Effective Use of Evidence-Based Practice to Address Geriatric Mental Health

2014 Geriatric Update
Meharry Consortium Geriatric Education Center
Effective Use of Evidence-Based Practice to Address Geriatric Mental Health

Moderator: Charles P. Mouton, MD, MS

Rahn K. Bailey, MD, DFAPA
Chair and Professor, Dept. of Psychiatry, Meharry Medical College

Mary Harkleroad, LCSW
President-Elect, Mental Health America of Middle Tennessee

Dan G. Blazer, MD, MPH, PhD
J.P. Gibbons Professor of Psychiatry Emeritus
Duke University School of Medicine

Peter V. Rabins, MD, MPH
Richman Family Professor for Alzheimer’s and Related Disease
Johns Hopkins University School of Medicine
Objectives

• Identify the importance of screening for mental health disorders in older adults, particularly in medical settings
• Describe health disparities relative to mental health problems and older adults
• Explain the role and significance of the Mental Health and Aging Initiative (MHAI) in addressing mental health issues in older individuals
• Describe best practice interventions for common mental health issues in late life
• Identify common mental health issues for seniors residing in the community and across levels of care
EFFECTIVE USE OF EVIDENCE-BASED PRACTICE TO ADDRESS GERIATRIC MENTAL HEALTH

Rahn Kennedy Bailey, M.D., D.F.A.P.A.
113th President National Medical Association
Chairman and Professor
Dept. of Psychiatry and Behavioral Sciences
Elam Mental Health Center
Meharry Medical College
Nashville, TN
DISCLOSURES

- Programs at Elam Mental Health Center
  - Adolescent Day Treatment
  - Rainbow Unit
  - SISTER’s Story (Supported Intensive System of Treatment, Empowerment, & Recovery)
  - Tennessee Psychiatric Association Innovative Grant
  - Project COPE (Community Outreach Prevention Education)
  - REACH (Recovery is for Everyone Accepting a Change in Health)
  - Adult Continuum
    - Detoxification
    - Residential Rehabilitation
    - Intensive Outpatient
    - Outpatient

- Private Grants
  - Eli Lilly
  - Janssen
  - Sunovian
  - Ortho McNeil

- Federal Grants
  - Treatment Access Project II
  - 5th Annual Lloyd C. Elam Symposium NIH Grant
  - NIMHD Translational Health Disparities Training August 2013
Discuss:

- Health Disparities relative to Mental Health Problems and Older Adults
- The Importance of Cultural Competence
- The importance of addressing health disparities in integrated behavioral care
- The need for screening Mental Health Disorders in Primary Care and strategies for earlier identification.
The older adult population is increasing in numbers and will continue to grow at an ever-increasing rate.

In 1997, 1 in 8 Americans were age 65 or over. Between 2010-2030, it is estimated to reach 1 in 5.

In addition, racial and ethnic diversity will become greater within the older adult population as the population continues to grow.

A large number of seniors have serious mental health needs that have major effects on the person and his/her family and the community at large.
Factors in Health Disparities

**Individual factors**
- Age
- Genetics
- Health behaviors
- Chronic illness

**System Factors**
- Health care
- Local public health
- Social services
- Social, economic and health systems

**Community Factors**
- Education
- Health care access
- Community norms
- Neighborhoods
Economic factors

- A percentage of older adults, including particular sub-sets of the population, have limited access to services due to factors related to income.
- Issues of financing services for lower income individuals must be addressed.

Women represent a large percentage of the older adult population.

- Factors which place women at higher risk for poorer health status are:
  - higher rates of poverty;
  - more likely to be a caretaker for their spouse; and
  - more likely to live alone.

Racial Trends

- Services and service providers must demonstrate cultural competence.
Depression, Anxiety and Other Conditions

- **Depression and anxiety disorders** are among the most common mental health problems in older persons. The conditions affect approximately 3-7 percent and 11 percent of the general older adult population, respectively.

- Older adults comprise approximately **13 percent of the U.S. population**, but account for almost **19 percent of all suicides**.

- Older adults account for only 7% of all inpatient psychiatric services, 6% of community mental health services and 9% of private psychiatric care;

- **Older adults die by suicide at a higher rate** than the national average; these rates increase after age 65, primarily among white men.
Epidemiology of Geriatric Depression

- Less Social Support
- Recent Adverse Life Events
- Female Gender
- Severe Impairments in Medical Health
EPIDEMIOLOGY OF GERIATRIC DEPRESSION

- Of 35 million seniors in the US
  - An estimated 2 million have a depressive illness
  - 5 million have sub syndromal depression
  - Less than 10% are treated
  - 1 in 10 Americans over 65 will be depressed

- 19% of all suicides are by patients over 65
  - Seniors comprise 13% of the population
  - The highest suicide rates in the U.S. are found in white men over age 85.

- Seniors have 50% higher health care costs if depressed

Gender – women more likely than men because they live longer than men (16% vs 11% of persons 71+)

Age – prevalence in older age groups is higher: 13% of persons 65+ have Alzheimer’s, and 50% of those 85+

Education – those with <12 years of education have 35% greater risk of developing dementia than those with >15 yrs of education

Race – African-Americans are reported to be more likely than whites to have the disease.

SUICIDE RISK FACTORS FOR ADULTS: DEMOGRAPHICS

- **Men at greater risk** than women; **Caucasians** account for more than 90% of all suicides
- **Age clusters**: age 15-19, 20-24 and over age 60
- **Marital status**: widowed, divorced and single individuals at greater risk than married individuals (more pronounced in men)
- **Living alone**: no children under age 18 living in household
- **Alcohol/Substance Abuse history**
- **History of mental illness**: previous suicide attempt
- 30% have seen a physician within 30 days & 60% have seen a physician within 6 months
“SAD PERSONS”..........A PNEUMONIC

- **Sex (male):** age 65 – 15.5:100,000; white male older than 85 - suicide rate of more than 50:100,000 compared to the US population in 2002
- **Age (older):** beginning at age 60
- **Depression**
- **Previous suicide attempts**
- **ETOH/SA**
- **Rational thinking loss (psychosis)**
- **Social supports lacking**
- **Organized plan to commit suicide**
- **No spouse (divorced > widowed > single)**
- **Sickness (physical illness)**
Older adults experience double jeopardy of a culture that traditionally has stigmatized mental illness & advanced age.

Older adults are less likely than younger persons to self-identify mental health problems or seek specialty mental health services.

This problem is further compounded by family members and professional providers who share the misperception that mental disorders are a “normal” part of aging.

Without addressing stigma, systemic reforms designed to improve access are unlikely to be successful.
Average annual health care costs for Medicare enrollees age 65 and over, in 2004 dollars, by age group, 1992–2004

Note: Data include both out-of-pocket costs and costs covered by insurance. Dollars are inflation adjusted to 2004 using the Consumer Price Index (Series CPI-U-RS).
Reference population: These data refer to Medicare enrollees.
Source: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.
STRATEGIES TO OVERCOME THE BARRIERS

- Educate the public on mental health and aging
  
  ✓ Deliver positive messages about mental health and aging
  
  ✓ Advertising experts should develop these messages for all forms of media—print, radio, and television.
  
  ✓ The campaign should target older adults, their children, and the general population.
Empower and educate older adults with mental illnesses

- It is important to reach older adults in our communities who are isolated, do not know much about aging and mental health, or may fear identifying themselves as possibly suffering a mental illness.

- Older adults in general should learn about aging well in terms of their mental health.

- An empowerment and education campaign should reach the people who work with older adults, volunteers and those who provide them physical and mental health care.

Mentally Healthy Aging: A Report on Overcoming Stigma for Older Americans, SAMHSA, 2005
Cultural competence: Defined by the U.S. Department of Health and Human Services as "a set of values, behaviors, attitudes and practices within a system that enables people to work effectively across cultures. The term refers to the ability to honor and respect the beliefs, language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services."

For people of color, access to mental health services and the quality of services received are greatly affected by the level of cultural competence within the mental health care system.

To increase cultural competence in health services,
- professionals must be educated on how to provide services in a culturally competent and sensitive matter (Dorsett, 2004)
According to the Center on Aging Society, by 2050, it is estimated that ethnically and racially diverse minorities will make up about 35% of the population over the age of 65 (Ihara, 2004).

Culturally competent care should focus not only on younger populations, but on older populations as well.

- **Barriers while receiving care:**
  - difficulties with language and communication
  - feelings of isolation
  - service providers lacking knowledge of other cultures, and
  - socioeconomic status

NAMI: Cultural Competence, A Key for Success, 2007
Minority groups will compose almost half of the U.S. population by 2050; the biggest increase will occur within the Hispanic population.

Projected percentage change in racial/ethnic composition of the United States population, 2000 to 2050

## Key Components of a Culturally Competent System

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<tr>
<th>Organizational Commitment</th>
<th>Policies and Procedures</th>
<th>Availability and access to quality services</th>
<th>Human Resources</th>
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| • This is demonstrated through the attitudes and beliefs held by the organization | • Policies and procedures will foster cultural competence | • Targeted engagement of multicultural communities, availability of language access services such as multilingual staff and trained interpreters | • An organization’s efforts should include staff training on cultural competence.  
• Staff at all levels in all functions of the organization should be part of such trainings. In addition to training staff, the organization should strive to create a culturally and linguistically diverse workforce. |
| Policies and Procedures | Availability and access to quality services | • Development of forms and informational materials in other languages, utilization of culture-specific practices, community specific outreach initiatives and others | • High quality service is achieved with cultural competence, which allows services to truly become patient-centered, safe and effective. |
Older adults who access behavioral health care often do so through their primary care providers, and treatment has largely consisted of prescription medications.

Yet, many providers are poorly equipped to address behavioral health issues due to:

- **Patient issues** (e.g., co-occurring medical conditions)
- **Provider issues** (e.g., lack of knowledge and time to screen for behavioral health conditions and deliver non-pharmacological interventions), and
- **System issues** (e.g., insufficient time to screen, diagnose, and treat both physical and behavioral health problems).
KEY ACTIONS FOR PRIMARY HEALTH CARE PROVIDERS

- **Incorporate brief behavioral health screening** as part of the standard flow of work - PHQ-9

- **Adapt existing collaborative depression care models** to include management of late-life anxiety, prevention of substance misuse/abuse, and linkages between aging service, behavioral health, and primary care networks.

- **Set aside time for regular clinical case discussions between behavioral health and primary care providers**, including time to discuss opportunities for improving collaboration.
Improving Mood, Promoting Access to Collaborative Treatment (IMPACT)

- Model of care designed to identify and address depression in older primary care patients

- A depression care manager is embedded within the primary care team and provides and coordinates depression care;

- Educates patients about depression and its treatment; provides behavioral activation;

- Uses the PHQ-9 depression screen to monitor depressive symptoms and response to medication, psychotherapy, or both;

- Works closely with the primary care provider and a consulting psychiatrist to revise the treatment plan when patients are not improving; and offers a brief course of problem-solving therapy
SCREENING, BRIEF INTERVENTION, REFERRAL TO TREATMENT (SBIRT)

- **SBIRT is a model of care** designed to identify and address unhealthy substance use, including alcohol, tobacco, and medication misuse or abuse.

- Patients receive brief screening to identify unhealthy substance use or misuse.

- Those with a positive screen receive a brief motivational intervention focused on changing unhealthy behaviors, or referral for additional treatment if needed.
MENTAL HEALTH AND AGING INITIATIVE

- **Mental Health and Aging Initiative (MHAI)** is significant in addressing mental health issues in older individuals through complete depression and substance abuse screening for senior residents at assisted living facilities.

- **Significance of MHAI**: it can be used as a tool for improving community members’ knowledge, awareness of Mental Health/Substance Abuse (MH/SA) risks, symptoms and outcomes among older individuals.
- Providing improved coverage of physical healthcare, which is important to older adults with mental and/or substance use disorders because they are highly likely to have co-occurring chronic physical disorders

- Providing improved coverage of mental health conditions

- Providing improved coverage of medications under Medicare Part D, including psychiatric medications

- Providing financial incentives for providers to enhance health and mental health services integration

- Emphasizing preventive interventions & services in the home and community instead of institutions
The chief underlying cause of health disparities is increasingly understood to be social and economic inequality (i.e., social bias, racism, limited education, poverty, and related environmental conditions) that either directly produce ill health or promote unhealthy behaviors that lead to poor health.

It is important to overcome the stigma and discrimination attached to mental illness by educating the public about mental health and aging.

In order to achieve better outcomes, service and service providers must demonstrate cultural competence.

Integrated programs help identify and address mental health conditions and substance misuse in older primary care patients at a very early stage, thereby improving quality of life.
Mental Health Issues Across Levels of Care and Caregiver Depression

Mary Harkleroad, LCSW

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Disclosures

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Focus of Presentation

• Overview of major mental health issues of senior adults across levels of care, assessment tools, and treatment considerations

• Best practice approaches to mental health assessment and treatment for senior adults across levels of care

• Recognizing caregiver depression, anxiety, and burden of care issues, tools for assessment, and clinical response
Mental Health Issues in Specialty Clinics, Nursing Homes, Assisted Living, Memory Units

- Increased prevalence of mental health issues
  - **Depression** (up to 30%-50% in institutional settings)
  - **Anxiety** (under-recognized)
  - **Delirium** (common co-morbid condition)
  - **Neuropsychiatric symptoms in Memory Units** (secured nursing home and assisted living units)
  - **Grief and/or Complicated Grief** (under-recognized)
Treatment Issues in LTC Settings

• Complex clinical issues (co-occurring complicated medical, psychiatric, and behavioral symptoms) with limited medical and nursing oversight in settings such as assisted living and free-standing memory units

• Direct admissions from home to Assisted Living and Memory Units for residents with dementia with limited history and assessment, and catastrophic reactions emerging

• Inadequate assessment of potential for falls, wandering, behavioral issues

• Insufficient geriatric psychiatrists and geriatric mental health specialists available

• Mental health companies with high volume expectations in LTC and Assisted Living, and limited supervision
Treatment Issues in LTC (con.)

- High turnover in administrative and direct care staff in LTC settings
- Assisted living facilities with social model vs. medical model, yet accepts complicated residents with co-morbid medical, neuropsychiatric disorders
- Staff education deficits, especially assisted living facilities
- Family supports, education, and adequate information/resources lacking
- Limited or inadequate psychosocial supports and psychotherapy available to senior adults LTC
General Risk Factors for Mental Health Issues in Seniors

- Co-morbid medical and neurological disorders including dementia, stroke, Parkinson’s Disease, cardio-vascular disease, delirium
- New admission, change in environment
- History of depression, anxiety, substance abuse, prior suicide attempt
- History of psychiatric hospitalization
- Pervasive losses (spouse, home, family, friends, financial)
- Loss of autonomy, functional loss, and loss of mobility
- Multiple medications
- Recent medical hospitalizations with newly added medications, including psychotropic medications
Assessment Tools for Seniors Across Levels of Care

- Assessment and scales may vary according to agency, practice setting, funding and scope of service
  - Individual/family interview
  - Careful review in institutional settings of documentation, medical records, MAR, and caregiver input, family consent and history
  - Psychosocial/environmental (initial intake)
  - **Cognitive Scales** (e.g., MMSE, Clock Drawing)
  - **Depression Scales** (e.g., GDS, short or long form, Cornell Scale for Depression in Dementia, Hamilton Depression Rating Scale)
  - **Dementia Scales** (e.g., Global Deterioration Scale, FAST Scale, Neuropsychiatric Rating Scale (NPI))
  - **Functional Status Scales** (Activities of Daily Living and Instrumental Activities of Daily Living)
  - **Side Effects of Psychotropic Medications** (Abnormal Movement Scale)
Holistic and Best Practice Model of Mental Health Intervention

- Psychosocial and family based model of care
  - Diagnosis
  - Plan of treatment to address family caregiver needs, senior adult, medical and non-medical treatment, and individualized
  - Family education, counseling, referral, and support group
Holistic and Best Practice Model of Mental Health Intervention (con.)

- **Multidisciplinary**
  - Internist/geriatrician with geriatric nurse/social worker
  - Integrated Behavioral Health/Primary Care Clinic
  - Neurologist (collaboration with APN, social work, and/or psychologist)
  - Geriatric Psychiatrist with APN, Nurse, Social Worker, Psychologist
  - Specialty Clinics (Academic, Research, Teaching Facilities)
  - Clinical and practice examples:
    - Geriatric Clinic in private psychiatry group practice with Geriatric Psychiatrist, APN, Social Worker, Neuropsychologist
    - Consultation Service in private psychiatry group practice
Impact of AD on Caregivers

• **Losses associated with AD**
  – Role changes
  – Competing demands
  – Financial burden
  – Support systems
  – Coping skills and abilities
  – Emotional distress, caregiver burden, depression, grief

• **Mortality and Caregiving**
  – Increased infectious illness episodes
  – Poorer immune response to influenza
  – Have wounds that heal more slowly
  – At greater risk for mild hypertension
  – May have greater risk for coronary disease

• **Stress Burden and Caregiving**
  – As many as 80% of caregivers experience high levels of distress
  – Major depression in 35-40% of caregivers
  – Anxiety disorders in 10% of caregivers
  – 40-50% of caregivers suffer from stress-related illness
Sources of Stress

- Diagnosis
- Emotional distress/grief
- Functional losses
- Personality changes
- Daily strain/burden of care
- Role changes
- Behavioral/psychiatric symptoms

- Caregiver coping/adaptation
- Lack of social support
- Financial stress
- Depression, anxiety, grief
- Increased financial burden
- Catastrophic reactions
- Decision making with progression
- Stage based issues and challenges
Tools for Recognizing Caregiver Stress, Burden, Depression

- Individualized assessment and interview—family dynamics and role functions; role changes; sources of family stress/conflict; emotional responses and understanding of AD; nature of disease progression and impact on caregiver; nature of family and social supports; community services.

- Caregiver assessment tools:
  - Problem Checklist and Strain Scale
  - Screen for Caregiver Burden
  - Burden Interview
  - Geriatric Depression Scale
  - Zung Self-Rating Scale
Major Supports and Service Needs of Caregivers

- **Early Stage Caregiving:**
  - Diagnosis and education about MCI, Normal Aging, AD and available treatments
  - Community resources
  - Referrals for neuropsychological or neurological evaluation
  - Health promotion strategies
  - Advance Directives, DPOA for Health Care and Financial
  - Functional assessment of strengths, abilities, and deficits (baseline)
  - Education and practical guidance regarding individualized care needs of family member and helpful strategies
  - Family decisions about disclosing diagnosis to family/friends

- **Early mid and Middle Stages:**
  - Treatment options and research trials
  - Ongoing education regarding AD and Stage based changes
  - “start where caregivers are”
  - Discuss financial safeguards, issues, and “readiness to take over”
  - Counseling regarding legal issues
  - Ensuring safety (home environment, driving, med management)
  - Caregiver counseling—role changes, impact of illness, supporting abilities, dealing with emotional responses
  - Referral for Support Groups/individual counseling
  - Finding long term medical assistance
Major Supports and Service Needs of Family Caregivers

- **Moderate and Late Moderate Stages:**
  - Counseling and education regarding
    - Impact of environment
    - Planning for long term care
    - Need to stop driving
    - Nutrition
    - Continence management
    - Expectations of current and next stages
  - Caregiver support, individual and family counseling, on-going assessment for caregiver depression, anxiety, stress, grief
  - Information and referral re. Support Groups, professional counseling and intervention for depression, grief management
  - Personalized caregiving strategies
  - Medical/psychiatric and non medical management of behavioral symptoms

- **Late Stages:**
  - Focus on care of caregiver
  - Information and education regarding late stage illness
  - Developing long term care plan and individualized counseling
  - Education about medication review, signs of illness, environment supports, personal/family supports (music, touch, presence)
  - Obtain/advise regarding increased home care support, transition to long term care, hospice care
  - Grief support, spiritual support
  - Medical guidance regarding end of life issues and decisions
  - End of life and caregiver support after death of loved one
  - Recognizing and responding to complicated grief
SUMMARY and GENERAL PRACTICE PRINCIPLES

- Mental health issues in senior adults are complex, often accompanied by co-morbid medical conditions, and multifactorial in nature.
- There is increased prevalence of mental health issues in LTC settings, and inadequate mental health services available.
- There is increased need for the development of practice standards.
- Assessment and treatment should be individualized and family focused.
- Best Practice assessment includes careful clinical interview with senior, family members, professional caregivers, review of medical issues, and appropriate scales.
SUMMARY and GENERAL PRACTICE PRINCIPLES (con.)

• Senior Adults with depression and anxiety benefit from combined treatment

• AD is stressful to family caregivers and frequently results in caregiver depression, excessive anxiety, prolonged grief and/or complicated grief

• Family expectations are shaped by past history, prior relationships, perceptions, personal and cultural values, religious orientation, accessibility to medical care and support

• Family caregivers benefit from individualized assessment, intervention, education, and support

“A glimpse is not a vision, but to a man on a mountain road by night, a glimpse of the next three feet of road may matter more than a vision of the horizon.” C.S. Lewis
Questions for the panel

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