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# 5

## COLLABORATIVE MODELS OF MENTAL HEALTH CARE FOR OLDER IOWANS

### CLINICAL PROCEDURES

### STEP FOUR: TREATMENT





The formal diagnostic assessment may lead to the identification of a diagnosable mental health problem or the identification of a psychiatric problem that contributes to a physical health or behavioral problem. In these cases, a treatment plan should be developed. This treatment plan should incorporate a collaborative approach to care that includes pharmaceutical and psychotherapeutic treatment and the provision of supportive services as needed. The treatment plan also should have the patient remain in contact with both the primary care and specialty mental health providers on a consistent basis over a six month period (or as long as treatment is warranted). On the following page, there is a depiction of the typical course of treatment in a collaborative care model.

In the remainder of this chapter, the key elements of a treatment plan are presented. These include a brief presentation of the pharmaceutical approaches to treating mental health problems among older adults, a review of the basic components of problem solving psycho-therapy, and a guide to supportive services that routinely are used by older adults.

This chapter also provides a treatment plan schedule, a detailed outline for conducting the first treatment session with an older client, educational materials that might be provided to the older client at the end of the first treatment session, and an evaluation form that should be completed every four to six weeks during the course of treatment.

## Typical Course of Treatment Provided within a Collaborative Model

	What Happens?	Who is involved?	Where does tx occur?
First Session	<ul style="list-style-type: none"> <li>- Review assessment</li> <li>- Approve tx plan</li> <li>- Start prescription</li> <li>- Introduce PST</li> <li>- Identify supp services</li> <li>- Set tx schedule</li> </ul>	<ul style="list-style-type: none"> <li>- Primary Care Provider</li> <li style="padding-left: 40px;">- Mental Health Specialist*</li> <li style="padding-left: 40px;">- Case Manager**</li> </ul>	Primary Care Office***
Week 2-3*	<ul style="list-style-type: none"> <li>- Start PST</li> <li>- Start supp services</li> </ul>	<ul style="list-style-type: none"> <li>- Mental Health Specialist</li> </ul>	- Defined by client
Week 4-5	<ul style="list-style-type: none"> <li>- Medication Monitor</li> <li>- Evaluation I</li> <li>- Adjust Tx Plan</li> <li style="padding-left: 40px;">- Continue PST</li> </ul>	<ul style="list-style-type: none"> <li>- Primary Care Provider</li> <li style="padding-left: 40px;">- Mental Health Specialist</li> <li style="padding-left: 40px;">- Case Manager**</li> </ul>	Primary Care Office***
Week 6-7	<ul style="list-style-type: none"> <li>- Continue PST</li> <li>- Cont supp services</li> </ul>	<ul style="list-style-type: none"> <li>- Mental Health Specialist</li> </ul>	- Defined by client
Week 8-9	<ul style="list-style-type: none"> <li>- Medication Monitor</li> <li>- Evaluation II</li> <li>- Adjust Tx Plan</li> <li style="padding-left: 40px;">- Continue PST</li> </ul>	<ul style="list-style-type: none"> <li>- Primary Care Provider</li> <li style="padding-left: 40px;">- Mental Health Specialist</li> <li style="padding-left: 40px;">- Case Manager**</li> </ul>	Primary Care Office***
Week 10-15	<ul style="list-style-type: none"> <li>- Continue PST</li> <li>- Cont supp services</li> </ul>	<ul style="list-style-type: none"> <li>- Mental Health Specialist</li> </ul>	- Defined by client
Week 16-17	<ul style="list-style-type: none"> <li>- Medication Monitor</li> <li>- Evaluation III</li> <li>- Adjust Tx Plan</li> <li style="padding-left: 40px;">- Continue PST</li> </ul>	<ul style="list-style-type: none"> <li>- Primary Care Provider</li> <li style="padding-left: 40px;">- Mental Health Specialist</li> </ul>	Primary Care Office***
Week 18-23	<ul style="list-style-type: none"> <li>- Continue PST</li> <li>- Cont supp services</li> </ul>	<ul style="list-style-type: none"> <li>- Mental Health Specialist</li> </ul>	- Defined by client
Week 24	<ul style="list-style-type: none"> <li>- Medication Monitor</li> <li>- Evaluation IV</li> <li style="padding-left: 40px;">- Complete or Continue Treatment</li> </ul>	<ul style="list-style-type: none"> <li>- Primary Care Provider</li> <li style="padding-left: 40px;">- Mental Health Specialist</li> </ul>	Primary Care Office***

\* as determined by individual model staffing resources

\*\* as allowed by client insurance and model staffing resources

\*\*\* primary care visits scheduled at end of first treatment session





The pharmaceutical aspect of an older individual's treatment should be defined and monitored by the primary care provider (or staff). This involves making an initial prescription, and then managing prescription and dosage levels as indicated by patient feedback as well as feedback offered by the qualified mental health specialist. The effects of pharmaceutical care should be evaluated routinely by scheduling the patient for office visits on the intermittent schedule depicted in the treatment plan. To assist with prescribing appropriate dosages, we provided tables for depression, anxiety and cognitive enhancers on the following pages.

### Depression

There is ample evidence supporting the effectiveness of pharmaceutical medication for older adults with diagnosed major clinical depression,<sup>44,45</sup> and prescriptions targeting the depression symptoms associated with anxiety, cognitive impairment and medical co-morbidities such as cardiovascular disease, endocrine disorders, and osteoarthritis also can be effective.

It is estimated that 50 to 65% of patients will experience a significant reduction in depressive symptoms after a six month trial. In particular, classes of Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs), Selective Serotonin Reuptake Inhibitors (SSRIs), and Tricyclic Antidepressants (TCAs) have comparable efficacy among older patients, though some suggest that TCAs create more side effects and SNRIs have fewer complications with other prescription medications.<sup>46</sup> The selection of any particular medication should be considered relative to ease of administration, potential interactions, and side effects.

A partial response is common among older adults, and dosage adjustment should be considered within 4 weeks of prescription initiation.<sup>47</sup> On the pages that follow, a list of anti-depressants and their recommended dosage for older adults is provided.

### Anxiety

Anxiety disorders are common among older adults yet research on the effectiveness of prescription medications is limited.<sup>48</sup> Three drug classes have been approved for anxiety disorders including antidepressants, buspirone (BuSpar), and benzodiazepines.<sup>49</sup> The antidepressants appear to be sensitive to the particular type of anxiety disorder (e.g., obsessive compulsive, panic, social phobia). BuSpar is reported to be particularly effective for Generalized Anxiety Disorder and anxiety that corresponds with medical problems. Benzodiazepines are the most commonly used and less resistant to age effects. However, these also have been associated with numerous side effects and long-acting benzodiazepines should be avoided.

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## Alcohol/Substance Abuse

There have been few research studies concerning the treatment of alcohol or other substance abuse among older adults.<sup>50</sup> Naltrexone has been shown to reduce the relapse rate for heavy drinking among older adults. Acamprosate has been shown to work with younger patient populations but there is no evidence concerning the effects on persons over the age of 65 and Disulfiram (Antabuse) may be particularly harmful for older adults.

Many problems related to alcohol or prescription medication misuse among older adults may be addressed by reviewing current prescription medication use and identifying those prescriptions considered to be a high risk among older adults and adjusting dosages accordingly.

## Dementia of the Alzheimer's Type – Cognitive Impairment

The relationship between Alzheimer's disease and cerebral-vascular disease has become increasingly intertwined and the American Association of Geriatric Psychiatry<sup>51</sup> considers that the management of vascular brain disease and its associated risk factors should be considered a form of treatment for persons with Alzheimer's disease and other causes of cognitive deterioration. Following this, the AAGP recommends initiation of low-dose aspirin therapy or, if appropriate, the initiation of other forms of anticoagulation as a treatment that might prevent the worsening of dementia symptoms.

The U.S. Food and Drug Administration (FDA) has approved three cholinesterase inhibitors (CEIs)--donepezil, rivastigmine, and galantamine--for the treatment for AD. Memantine also has been approved for persons with dementia. These drugs improve or slow cognitive losses and improve global functioning (relative to placebo) in mild to moderate AD, and should be considered as part of treatment. Yet the long-term effects are unclear. The AAGP reports that some data suggest that CEIs may also delay nursing home placement, reduce caregiver stress, and yield economic benefits.

The AAGP also states that the treatment of neuropsychiatric symptoms among persons with dementia and cognitive impairment (e.g., agitation, aggression, delusions, hallucinations, repetitive vocalizations, and wandering) with anti-psychotic medications should be conducted cautiously. No psychoactive medication should be prescribed without a formal psychiatric consultation. In addition, depression may affect as many as 50% of patients with AD but the efficacy of SNRIs, SSRIs, and TCAs are not well-established in this patient population. Finally, the AAGP does not support the use of the following in the treatment of dementia or cognitive impairment among older adults: anti-inflammatory agents, estrogen, ginkgo, and vitamin E.





Drug Name	Starting Dose in Elderly (mg)	Titration Schedule	Max Daily Dose	Side Effects
<b>Serotonin Reuptake Inhibitors (SSRIs)**</b>				
Citalopram (Celexa)	10 qd	Increase to 20 mg after 1 wk, To 30 mg after 4 wks, To 40 mg after 6 wks	40	Dry mouth, relatively few drug interactions
Escitalopram (Lexapro)	10 qd	Increase to 20 mg after 1 wk	20	Few drug interactions
Fluoxetine* (Prozac)	10 qam	Increase to 20 mg after 1 wk, To 30 mg after 4 wks, To 40 mg after 8 wks	40-60	Fluoxetine has a very long half life
Paroxetine* (Paxil)	10 qd	Increase to 20 mg after 1 wk, To 30 mg after 4 wks, To 40 mg after 6 wks	40	Dry mouth, constipation, weakness/fatigue
(Paxil CR)	25 qd			Slow release formulation
Sertraline (Zoloft)	25 qd	Increase to 50 mg after 1 wk, To 100 mg after 3 wks, To 150 mg after 6 wks	150-200	
<b>Serotonin and Norepinephrine antagonist</b>				
Mirtazapine* (Remeron)	15 qhs	Increase to 30 qhs after 3 wks, To 45 qhs after 6 wks	45	Sedation w low dose Weight gain
<b>Norepinephrine- and dopamine- reuptake inhibitor</b>				
Bupropion Wellbutrin SR* Wellbutrin XL* Zyban	75 qd	Increase to 75 bid after 4 days, To 100 bid after 2 wks, To 150 bid after 4 wks, To 150 tid after 6 wks	450	Insomnia/agitation Risk of seizures at high doses
	100 qd (SR) 200 qd (XL)	Increase to 100 bid after 1 wk, To 150 after 3 wks, To 150 tid after 6 wks	400	Once or twice daily dosing with SR preparation
<b>Serotonin and Norepinephrine reuptake inhibitor</b>				
Venlafaxine (Effexor XR)	37.5 qd (XR)	Increase to 75 after 1 week To 150 mg after 3 weeks To 225 after 6 weeks	225	Nausea, agitation/insomnia Elevations in BP at higher doses (>150 mg/day)
Duloxetine (Cymbalta)				Slow release preparation allows once daily dosing
<b>Primarily Norepinephrine reuptake inhibitor</b>				
Desipramine (Norpramin, Pertofrane)	25 qhs		150-200	
Nortriptyline (Aventyl, Pamelor)	10 qhs		75-125	

## Pharmaceutical Treatment for Cognitive Aspects of Dementia<sup>52</sup>

Drug Name	Starting Dose in Elderly (mg)	Titration Schedule	Max Target Dose	Side Effects
<b>Cholinesterase Inhibitors</b>				
Donepezil (Aricept)	5 mg/d	Increase to 10 mg after 1 month	10 mg/d	Nausea, diarrhea, insomnia, agitation
Galantmine (Razadyne, Razadyne, ER)	4 mg q 12h	Increase to 8 mg q 12h after 1 month	12 mg 12h	
Rivastigmine (Exelon)	1.5 mg q 12h	Increase to 3 mg q 12h	6 mg q 12h	
<b>NMDA Antagonist</b>				
Memantine (Namenda)	5 mg/d	Increase 5 mg weekly til 10 mg 12h	20mg d	Impaired kidney function





The Collaborative Models of Mental Health Care for Older Iowans assume that providing problem solving therapy in addition to prescription medication will provide the best clinical results for older patients. Problem solving therapy (PST) is a therapeutic technique that evolved from the cognitive-behavioral and insight oriented traditions of psychotherapy.<sup>53</sup> PST specifically consists of a time-limited process for developing individual skills and applying these skills to resolve specific problems.

In particular, PST requires older patients to identify primary psychological problems, identify the antecedents or causes of these problems, and then develop effective responses. The approach has been shown to benefit older persons with depression, substance abuse disorders, persons who are experiencing mild to moderate cognitive impairments and individuals who experience co-occurring medical problems such as cancer, diabetes, and chronic pain.<sup>54,55</sup>

PST involves working through seven distinct stages. These stages include: (a) selecting and defining a problem, (b) establishing achievable goals for problem resolution, (c) generating multiple solutions to the problem, (d) establishing guidelines for problem solving, (e) choosing a solution, (f) implementing the solution, and (g) evaluating the outcome.

A traditional approach to PST involves between 10 and 15 sessions (total of nearly 20 hours of provider-patient encounter time). However, because we recognize that each site which implements a collaborative model of mental health care for older Iowans will be different, we did not establish that PST has to consist of any particular number of sessions. Rather, we encourage the mental health providers to develop PST treatment plans in coordination with the older adults and these plans should meet the particular needs and capabilities of the older adult. Having said that, we expect that the PST treatment plan should consist of no less 6, but no more than 18 sessions during a six month period.

PST should be provided by a qualified mental health specialist or someone who is specially trained in PST and is working directly under the supervision of a qualified mental health specialist.

By the end of the introductory treatment session, the client should be informed about the PST approach. This includes knowing how many sessions are involved, what is expected to occur within any particular session, what is expected to happen between sessions, and the cognitive behavioral tradition that supports PST.

The first PST treatment session should work through the first stage of PST, and the ensuing sessions should focus on working through the remaining stages. It is possible that if the patient makes sufficient progress through the seven stages during the six month window, then PST can be repeated in manner so the therapist and client select another problem to address. Indeed, the treatment approach should be designed so that relatively easy problems are solved initially and the client builds up momentum to address some of the more difficult problems identified during the first stage of treatment.

### The First Stage

- Select and define a problem

  - Explore and clarify problem

  - Break down large problem into small, manageable problems

  - State the problem in a clear and concise form

### The Second Stage

- Establish realistic and achievable goals for solving the problem

### The Third Stage

- Generate multiple solutions and alternatives to solve the problem

### The Fourth Stage

- Select the most feasible solutions to pursue

### The Fifth Stage

- Define an implementation strategy

### The Sixth Stage

- Implement the solution

### The Seventh Stage

- Evaluate the outcome





Supportive services can play a critical role in maintaining an older person's mental health and also help those with a persistent disabling condition such as Alzheimer's disease. Yet many older adults are unaware of the variety of supportive service options that are available to them.<sup>56</sup> A part of the collaborative model should include providing basic education about the different service options that are available to an older adult and to link the individual a full range of supportive services including home health care, nutrition programs, homemaker and chore assistance, emergency response, transportation, and other services that were indicated during the diagnostic assessment.

There also are a number of community-based programs that can help older adults. For example, adult day health care programs are designed to assist individuals who are experiencing significant physical and mental disabilities. Health promotion, disease prevention, and holistic services also can help maintain a person's physical and mental health.<sup>57</sup>

Transportation and mobility are critical to the physical, social, and psychological well-being of older persons as well. Access to medical facilities, health promotion programs, and other social services is dependent on the ability to use transportation. Maintaining an active social life also depends on an individual's accessibility to family, friends, recreational, and cultural activities. Important elements of psychological health are enhanced by mobility, affecting whether a person can maintain freedom from isolation and the ability to choose a range of activities.<sup>58</sup>

Aging successfully entails continued growth and development, and developing the capacity to respond optimally to the inevitable challenges of growing old. Leisure, physical, spiritual, and educational activities provide several benefits for older adults. These activities can replace work roles, expand on pre-retirement skills and interests, assist in maintaining a positive self-concept, self-reliance and independence, and promote overall well-being. In addition, participating in leisure, spiritual, and educational activities can help older adults deal more effectively with stressful life events through shared companionship, reduced feelings of loneliness, and increased ability to cope with significant life changes.

In developing the treatment plan the mental health specialist should consider how supportive services can enhance the older client's life. Involving the older individual in such programs and services should be included as part of the treatment. If possible, the collaborative model should enlist the support of a case manager who can assist in this process. Case management services typically are offered through local community hospitals, area agencies on aging, or other community-based social service programs.

## TREATMENT PLAN

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A treatment plan should be designed to be carried out over a six month period (24 weeks). The plan should incorporate a collaborative approach in providing pharmaceutical and psychotherapeutic treatments, and supportive services as needed. The plan also requires ongoing consultation between the primary care staff and the mental health specialist.

There are six key components in the treatment plan. The first is selecting the most appropriate prescription medication. The second is to define the course of problem solving therapy. The third is to identify supportive services that will benefit the older client. The fourth is to establish an appointment schedule. The fifth involves routinely evaluating treatment progress during the six month period. The last component involves establishing a course for continued care after the initial six month period.

More specifically, the treatment plan should identify a primary diagnosis or problem, and establish treatment goals. The plan should feature no less than four appointments with the primary care physician to assess the effect of pharmaceutical medication. The plan should feature no less than 6 and no more than 18 PST sessions. The plan should identify supportive services that should be accessed by the older adult during the course of treatment. The plan also should include four sessions that involve patient evaluation and treatment plan modification.

While it is expected that medication management sessions will take place in the primary care physician office, the client and mental health specialist should determine the best location for other treatment sessions. In some models, the older adult may determine the best place to continue to receive care is within the primary care office; in other models, the care can be provided in a specialty mental health clinic or private office. Individuals with certain types of insurance can have treatment delivered in their own home or over the telephone.

A standard treatment plan is presented on the following pages. After being filled out, the mental health specialist should review the plan with the primary care staff who will be involved with prescribing medication, and the plan should then be discussed with the client. Treatment should begin as soon as the client agrees to the treatment plan.





## TREATMENT PLAN

SITE: \_\_\_\_\_

PATIENT INITIALS: \_\_\_\_\_

PARTICIPATING STAFF:

Mental Health Specialist \_\_\_\_\_ p: \_\_\_\_\_

Primary Care Staff \_\_\_\_\_ p: \_\_\_\_\_

Consulting Psychiatrist \_\_\_\_\_ p: \_\_\_\_\_

Client Emergency Contact \_\_\_\_\_ p: \_\_\_\_\_

## TREATMENT OVERVIEW:

Presenting Problem: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Diagnosis: \_\_\_\_\_

Other Diagnosis: \_\_\_\_\_

Goal of Treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Treatment Initiation: \_\_\_\_\_

Expected Date of Treatment Completion: \_\_\_\_\_

## TREATMENT METHODS:

### PRESCRIPTION MEDICATION:

Treatment target: \_\_\_\_\_

Type/Brand Name: \_\_\_\_\_

Dosage/Frequency: \_\_\_\_\_

Adjustment Dates: \_\_\_\_\_

### PROBLEM SOLVING THERAPY:

Treatment Target(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

#### Method of Focused Intervention:

Homework \_\_\_\_\_

Activity \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### SUPPORTIVE SERVICES

Treatment Target: \_\_\_\_\_

\_\_\_\_\_

#### Recommended Services:

\_\_\_\_\_

\_\_\_\_\_

#### Contacts:

\_\_\_\_\_

\_\_\_\_\_





# TREATMENT SCHEDULE:

		Dates	Place
Session 1:	Agree to Treatment Plan Prescribe medications Review PST - Supportive Services Educational Materials	_____	_____
Week 2-3:	Medication Check-Up Problem Solving Therapy Supportive Services	_____ _____	_____ _____
Week 4:	Medication Management Problem Solving Therapy Evaluation I Treatment Adjustments	_____	_____
Week 5-7:	Problem Solving Therapy Supportive Services	_____ _____	_____ _____
Week 8:	Medication Management Problem Solving Therapy Evaluation II Treatment Adjustments	_____	_____
Week 9-15:	Problem Solving Therapy Supportive Services	_____ _____ _____ _____	_____ _____ _____ _____
Week 16:	Medication Management Problem Solving Therapy Evaluation III Treatment Adjustments	_____	_____
Week 17-23:	Problem Solving Therapy Supportive Services	_____ _____ _____ _____	_____ _____ _____ _____
Week 24:	Medication Management Problem Solving Therapy Evaluation IV Treatment Plan Continuation	_____	_____

# CLIENT EVALUATION

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SITE: \_\_\_\_\_

PATIENT INITIALS: \_\_\_\_\_

PARTICIPATING STAFF:

Mental Health Specialist \_\_\_\_\_ p: \_\_\_\_\_

Primary Care Staff \_\_\_\_\_ p: \_\_\_\_\_

Initial Screening Date: \_\_\_\_\_

Initial Screening Score: \_\_\_\_\_

Initial Screening Impression: \_\_\_\_\_

\_\_\_\_\_

Diagnostic Assessment Date: \_\_\_\_\_

Assessment Test Scores:

PHQ9 \_\_\_\_\_

ZUNG \_\_\_\_\_

SMAST-G \_\_\_\_\_

MMSE \_\_\_\_\_

SF-12 \_\_\_\_\_

Other: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Treatment Initiation date: \_\_\_\_\_

Treatment Plan Goals: \_\_\_\_\_

\_\_\_\_\_



# CLIENT EVALUATION



## EVALUATION 1 (4 weeks)

PHQ9 \_\_\_\_\_ SMAST- G \_\_\_\_\_ SF-12 \_\_\_\_\_

ZUNG \_\_\_\_\_ MMSE \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## EVALUATION II (8 weeks)

PHQ9 \_\_\_\_\_ SMAST- G \_\_\_\_\_ SF-12 \_\_\_\_\_

ZUNG \_\_\_\_\_ MMSE \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## EVALUATION III (16 weeks)

PHQ9 \_\_\_\_\_ SMAST- G \_\_\_\_\_ SF-12 \_\_\_\_\_

ZUNG \_\_\_\_\_ MMSE \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## EVALUATION IV (24 weeks)

PHQ9 \_\_\_\_\_ SMAST- G \_\_\_\_\_ SF-12 \_\_\_\_\_

ZUNG \_\_\_\_\_ MMSE \_\_\_\_\_

Other: \_\_\_\_\_

The initial treatment session should reach five goals. The first is for the provider and older client to agree upon a treatment plan that can be followed over the next six months. The second is for the provider to inform the patient about the prescription drug treatment plan and review the importance of adhering to the medication regimen. The third is to discuss how treatment in general and PST in particular will unfold over the six month timetable. The fourth is to provide some basic educational materials that address the particular psychological problem that the older adult appears to be facing. The last goal is to establish a therapeutic relationship with the older client as this will encourage his or her continued participation in treatment.

To reach these goals, the provider must portray a sense of confidence in the treatment approach. The client should believe that at the end of the six months, she will indeed be feeling better. The provider also should establish a sense of partnership with the client. This entails suggesting that the effects of medication and problem solving therapy are a function of patient motivation and participation. Treatment success also depends on the ability to remain focused on the treatment plan and use their allotted sessions efficiently.

### Educational Materials

On the following pages, there are some basic education materials that can be given to the older adult. These materials provide a brief introduction to the problem that he or she might be experiencing. The client should review the appropriate educational material prior to the start of PST sessions. Additional educational materials pertaining to the Collaborative Models of Mental Health Care for Older Iowans can be found at the website for the Iowa Coalition for Mental Health and Aging. <http://www.icmha.org>





# FACTS ABOUT DEPRESSION AND AGING

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“Do not ignore warning signs of depression.  
Treatment can be more successful if family members participate in care.”

## **Is feeling depressed a normal part of growing older?**

It is easy to think that depression occurs as a result of illness or life events, such as the loss of loved ones. But, even with loss and difficulties, life offers pleasure and happiness. It is not normal for older people to be “down in the dumps” for a long time. Older persons without depression are able to bounce back from hard times and find joy in life.

It’s important to recognize that anyone can get depressed for a while, but when someone gets stuck in depression, they should be evaluated for a depressive illness. When depression lasts for more than a week, it usually requires and responds to treatment.

## **What are common signs of depression?**

Older persons may deny feeling sad or depressed. For this reason, friends and family should watch for the following signs:

- loss of interest in self- care and/or following medical advice
- little interest in social activities
- feeling “empty” inside
- trouble sleeping and/or anxiety
- trouble concentrating or remembering things
- unexplained aches and pains
- change in appetite and weight
- feeling hopeless about the future
- feelings of helplessness
- easily irritated and/or listless
- feeling that one is a burden

## **What causes depression?**

There is no single cause of depression. Depression may be related to changes in brain chemistry that affect mood; however, mood changes and signs of depression can be the result of medications that an older person is taking, or can be the direct result of physical illnesses.





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### **What treatment options are available for depression?**

Good news about depression: treatment works! Counseling and medications are the primary methods of treatment. Counseling helps to undo negative thinking patterns and helps people sort out conflicts, solve problems and deal with interpersonal conflicts. Medications are helpful in many cases.

### **How long does it take for medications to work?**

Doctors often start older people on low doses of medications. They may increase the medicines, as tolerated, to doses that are usually effective in younger patients. Antidepressants should begin to make a difference by 4-6 weeks. If this goal isn't met, the treatment may be intensified or adjusted.

### **What else should I know about anti-depressant medications?**

Any side effects that occur should be discussed with the doctor. Side effects vary depending on the particular antidepressant prescribed. Those that do occur generally get better with continued treatment. People who take medication should continue to take it, even after they start feeling better. The decision to stop taking the medication should be made together with the doctor, since it may take several months for best results. Today's medications are not addicting. Some medicines used to treat anxiety have the potential for abuse and addiction, but are no longer routinely prescribed to treat depression.

### **What about St. John's Wort and other herbal remedies?**

It's unclear whether St. John's Wort is helpful for mild depression. People who want to take St. John's Wort or other supplements should speak to a health professional. The provider can help make sure that there are no medical reasons for depression. He or she can also ensure that the depression is not more severe than it appears.

### **What resources are available for help or more information?**

- Bloomfield HH, McWilliams P. How to Heal Depression. Los Angeles, Prelude Press, 1994.
- National Institute of Mental Health, [www.nimh.nih.gov](http://www.nimh.nih.gov), 800-421-4211 National Institute on Aging, "Age Pages" under "Health Information," look for Depression: A Serious but Treatable Illness, [www.nih.gov/nia](http://www.nih.gov/nia), 800-222-2225
- National Mental Health Association, [www.nmha.org](http://www.nmha.org), 800-969-NMHA or TTY 800-433-5959

by Hillary R. Bogner MD, MSCE and Joseph J. Gallo MD, MPH

# FACTS ABOUT MEMORY AND DEMENTIA

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Many older adults have memory lapses: forgetting the name of someone close to us or misplacing our car keys or even our car. So, how do we know when we or someone we love is actually developing dementia?

## **What is dementia?**

Dementia is a condition of declining mental abilities, especially memory. The person will find it hard to do things he or she used to be able to do easily. Some examples are trouble balancing a checkbook, driving a car safely, or planning a meal. He or she will often have problems finding the right words and may become confused when given too many things to do at once. The personality of a dementia sufferer may also change. He or she may become aggressive, paranoid, withdrawn, or depressed.

## **Isn't dementia just old age or senility?**

Aging alone does not stop us from taking care of ourselves. As we get older, it may take longer to remember names or to find the right word to say. Mild changes in thinking and remembering information (also known as mild cognitive impairment) may happen as we age, delaying or making thought processes more difficult.

The loss of memory and other mental problems caused by dementia are bad enough to keep us from doing things we used to do easily. Researchers are trying to understand if dementia is an abnormal extension—a more severe form—of the mild, expected memory changes experienced by older adults, or if it is entirely different situation. While dementia is more common in old age, it is not “normal.” Changes in memory should be evaluated.

## **What causes dementia?**

Alzheimer's Disease is the most common type of dementia. But, there are many other causes of dementia. They include strokes, low vitamin B12 levels, thyroid conditions, depression, AIDS, and other infections. In addition, medications and some illnesses can cause confusion (delirium) in older people. This may look like dementia because it also affects memory.

## **Is there any point to seeing my doctor?**

There are important reasons to get an evaluation. First, there are now treatments available for Alzheimer's disease. They can improve the symptoms and slow the progress of the disease. Second, there are other causes of dementia and confusion. Sometimes the person may return to normal once his or her medications are changed or medical illness is treated. Third, the doctor's office should be able to assist you in finding community resources for information, support groups, and help at home.





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### **What can be done to treat dementia?**

If the diagnosis is Alzheimer's or a related dementia, treatment is available to control the symptoms, delay the onset of the severity of the progression of the disease, improve the quality of life, and lengthen the time the individual can stay in their family home.

As the disease progresses, behavioral problems are common. Alzheimer's patients can become easily agitated and have difficulty with both long and short-term memory, have problems with judgment, and begin to have difficulty with such basic daily activities as dressing, eating, grooming, and using the bathroom. Some of the most common problematic behaviors include: agitation, aggression, combativeness, delusions, hallucinations, insomnia, and wandering. Behavioral symptoms may be the result of a treatable problem such as pain, infection, discomfort, and can be treated through both non-pharmacological and pharmacological treatments.

Medicines approved for treating Alzheimer's disease are donepezil [Aricept], galantamine [Reminyl], and rivastigmine [Exelon]. They work by raising the levels of acetylcholine in the brain. They all can cause some stomach problems. Otherwise, they are generally well-tolerated. Vitamin E may slow the progress of Alzheimer's disease. However, since it can increase bleeding, it should be used with caution in people taking blood thinners.

### **Is a nursing home really necessary?**

This is a very individual matter. Often families feel guilty about placing a loved-one in a nursing home. With good help at home, safety measures (such as removing the knobs from stoves) and day care options, the person can stay at home for a long time. A good nursing home can provide safety and social interactions that may give your loved-one a great deal of pleasure and security. It can also give you a chance to sleep and do your daily tasks with some peace of mind.

### **Where do I go for more information or support?**

The National Alzheimer's Association

1-800-272-3900

e-mail: [info@alz.org](mailto:info@alz.org).

website: <http://www.alz.org>.

The Alzheimer's Disease Education and Referral Center

1-800-438-4380

e-mail: [adear@alzheimers.org](mailto:adear@alzheimers.org)

American Association for Geriatric Psychiatry

7910n Woodmont Avenue, Suite 1050

Bethesda, MD 20814

by Gary Odenheimer, MD

# FACTS ABOUT DRINKING AND SUBSTANCE ABUSE

Anyone at any age can have a drinking problem. Great Uncle George may have always liked his liquor, so his family may not see that his drinking behavior is getting worse as he gets older. Grandma Betty was a teetotaler all her life—she started having a drink each night to help her get to sleep after her husband died. Now no one realizes that she needs a couple of drinks to get through each day, but such alcohol use deserves special attention. Because the aging process affects how the body handles alcohol, the same amount of alcohol can have a greater effect as a person grows older. Over time, someone whose drinking habits haven't changed may find she or he has a problem.

## Facts About Alcohol and Aging

- Some research has shown that as people age they become more sensitive to alcohol's effects. The same amount of alcohol can have a greater effect on an older person than on someone who is younger.
- Some medical conditions, such as high blood pressure, ulcers, and diabetes, can worsen with alcohol use.
- Many medicines—prescription, over-the-counter, or herbal remedies—can be dangerous or even deadly when mixed with alcohol. This is a special worry for older people because the average person over age 65 takes at least two medicines a day. Here are some examples:
  - Aspirin can cause bleeding in the stomach and intestines; the risk of bleeding is higher if you take aspirin while drinking alcohol.
  - Cold and allergy medicines (antihistamines) often make people sleepy; when combined with alcohol, this drowsiness can be worse.
  - Alcohol used with large doses of the pain killer acetaminophen can raise the risk of liver damage.

## How to Know if Someone Has a Drinking Problem

There are two patterns of drinking: early and late onset. Some people have been heavy drinkers for many years. But, as with great Uncle George, over time the same amount of liquor packs a more powerful punch. Other people, like Grandma Betty, develop a drinking problem later in life. Sometimes this is due to major life changes like shifts in employment, failing health, or the death of friends or loved ones. Often these life changes can bring loneliness, boredom, anxiety, and depression. In fact, depression in older adults often goes along with alcohol misuse. At first, a drink seems to bring relief from stressful situations. Later on, drinking can start to cause trouble.





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Not everyone who drinks regularly has a drinking problem, and not all problem drinkers drink every day. You might want to get help if you or a loved one:

- Drink to calm your nerves, forget your worries, or reduce depression.
- Gulp down drinks.
- Frequently have more than one drink a day. (A standard drink is one 12-ounce bottle or can of beer or a wine cooler, one 5-ounce glass of wine, or 1.5 ounces of 80-proof distilled spirits.)
- Lie about or try to hide drinking habits.
- Hurt yourself, or someone else, while drinking.
- Need more alcohol to get high.
- Feel irritable, resentful, or unreasonable when not drinking.
- Have medical, social, or financial worries caused by drinking.

### **Getting Help**

Studies show that older problem drinkers are as able to benefit from treatment as are younger alcohol abusers. To get help, talk to your doctor. He or she can give you advice about your health, drinking, and treatment options. Your local health department or social services agencies can also help.

There are many types of treatments available. Some, such as 12-step help programs, have been around a long time. Others include getting alcohol out of the body (detoxification); taking prescription medicines to help prevent a return to drinking once you have stopped; and individual and/or group counseling. Newer programs teach people with drinking problems to learn which situations or feelings trigger the urge to drink as well as ways to cope without alcohol. Because the support of family members is important, many programs also counsel married couples and family members as part of the treatment process. Programs may also link individuals with important community resources.

Scientists continue to study alcohol's effects on people and to look for new ways to treat alcoholism. This research will increase the chance for recovery and improve the lives of problem drinkers.

### **For More Information**

#### **National Institute on Alcohol Abuse and Alcoholism (NIAAA)**

5635 Fishers Lane MSC 9304

Bethesda, MD 20892-9304

301-443-3860

[www.niaaa.nih.gov](http://www.niaaa.nih.gov)