

**DBHS Practice Protocol
Older Adults: Behavioral Health Prevention, Early Intervention, and
Treatment.**



**Developed by the
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Division of Behavioral Health Services
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Title

Older Adults: Behavioral Health Prevention, Early Intervention, and Treatment.

Goal/What Do We Want to Achieve Through the Use of this Protocol?

The purpose of this protocol is to improve the quality and accessibility of prevention, early intervention, and treatment programs targeting older adult populations.

Target Population(s)

This practice protocol refers to prevention, early intervention, support, and treatment services for adults who are age 55 and older, their caregivers, and professionals who have contact with this population.

Prevention targets populations who do not have a diagnosable behavioral health problem and who are not enrolled in the behavioral health system.

Early Intervention targets populations who are showing signs and symptoms of a behavioral health problem or “failure to thrive” as diagnosed by primary care provider.

Treatment targets persons with diagnosable behavioral health disorders of sufficient severity to require symptom focused services and recovery supports.

Recovery Support targets persons with a diagnosed behavioral health disorder who are in recovery.

Background

According to the governor’s report ‘Aging 2020: Arizona’s Plan for an Aging population’, by year 2020, a quarter of Arizona’s population will be over the age of 60. Approximately 16% of older adults suffer from a behavioral health disorder, the most common of which are substance abuse, depression, anxiety (Bartels, Dums, Oxman, Schneider, Arian, Alexopoulos, Jeste, 2002). The most common mental health disorders among older adults are depression and anxiety.

The prevalence of depression in older adults ranges from 8 to 20% in the general population, 37 % in primary care and 50 % in nursing homes. Physical illnesses, such as a stroke and diabetes, as well as diseases that cause chronic pain, such as arthritis, make a person more likely to suffer from depression. In the older adult population, 80% of older adults have one chronic health issue, 50% of older adults have 2 or more. Depression is most common in individuals who have other illnesses, such as heart disease or cancer, or whose function becomes limited, (CDC, 2009). Additionally, the more medications a person takes, the more likely they are to develop depression (Bartels, et Al., 2005; CMHS, 2005; December, 2006; National Center on Elder Abuse 2000).

Approximately 3-14% of older adults are affected by anxiety disorders in a given year. Anxiety disorders typically manifest themselves at the same time as other illnesses. In older adults, anxiety disorders often occur at the same time as depression, heart disease, diabetes, and other medical problems. Risk factors associated with developing anxiety disorders later in life include: being female; having several chronic medical conditions; being single, divorced or separated; and having less education. Treatment of anxiety disorders in older adults can be achieved through medication and/or psychotherapy (National Institute of Mental Health, 2010).

Suicide

The population of individuals age 65 and over represent 13% of the U.S. population, and account for nearly one-fifth of U.S. suicides. Older adults are less likely to report thoughts of suicide compared to younger adults. The methods of suicide are more likely to be deliberate and lethal. The common methods that older adults use for suicide are firearms and poisons. Of firearm use men account for 77%, women 34%; and for poison men account for 12% and women 29% (SAMHSA, 2006). Men over the age of 65 commit suicide at a rate three times that of other adults and account for 20% of all suicide deaths. Non-Hispanic white men 85 or older have a higher rate with 48 suicide deaths per 100,000, (NIMH, 2009). Depression is a risk factor for suicide. Depression may be caused by many situations that an individual may be going through such as loss of loved one, having to move out of one's home, or not being able to care for oneself. It is important to bring awareness of the preventable issue of suicide in the older adult population. One way to prevent suicides is to increase access to geriatric specialty health care.

Substance Abuse

Men aged 60 and older have a prevalence rate of alcohol abuse/dependence ranging from 1.4% to 3.7%, which is higher than the rate for women and lower than the rate for younger people. Two thirds of older adults who abuse alcohol are life span abusers of alcohol and are more likely to suffer health related consequences related to substance use. A third are new abusers who commenced drinking heavily in late life precipitated by a negative life event such as the death of a spouse, physical illness or other negative event. Substance abuse commonly co-occurs with a mental health disorder such as depression. Women receive twice the number of prescriptions obtained by men and are more likely to be prescribed psychotropic medications, (any medication capable of affecting the mind, emotions, and behavior; medications that are used to treat mental health patients. (MedicineNet.com, 2010)), so there is a higher risk for drug misuse among women than men. High income, well-educated seniors are more likely to engage in heavy drinking. Older men who are separated or divorced have higher rates of alcohol problems than other groups with marital disruption. For females however, alcohol problems are correlated with marriage, especially when married to a man with an alcohol addiction (Benshoff, 2003; Carlson, 1994; Nemes, 2004; Rigler, 2000).

Rates for illegal drug use among those 60 or older are less than one percent, and commencement of illicit substance abuse in older adults is very rare. As the baby boomer generation ages, substance abuse is increasing in prevalence (Patterson, 1999). By 2015 baby boomers will represent 45% of the U.S. population (Center for Disease Control and Prevention, 2010).

Risk Factors

Risk factors for development of behavioral health disorders include age, ethnicity, income, medical conditions, and changes in social supports, bereavement, and hopelessness. African Americans and Native Americans are likely to have fewer substance abuse problems as seniors because they have a higher mortality rate at a younger age. Between 5 and 10% of older adults suffer from chronic insomnia, which is a risk factor for depression. Seniors who are socially active are more susceptible to heavy drinking, and those who are isolated are less likely to drink heavily, but have a higher risk of depression and suicide. Older adults are prone to experiencing loss. In some cases grief develops into pathological symptoms, including guilt, obsession with death, hopelessness, loss of self-worth, and other impairments (Carlson, 1994; CSAP 2006; NCEA, 2000; Kurlowicz, 2003, NIMH, 2003; Patterson, 1999; Reynolds & Kumpfer, 1999).

Healthy Aging

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) prevention, treatment, and recovery programs seek to promote healthy aging, which may be defined as the absence of serious illness or disability. A number of factors contribute to the positive emotional and psychological well-being of older adults including positive spirituality, social support, and physical health, avoidance of substance use, socioeconomic status, coping skills, and personal attributes.

Positive spirituality

Spirituality increases with age, although attendance at religious services decreases after age 70. Belonging to a religious denomination that prohibits alcohol use is an important factor associated with less drinking and depression (Carlson, 1994; Gall and Swazbo, 2002; Vaillant and Mukamal, 2001; Faison and Steffen, 2001).

Sense of purpose or meaning in life

Older adults who have a sense of meaning or purpose in life are less likely to attempt and complete suicide (Holkup, 2002).

Social support

Supportive social contacts, particularly family and close friends are an important component of healthy aging and are correlated with healthy eating, and less use of alcohol, tobacco, and drugs. (Abeles, et al., 1998; American Psychological Association, 2003; Volz, 2000). A warm marriage is highly correlated with successful aging in men (Vaillant and Mukamal, 2001). Having children is a protective factor for women against completion of suicide (Holkup, 2002).

Good physical health/ physical activity

Good physical health, regular physical activity, and a healthy diet are correlated with life satisfaction, healthy aging, and cognitive functioning in older adults (Abeles, et al., 1998; Gall and Swazbo, 2002; Weuve, Kang, Manson, Breteler, Ware, and Grodstein, 2004). Some examples of physical activity with positive effects for older adults include weight bearing exercises, stretching, walking, swimming, water aerobics, as well as low impact aerobics. Getting involved in a sport such as golf or tennis not only provides exercise but also creates an opportunity for social interaction. Community sports programs are excellent ways to become socially interactive.

Abstinence from alcohol and cigarette use

Individuals who avoid engaging in alcohol or cigarette use as young adults are more likely to be happy and healthy as they age. In the older adult population, 9.3% of adults aged 65 years and older are current smokers (CDC, 2009).

Non use of tobacco is more important to healthy aging than non-use of alcohol, due to the severe physical health effects of tobacco (Peel, McClure, and Bartlett, 2005; Valiant and Mukamal, 2001). The absence of tobacco use and alcohol will bring a healthier way of aging.

Autonomy

The ability to have a sense of control in one's life lowers the risk of developing behavioral health problems. The ability to care for oneself is closely linked to life satisfaction. Being engaged in the community includes involvement in relationships with other people, being involved in spiritual institutions, volunteering, participating in social activities, and civic involvement. Older adults with a strong sense of attachment to their community are more likely to feel satisfied with their life. Older adults who live in a community have lower rates of depression than older adults who are rehabilitated in older adult care facilities, or isolated due to location, disability, financial circumstances, (Abeles, et al., 1998; Faison and Steffen, 2001).

Personal attributes

Personal attributes including optimism, self-acceptance, a sense of humor, a sense of purpose and flexibility can protect older adults from the development of behavioral health problems, such as depression and substance abuse. Older adults who are willing to try new experiences and engage in challenging activities are better able to maintain neural connections in their brains, thus protecting cognitive functioning (American Psychological Association, 2003; Hong, 2004).

Use of healthy coping skills protects against development of behavioral health disorders for persons of all ages. Humor is an example of a coping skill that works by alleviating stress and reducing perception of pain (Vaillant and Mukamal, 2001).

Barriers to Service

The majority (63%) of older adults who have a behavioral health disorder do not receive the services they need. Barriers to services include stigma, misdiagnosis, social isolation, and poor coordination between physical and behavioral health care. Family and physicians may view depression as a natural process in aging, or believe that older adults at that age are too old to be treated for a substance abuse problem. Older adults, health care providers, and caretakers may mistakenly believe signs and symptoms associated with behavioral health problems to be a normal part of aging or view psychological pain and discomfort as a normal process, which should be endured without complaint (Connel, 1999). Few older adults seek help from a behavioral health treatment professional (American Psychological Association Online, 2006). Older adults with psychiatric illnesses are more likely to receive inappropriate pharmacological treatment and are less likely to be treated with psychotherapeutic interventions than younger primary care patients (Bartels, et al, 2002).

Stigma

Some older adults will reject treatment for behavioral health disorders or diagnosis of behavioral health disorders because of stigma (Reynolds and Kumpfer, 1999). Many older adults see substance abuse as a moral failing rather than a legitimate behavioral health problem (Benshoff, Harrawood, and Koch, 2003). Stigma also contributes to early discontinuation of treatment or noncompliance with treatment regimens (Ell, 2006).

Misdiagnosis

Depression and substance abuse in older adults can be manifested as physical ailments, failure to thrive and/or dementia, “pseudo-dementia or reversible dementia”. Symptoms of depression include insomnia, loss of appetite, weight loss, and fatigue. Each of these symptoms is easily mistaken for physical illness (Reynolds and Kumpfer, 1999). Comorbid medical conditions, inability to express somatic complaints, and language barriers are all factors that complicate appropriate diagnosis in older adults. A large number of older adults with behavioral health disorders remain undetected and untreated. Older adults are less likely than younger adults to complain of depression or sad feelings. Language barriers and practitioner focus on physical health conditions can complicate the screening process (Patterson, 1999).

Isolation

Social isolation brought about by physical ailments, depression, education, or transportation limitations presents a barrier to service seeking (Benshoff et al, 2003; Reynolds and Kumpfer, 1999).

Coordination between physical and behavioral health

Half of older adults who seek treatment for behavioral health conditions receive that treatment from their primary care provider rather than a behavioral health professional (American Association for Geriatric Psychiatry, 2006). Although physical illness is a risk factor for depression, substance abuse, and suicidal behaviors among the elderly, primary care providers do not always screen for behavioral health problems among their patients. A large number of older adults who complete suicide have visited their primary care provider within the same month, week, or even day of their suicide (Klausner and Alexopoulos, 1999).

Recommended Process/Procedures

Prevention and treatment in older adults should center on the concept of healthy aging, respect, and promotion of autonomy. Healthy aging involves positive spirituality, social connections, good physical health, cognitive functioning, autonomy, and high engagement with life.

Common elements of best practice across prevention, early intervention, and treatment include cultural competency, age appropriateness, group-based activities, provision of transportation and/or location of services in a setting comfortable and accessible to the participant (Benshoff, et al., 2003; Blow, 1998).

Effective programs enhance social support through peers, families, groups, and teaching relationship building skills. Peer support and education programs may be provided in a group, community, or home setting. Older adults benefit more from group interaction, when groups are composed of other older adults (Bartels, et al., 2002). Effective programs attend to physical health issues such as nutrition, sleep habits, medication, and pain (Kurlowicz, 2003). Staff and

volunteers who work with older adults should receive specialized training in geriatrics as well as behavioral health (Shafer, 2001).

Prevention

Effective prevention programs support healthy aging among persons who do not have a diagnosable behavioral health problem, but who may be at risk to develop one. Appropriate target populations include: the bereaved, pre-retirement/newly retired, persons who are not yet older adults (ages 50-55), adults with a serious medical condition and/or physical disability, and caregivers of older adults. Although there are a number of prevention programs targeting working age adults which are on the National Register of Effective Programs, (http://www.modelprograms.samhsa.gov/matrix_all.cfm) there are no nationally recognized exemplary programs targeting older adults.

Effective strategies include gatekeeper training, peer leadership, caregiver support, and life skills training. Prevention programs should involve multiple strategies and coordination with other community organizations through local substance abuse coalitions.

Training

Gatekeeper training is one of the most common approaches to prevention of suicide. This strategy involves training persons who have contact with older adults to recognize signs and symptoms of behavioral health problems, strategies for intervening with a suicidal person and the process for making referrals into treatment. Gatekeeper programs designed to educate physicians about signs and symptoms of suicide in older adults have been shown to have short term reductions in suicide (Klaussner and Alexopoulos, 1999; Rosenberg, 1996).

Gatekeeper training should involve multiple sessions over time with opportunities to practice skills. Trainings should be grounded in principals of adult learning involving hands on activities. Gatekeepers to target include medical professionals, care home staff, home based services staff, peers, and senior center staff (APA Online, 2006; Bartels, et al, 2002).

Prevention programs can help gatekeepers to recognize the importance of screening for depression and substance abuse. Prevention programs can help educate gatekeepers about screening tools and their use in medical settings. Some noteworthy gatekeeper training programs for suicide prevention are “Applied Suicide Intervention Skills Training”, “safeTALK”, and “Question Persuade and Refer”.

Peer Leadership

Peer leadership involves a variety of activities such as service learning, peer education, peer facilitated education, support groups, and home visitation.

Service learning: Volunteer and community service programs can reduce symptoms of depression, cognitive decline, and decrease mortality rates (Lum and Lightfoot, 2005). Volunteer work may involve activities such as mentoring children, answering phones for a warm line, provision of support and/or transportation to home bound peers, or participation in community based coalitions concerned with health and wellness issues (Rosenberg, 1996).

Community health educators (also called promotoras, senior companions, or peer educators) are trained paid or unpaid lay health workers who work with individuals or groups of people to provide support, health education, advocacy, screening, and assessment of home environmental

issues that may create risk for development of behavioral health problems. Services may be provided in a group community or home setting. Community health educators are usually of the same age, ethnic and racial background of the targeted population and are fluent in the preferred language of the population. Community health educators can break through age-related barriers that younger professionals may not be able to bridge. Use of community health educators to convey health messages has been rigorously evaluated with older Latino, White, African American, and Asian populations and found to improve participation in screening, preventative health care, decrease utilization of behavioral health treatment services, improve overall health, and improve cognitive function (Philis-Tsimikas, Walker, Rivard, Talavera, Reimann, Salmon, Araujo, 2004; Siegel, Berliner, Adams, and Wasengarz, 2003, Whitley, 2006).

Support groups, peer education, and counseling: Support groups facilitated by trained peers are effective in preventing behavioral health problems. Group interventions have been shown to be effective with older adult populations (SAMHSA, 2006).

Family and Caregiver support and Education

Caregiver support and education programs can delay the placement of older adults with medical or psychiatric disabilities into rehabilitation facilities. Two types of caregivers are of particular importance, caregivers of disabled older adults and older adults who provide full time care to grandchildren. Caregivers of disabled older adults benefit from education in the cognitive and behavioral changes experienced by their care recipient (Abeles, et al., 2002). Grandparents who are parenting young children need support in their role as a grandparent.

Education

Life skills training is provided in a group format to older adults at risk to develop a behavioral health problem. At least 16 hours of training is provided over multiple sessions. Some form of booster sessions should be offered after completion of the program. Services should be provided in locations accessible by older adults such as community centers, health care facilities, residential care facilities and senior centers. Suggested topics of training include: medication management, bereavement, maintaining cognitive health, healthy aging, and development of coping skills, information about changes in metabolism of alcohol and other drugs, physical activity, healthy diet (Carlson, 1994). Materials for older adult programs should be age appropriate and developed with consideration of the cultural beliefs of the target population. Education should be grounded in principles of adult learning and use of a variety of teaching tools in order to be successful. The needs and characteristics of the older population should be taken into consideration when preparing age and culturally appropriate materials. For example, using a large type and attractive format can make materials more visually appealing to older adults.

Community Development and Coalition Utilization

Prevention is most effective when grounded within a holistic community approach (Siegel, Berliner, Adams, and Wasengarz, 2003). Prevention services should always be coordinated with other community organizations through grass roots coalitions that are formed to address issues of concern to the community, which include participation of older adults. Prevention programs serving older adults should be active participants in local substance abuse prevention coalitions, healthy community coalitions, domestic violence coalitions, and behavioral health and aging coalitions. Coalitions can develop alcohol and substance abuse policy guidelines for long term

care facilities, create of hotlines, and most importantly, create partnerships for provision of services (Carlson, 1994; Ell, 2006; US Department of Health and Human Services, 2004).

Personal and Cultural Development

Personal and cultural development enhances sense of growth, accomplishment and purpose. The focus of personal and cultural development activities should be on participatory activities that build self-awareness and self-confidence, particularly in relation to their community environment. Examples of personal and cultural development activities include: reminiscence activities, visual arts, theater arts, holiday/cultural celebrations, and community gardens.

Engagement strategies

Outreach and engagement are key components of effective prevention programs (SAMHSA, 2006). Core strategies include selection of an appropriate service setting, provision of transportation, childcare, and delivery of services in a culturally competent manner.

Service Setting: Services should be provided in places that are most comfortable to the senior citizen such as residential homes and senior centers. Prevention programs are encouraged to integrate older adults into the community rather than providing all services within the home setting, which may contribute to isolation of the older adult from social supports in the community.

Transportation: Medical and physical conditions may prohibit/limit driving capabilities, promote isolation, reduce independence, and diminish quality of life and health. Provision of transportation is a critical element of effective prevention programs. When services are rendered outside of the participant's home, prevention programs should offer transportation to the program site (Siegel, Berliner, Adams, and Wasengarz, 2003).

Child Care: Child care should be provided for older adults who are caring for young children such as grandchildren.

Cultural competency: Recognition of and respect for the diversity within older adult populations is a critical element of program success. Gender, age, language, and culture have substantial impact on engagement of participants and effectiveness of services rendered. Staff should be aware of the diversity within older adult populations and receive training in cultural competency and gerontological issues.

Culturally competent prevention programs involve the targeted population in assessment of community need and design of preventative services. Prevention services should be provided in the language preferred by participants. Programs should utilize staff and volunteers who are of the same age group, gender, ethnic, and racial group of the targeted population. Programming should be grounded in the traditional beliefs and practices of the targeted population. Programs should consider that older adults being served may have lived through negative experiences that have shaped their lives (i.e., Bureau of Indian Affairs boarding schools, segregation, and discrimination). As a result, they may harbor distrust of healthcare providers and staff member of different cultural and ethnic backgrounds from themselves. It is important to keep in mind the referrals made for the individual. The U.S. Administration on Aging has provided an excellent resource for professionals on providing respectful, inclusive and culturally sensitive services for older adults and their families.

The name of the resource is “A tool kit for Serving Diverse Communities” and can be downloaded on this link:

http://www.aoa.gov/AoAroot/Press_Room/For_The_Press/pr/archive/2010/June/DiversityToolkit.aspx

Early Intervention

Early intervention in behavioral health problems facilitates effective treatment. Early intervention practices include identification of behavioral health problems and facilitation of acquisition of treatment services through hotlines, warm lines, mobile crisis intervention, means restriction, and screening. Diagnosis of behavioral health conditions among older adults can be complicated, as the symptoms of many physical health problems can mimic the symptoms of behavioral health issues. For example, confusion or memory issues may be related to depression or to dementia. Several approaches to early intervention and/or diagnosis are detailed below.

Hotlines and warm lines: Hotlines, which provide over the phone crisis intervention, are not commonly used by older adults. Warm lines which provide education, support, companionship, and referral can be staffed by trained and supervised volunteers (Rosenberg, 1996).

Means restriction involves removing any tools a person could use to complete a suicide from their environment, thus making an impulsive act of suicide less likely. An example of this would be a family member removing all firearms from the home of a depressed older adult (Rosenberg 1996).

Screening for behavioral health problems such as depression and substance abuse is an essential element of early intervention. Screening can facilitate access to behavioral health treatment services earlier in the course of their disease. It is particularly effective when included as a routine component of medical examinations because many older adults with behavioral health disorders will seek medical care rather than behavioral health care. Patients should be educated about the purpose of the screening and have an opportunity to provide active consent (Ell, 2006; Blow, 1998; Nemes, Rao, Zeiler, Munly, Holtz, Hoffman, 2004).

Major life changes should trigger a new behavioral health screening. Clinicians and medical providers should use screening tools that have been normed with older adults (Abeles, 1998). It is important to note that most assessment instruments have not been normed with ethnic minority older adults and may therefore be of limited utility with these populations.

Instruments normed with older adults and recommended by SAMHSA, the American Psychological Association and others include (SAMHSA, 2006; Abeles, et al., 2002; Irwin, Artin, and Oxman, 1999, Ell, 2006):

1. Alcohol Use Disorders Identification Test (AUDIT)
2. Beck Depression Inventory
3. Brief Psychiatric Rating Scale (Available online at <http://www.priory.com/psych/bprs.htm>).
4. Center for Epidemiological Studies Depression Scale (CES-D)
5. CAGE: (A questionnaire for drinking alcohol and drug use provided by SAMHSA) Responses on the CAGE are scored 0 for “no” and 1 for “yes,” with a higher score being an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.
6. Hamilton Depression Rating Scale

7. Michigan Alcohol Screening Test-Geriatric Version (MAST-G)
8. Patient health Questionnaire Module (PHQ-9)
9. The Geriatric Depression Scale (GDS) (Available online at <http://www.geridoc.net/gds.txt>)

Pocket screening instruments may be found at:

http://kap.samhsa.gov/products/brochures/pdfs/Pocket_2.pdf (Blow, 1998).

Diagnostic Issues

Mood disorders often manifest differently in older adults than in younger adults. Symptoms may include anxiety, problems with memory, agitation, and somatic complaints (Abeles, et al., 1998). Co-occurrence of dementia and/or delirium is common, occurring in up to 20% of older adults with major depression. It is important to differentially diagnose between these conditions.

Depression has a more abrupt onset than dementia and commonly occurs with a significant life change, loss of family member, friends, following major surgeries, loss or change in ability to perform activities of daily living or activities the person had been involved in prior to the life changing event, and sudden changes in motivation and mental status. Memory may be patchy, but the patient is able to think. The thought process involves helplessness, hopelessness, and guilt. Important indicators of depression include down cast moods; tearfulness; recurrent thoughts of suicide and death, family history of mood disorders, lack of interest, psychomotor disturbances, appetite change, weight loss, fatigue or loss of energy, history of behavioral health problems, insomnia, fear, memory problems, poor concentration and preoccupation with poor health. Older adults with depression should be screened for suicide risk (Reynolds, et al., 2002; Registered Nurse Association of Ontario, 2003; Rynn, DeMartinis, and Rickels, 1999).

Dementia has a slower, more progressive onset involving diminishment of recent and past memory. In dementia, the person may have difficulty finding words and understanding abstract concepts. Agitation is more symptomatic of physical health problems (Registered Nurse Association of Ontario, 2003). However, it is important to remember that the nature of dementia and the type of depression has an impact on its onset. For example, Alzheimer's type dementias with co-morbid depression have a quicker onset. Pseudodementia, dementia secondary to depression can only be ruled out by an empirical treatment with antidepressant treatment, the most effective being electroconvulsive therapy.

Delirium which is an acute confusion state of mind is a transient global disorder of cognition (Alagiakrishnan, MD, MBBS, Blanchette, MD, 2010). It has a sudden onset and is of short duration, usually waxing and waning in nature (less than a month). Delirium is considered a syndrome and not a disease, and should be treated as a medical emergency. It is often unrecognized or misdiagnosed, and commonly mistaken for dementia, depression, acute schizophrenic reaction, or part of old age, (Alagiakrishnan, MD, MBBS, Blanchette, MD, 2010). It is usually secondary to medical problems such as medication side effects, infections, toxic or metabolic problems; cardiac and pulmonary conditions leading to low oxygen delivery to the brain, neurological illnesses, etc. It is characterized by impaired memory, distorted, incoherent thinking and hallucinations, which get worse at night and first thing in the morning (Registered Nurse Association of Ontario, 2003). Delirium can occur at any age, but usually affects patients and older adults who have compromised mental status. The diagnosis of delirium requires a

careful review of the individuals' mental status as well as a complete history of the patient's family, the staff, and medical chart review (Alagiakrishnan, MD, MBBS, Blanchette, MD, 2010).

Suicide: Any person with a history of suicide attempts should be screened for suicidal ideation. Other indicators of suicide include: hoarding of medications, purchasing of weapons, writing a will, depression, substance abuse decline in health, isolation, abnormal sleep patterns, and sudden change in religious belief or practice. Older adults should be screened for suicide following major life changes (Holkup, 2002).

Substance Abuse: Older adults experience changes in their tolerance for alcohol due to physiological changes associated with aging. This means smaller amounts of use may be indicative of abuse. More than one drink per day or more than two drinks during a special occasion could be indicative of substance abuse (Patterson, 1999; Blow, 1998; Widlitz and Marin, 2002). Substance abuse is easily confused with physical health problems, dementia or depression (Benshoff, et al., 2002). Indicators of substance abuse include falls, vehicular accidents, and malnutrition. Prescribed medications can also be the source of problems; opiates, anti-cholinergic medications, anti-anxiety medications, whether they are taken as prescribed or abuse (taken in excess of how prescribed).

Laboratory tests of thyroid function are recommended when behavioral health conditions are suspected. Episodes of depression in older adults are commonly associated with a slightly decreased level of thyroxin and a slightly higher level of thyroid stimulating hormone. Patients can have normal levels of TSH and thyroxin, but low levels of T3. Additionally B12, foliate, vitamin D and magnesium deficiencies are quite common among this group and should be tested for. Oxygenation and cardiac ejection fraction should be evaluated as indicated. Serology for HIV and syphilis should be considered as well.

Treatment – Counseling

A combination of medication (see medical services below) and counseling is the most effective treatment. Patients should be evaluated for the potential benefit of medications in addition to counseling. Some patients will refuse counseling and medication or ECT is the only treatment choice (For example, the diabetic who is overweight and refuses to change diet or exercise). A number of therapeutic approaches are effective with older adult populations including: motivational interviewing, interpersonal psychotherapy, cognitive-behavioral therapy, and problem solving therapy. These therapies are more effective when offered in combination with anti-depressants, psycho education, and/or case management. Treatment can be effectively co-located within medical settings. For a thorough resource on best practices in substance abuse treatment with older adults, see SAMHSA TIP 26: Substance Abuse among Older Adults (Bartels, et al., 2002; Reynolds and Kumpfer, 1999; Blow, 1998).

Therapeutic Approaches

Supportive counseling, interpersonal psychotherapy, and cognitive-behavioral therapy are effective in reduction of symptoms associated with depressive disorders, anxiety, sleep disturbances, and other behavioral health problems. Overall goals of therapy include helping older adults to find their strengths, build social support networks, and develop hope and meaning in their lives (Kurlowicz, 2003; Abeles, et al., 1998).

Cognitive behavioral therapy modifies distorted thought processes and helps in development of coping skills. This form of therapy has been shown to be effective in older adults, particularly in treating late-life alcohol abuse (Bartels, et al., 2002; Faison and Steffen, 2001; Ell, 2006).

Interpersonal therapy helps people to cope with grief, conflicts, and changes in life. This type of therapy has been shown to be effective with older adults (Faison and Steffen, 2001; Ell, 2006).

Reminiscence therapy involves review of past successes and challenges. The clinician helps the patient to find meaning in past experiences, forgive people, and reinterpret past experiences. Reminiscence therapy is effective in both group and individual settings and is effective in development of resiliency social intimacy, and self-esteem. It has been shown to be more effective when combined with other forms of therapy such as problem solving therapy (Gaskamp, et al., 2004, Abeles, et al., 1998, Klausner and Alexopoulos, 1999; Faison and Steffen, 2001).

Problem-Solving Therapy is an approach in which behavioral health recipients identify problems contributing to their behavioral health problems and work on development of solutions to those problems. This type of therapy is effective in treatment of depression (Ciechanowski, Wagner, Schmaling, Schwartz, Williams, Diehr, Kulzer, Gray, Collier, and Logerfo, 2004; Blow, 1998, Kurlowicz, 2003; Klausner and Alexopoulos, 1999; Ell, 2006).

Other therapeutic approaches: Dialectical behavior therapy, music therapy, relaxation therapy, and art therapy can also be effective in older adult populations. Research on psychodynamic therapy has had inconsistent results in older adult populations (Faison and Steffen, 2001; Klausner and Alexopoulos, 1999; Kurlowicz, 2001).

Group based education and therapy: Older adults benefit from group interaction, particularly when groups are composed of other older adults and are supportive rather than confrontational (Benshoff, 2003). Group therapy is effective in the treatment of bereavement, depression, anxiety, and other behavioral health disorders as well as in reduction of symptoms such as pain (Abeles, et al., 1998; Blow, 1998). Groups can teach skills to rebuild social support networks as well as address issues such as coping with depression, loneliness and loss. Studies indicate that groups may be effectively facilitated by persons who are not behavioral health professionals (Klausner and Alexopoulos, 1999; Ell, 2006).

Case management services that reinforce compliance with medication and therapy can have a positive impact on treatment of behavioral health disorders in older adults (Katon, Schoenbaum, Fan, Callahan, Williams, Hunkeler, Harpole, Zhou, Langston, Unutzer, 2005).

Unskilled respite care: Caregivers of older adults with physical and mental disabilities benefit from provision of respite care. Respite may be provided in a variety of settings: community center.

Self-help/peer services (peer support): Older adults can effectively facilitate support and education groups for other older adults as described above.

Home care training family (family support): Support services provided to family members and/or caregivers can assist caregivers to better understand the behavioral health needs of their loved one and focus on effective resolution of problems related to care giving.

Supported housing: This approach assists older adults to continue to live independently. Supportive services may include case management, socialization, recreation activities, vocational and independent living skills training such as; personal hygiene, household tasks, transportation utilization, money management, and the development of natural supports needed to access services in the community provided at the client's home.

Adult foster care home: A licensed 24-hour personal care, protection, and supervised facility for individuals who are mentally ill, over 60 and cannot live alone but who do not need continuous nursing care. This level of care provides room and board and may require assistance with bathing, grooming, dressing, eating, walking, toileting and administration of medication. People requiring this level of care are referred to Arizona Long Term Care System (ALTCS) for this form of placement. Please note that ALTCS has programmatic levels of care defined to their specifications.

Semi-independent living: A community based therapeutic living environment designed for residents with deficits in independent living skills but offers a less restrictive and less programmed environment than 24-hour residential treatment program or skilled living facility. These placements may be in an apartment or house model setting. Residents go into the community for socialization, work and outside activities as they please. Services are voluntary and may be delivered on-site or in the community.

Health promotion strategies are designed to disseminate information to at-risk older adults in order to increase knowledge and change attitudes about substance abuse through activities such as group discussion. Health promotion and education services aid in understanding behavioral health diagnosis, medications, and cognitive changes as well as to develop problem solving skills and adherence to treatment. Health promotion strategies can be used to help patients develop a healthier diet, encourage exercise, and understand strategies for improving sleep (Kurlowicz, 2003). This intervention acts as an addition to any kind of therapy (Reynolds, Alexopoulos, and Katz, 2002).

Health promotion should include age-appropriate written materials with large, easily read fonts. Education should take place at a slower pace and be adapted for an older adult audience. Education is effective when peer led. Some older adults are more willing to participate in educational activities than therapeutic groups (Ell, 2006).

Participant engagement and retention

Motivating change is a key element of treatment. Understanding reasons that motivate older adults to stop drinking, such as health effects and costs, can help stimulate change. Motivational interviewing is an effective method of engaging people and helping them to develop motivation for change. Caring touch (holding hands, pats on the shoulder) can have positive impacts on an older adult's sense of well-being, self-esteem and satisfaction with life (Gaskamp, Sutter, Meraviglia, 2004). Reinforcement should be provided for change in behavior (Shafer, 2004).

Treatment should be culturally relevant, age-specific, and non-confrontational while promoting self-esteem and respect. Additionally, staff should receive training in working with older adult populations. Gender based treatment should be available.

Home based provision of treatment services has been shown to be effective in the treatment of depression in older adults with co-morbid medical conditions that limit mobility (Ciechanowski, et al., 2004). Transportation should be provided as needed.

Medical services

Combining anti-depressant medication with psychotherapy for treatment of severe depression is recommended as these two approaches are most effective when used together (Bartels, et al., 2002; Reynolds and Kumpfer, 1999). Older adult patients are more sensitive to medications and highly prone to side effects, adverse reactions, and drug-drug interactions. Clinicians should consider starting at low doses and making changes cautiously and slowly. Medications in older adults can complicate existing medical conditions and can mimic the physiologic symptoms of dementia. Coordination with primary care providers is essential.

Training and Supervision Recommendations

DBHS will provide a training of trainers for key Tribal and Regional Behavioral Health Authorities (T/RBHAs) and provider trainers in the application of this protocol. T/RBHAs will ensure that each staff member who works with older adults participates in the training.

Anticipated Outcomes: How will this doc be used to get those outcomes?

It is anticipated that this protocol will result in:

1. Increased referrals of older adults to treatment services;
2. Improved outcomes for prevention programs serving older adults;
3. Increased community and professional awareness of behavioral health issues among older adults;
4. Increased professional knowledge of best practices among older adults; and
5. Effective treatment practices with older adults.

Older Adults: Behavioral Health Prevention, Early Intervention, and Treatment Desktop Guide

Key elements to remember about this protocol:

1. Prevention approaches that are effective include gatekeeper training, peer leadership, family and caregiver support, education, personal and cultural development and community development.
 - A. Group activities are highly effective with older adults and are preferable to delivery of in home preventative services as they are more likely to decrease isolation.
 - B. Older adults can be effectively engaged as peers in the delivery of support and education services to persons of all ages.
 - C. Prevention services should always be coordinated with the local substance abuse prevention coalition and coalitions addressing behavioral health and aging issues.
 - D. Engagement strategies include location of services in a place comfortable to the participants, provision of transportation, respite care and delivery of culturally competent services.
2. Early Intervention involves identification of behavioral health problems.
 - A. Warm lines staffed by volunteers are more likely to be used than hotlines.
 - B. Screening for behavioral health conditions should be a routine component of primary health care visits.
 - C. Several screening tools have been normed and validated with older adults. Most have not been tested with older adults of diverse ethnic backgrounds.
 - D. Behavioral health conditions are easily confused with dementia, delirium, and other health problems. Care should be taken in diagnosis of older adults
 - E. Any older adult with symptoms of depression, a history of suicide, and/or a serious life change should be screened for behavioral health disorders and suicide.
3. Treatment
 - A. Therapeutic approaches that are effective with older adults include: cognitive behavioral therapy, interpersonal therapy, reminiscence therapy, problem solving therapy, and group based education and support.
 - B. Support services that are effective with older adults include: case management, respite, peer support, family support, and supported housing.
 - C. Participant engagement and retention involves delivery of culturally competent care.
 - D. Medical services
 - a. Physiological changes that occur in older adults affect metabolism of medications;
 - b. Select medications with the least side effects;
 - c. Start with the lowest dose and build slowly;
 - d. Medical services should be delivered in collaboration with the primary care provider; and
 - e. Detox with older adults may take longer. Care should be taken to closely monitor detox services.

Benefits of using this best practice:

Anticipated benefits to be gained by using this Protocol:

1. A larger number of older adults will be served because services delivered will be more cost-effective and efficient;
2. The quality of programs serving older adults will increase; and
3. Integrate effective prevention practices in older adults programs.

Definitions

1. **Addiction:** The compulsion and craving to use alcohol or other drugs regardless of negative or adverse consequences
2. **Assessment:** The ongoing collection and analysis of a person's medical, psychological, psychiatric and social condition to determine if a behavioral health disorder exists, the need for behavioral health services, and to ensure that the person's service plan meets the individual's (and family's) current needs and long-term goals.
3. **Best practices:** Strategies, activities and approaches that have been shown to be effective, through research and evaluation at preventing and/or or delaying substance abuse, violence, or other problem behaviors.
4. **Caregiver:** An individual who has the principal responsibility for caring for a child or dependent adult.
5. **Cultural competence:** A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals to enable that system, agency or those professionals to work effectively in cross cultural situations.
6. **Culturally based:** Developed in collaboration with or by the targeted population.
7. **Culturally relevant:** A prevention program, message, or strategy development that is meaningful to the identified population.
8. **Culture:** The shared values, norms, traditions, customs, arts, history, folklore, music, religion, and institutions of a group of people.
9. **Curriculum:** A written document that details the workshops, lessons, and/or presentations used in life skills education, parent/family education, public information, marketing, alternative activities, community education, and/or training services.
10. **Dependent Adult:** A person 18 years of age or older who is unable to protect his/her own interests or unable to adequately perform or obtain services necessary to meet essential human needs, as a result of a physical or mental condition that requires assistance from another, or as defined by department rule. (Definition from Iowa Human Services Department).

11. Early Intervention: The identification of individuals with suspected behavioral health problems for the purpose of addressing the problems before they become worse. It may involve referring individuals for assessment and treatment, for example, and routine evaluations done by health care providers.
12. Evidence Based: Programs or practices that have several of the characteristics listed below: replication, sustained effects, published in a peer reviewed journal, a control group study, cost benefit analysis, adequately prepared and trained staff, appropriate supervision, include assessment and quality assurance processes, consumer and family involvement, cultural, gender, and age appropriateness, and coordination of care.
13. Gatekeeper: An individual who has access to a group of people.
14. Older adult: A person who is age 55 or older.
15. Outcome: The immediate desired change in attitudes, values, behaviors, or conditions. Stated in the following format: "By a specified date, there will be a change (increase or decrease) in the target behavior, among the target population."
16. Prevention: The creation of conditions, opportunities, and experiences that encourages and develops healthy, self-sufficient children and that occur before the onset of problems (Arizona Revised Statutes). Prevention is an active process that creates and rewards conditions that lead to healthy behaviors and life styles (Center for Substance Abuse Prevention, (CSAP)).
17. Protective factor: An attribute, situation, condition, or environmental context that develops resiliency in individuals and prevents the likelihood of Alcohol Tobacco and Other Drug (ATOD) use.
18. Resilience: The personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, and other stresses and to go on with life with a sense of mastery, competence, and hope (New Freedom Commission on Mental Health, 2003).
19. Risk factors: Conditions that increase the risk of a particular problem from developing.
20. Substance abuse: The continued use of alcohol or other drugs in spite of negative consequences.
21. Substance use: The ingestion of alcohol or other drugs without the experience of any negative consequences.

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