressed through discussions of multiple-method and multidimensional assessment. The authors follow this with a discussion of psychometric considerations for developing or selecting assessment instruments suitable for older adults.

**Resources for Older Adults and their Families**

American Psychological Association (APA) Office on Aging www.apa.org/pi/aging APA

Resources for Caregivers of Adults and Older Adults [http://www.apa.org/pi/about/publications/caregivers/resources/adults-older.aspx](http://www.apa.org/pi/about/publications/caregivers/resources/adults-older.aspx)

APA Division 12 - Society for Clinical Geropsychology [www.geropsych.org](http://www.geropsych.org)

APA Division 20 - Adult Development and Aging [http://apadiv20.phhp.ufl.edu](http://apadiv20.phhp.ufl.edu)

Center for Medicare and Medicaid Services Partnership to Improve Dementia Care in Nursing Homes [http://www.nhqualitycampaign.org/star_index.aspx?controls=dementiaCare](http://www.nhqualitycampaign.org/star_index.aspx?controls=dementiaCare)

Children of Aging Parents [http://caps4caregivers.org](http://caps4caregivers.org)

Eldercare Locator [http://www.eldercare.gov/LeadingAge](http://www.eldercare.gov/LeadingAge)


National Clearinghouse for Long-term Care [http://www.longtermcare.gov/LTC/Main_Site/index.aspx](http://www.longtermcare.gov/LTC/Main_Site/index.aspx)

National Coalition on Mental Health and Aging [www.ncmha.org](http://www.ncmha.org)

National Consumer Voice for Quality Long-Term Care [http://www.theconsumervoice.org](http://www.theconsumervoice.org)


Psychologists in Long-term Care (PLTC) [http://www.pltcweb.org/](http://www.pltcweb.org/)

**Generations United** [www.gu.org](http://www.gu.org)

Generations United (GU) focuses solely on promoting intergenerational strategies, programs, and policies. GU serves as a resource for educating policymakers and the public about the economic, social, and personal imperatives of intergenerational cooperation.

**National Council on Aging (NCOA)** [www.ncoa.org](http://www.ncoa.org)

Founded in 1950, NCOA is the nation's first association of organizations and professionals dedicated to promoting the dignity, self-determination, well being, and contributions of older persons.

**Senior Corps** [www.seniorcorps.org](http://www.seniorcorps.org)

Senior Corps is a network of programs that tap the experience, skills, and talents of older citizens to meet community challenges with Foster Grandparents, Senior Companions, and RSVP (Retired and Senior Volunteer Program). Senior Corps, part of the USA Freedom Corps, is administered by the Corporation for National and Community Service, the federal agency that also oversees AmeriCorps and Learn and Serve America.

**AARP** [www.aarp.org](http://www.aarp.org)

AARP conducts and publishes a wide range of studies on aging. Most of it is available at their Online Research Center at [http://research.aarp.org/](http://research.aarp.org/).
Administration on Aging www.aoa.gov
This government agency, which is part of the Department of Health and Human Services, provides a great deal of information about the economic and health status of older Americans.

U.S. Census Bureau www.census.gov
Provides a wide range of statistics on demographics as well as economics of Americans of all ages.

Centers for Medicare and Medicaid Services
http://cms.hhs.gov/researchers/
A good source for data on the health status of older Americans.

Federal Interagency Forum on Aging-Related Statistics
http://www.agingstats.gov
This site provides access to a comprehensive report, Older Americans 2012: Key Indicators of Well-Being.

Civic Ventures www.civicventures.org
This non-profit organization, which is the parent of Experience Corps, conducts research and publishes studies on topics such as attitudes toward retirement and volunteering and civic engagement among older Americans. Most of this research is available online.

Independent Sector www.independentsector.org
An excellent source of information about the involvement of Americans as volunteers. Independent Sector has just published a new report, Experience at Work: Volunteering and Giving Among Americans 50 and Over.

International Longevity Center www.ilcusa.org
An independent research organization that conducts and publishes research on many subjects related to the extension of the life span and its social and economic impacts.

The Eldercare Locator (1-800-677-1116) can direct you to your Area Agency on Aging. They will give you information on local long-term care resources and programs. Visit their website at http://www.aoa.dhhs.gov.

The Nursing Home Information Service at the National Council of Senior Citizens has information on community services and offers a free


Each state Office of the Long-Term Care Ombudsman visits nursing homes on a regular basis and handles complaints. Find your ombudsman by calling the National Association of State Units on Aging at 202-898-2578. The association has publications about long-term care and can provide a list of facilities.

Other sources of information include:

The American Association of Homes and Services for the Aging
901 E Street, N.W., Suite 500
Washington, D.C. 20004-2011
202-783-2242
http://www.aahsa.org

The Assisted Living Federation of America
Suite 400, 10300 Eaton Place
Fairfax, VA 22030
703-691-8100
http://www.alfa.org

The American Health Care Association
1201 L Street, N.W.
Washington D.C. 20005
202-842-4444

The National Citizens' Coalition for Nursing Home Reform's publication list is available from Suite 202, 1424 16th Street, N.W., Washington, D.C. 20036-2211; call 202-332-2275.

For more information about health and aging, contact:

National Institute on Aging
Information Center
P.O. Box 8057
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Clingan-Fisher, Deanna. “Elder Abuse and the Legal Services Connection,”


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


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


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


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


World Health Organization, *Aging and Life Course*

WHO, *Second Generation Surveillance for HIV/AIDS*

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


*About the Course Presenter:*

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