Mental Health and the Older American: Perspective for Leadership in Senior Living

By

Dr. Paul Nussbaum
Board Certified: Clinical and Geropsychology
Adjunct Professor of Neurological Surgery
University of Pittsburgh School of Medicine
President Brain Health Center
www.brainhealthctr.com
drnuss@me.com
(724) 719-2833

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> *We have come to medicalize aging, frailty, and death, treating them as if they were just one more clinical problem to overcome. However it is not only medicine that is needed in one's declining years but life- a life with meaning, a life as rich and full as possible under the circumstances (Oliver Saks, 2014).*

Dr. Saks' view has support from the World Health Organization (WHO) that defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

Healthy Aging in America:

Older adults are no different than younger adults and indeed the ingredients to real health are not bound by age. For many years and throughout the research on aging generated over many decades, it has been established that successful aging is indeed not a medical issue, nor something that needs treated or cured. Rather, the critical factors that enrich our lives, support our existence, and encourage our creativity and longevity have much more to do with natural human factors.

Older adults who thrive have mastered and captured the following:

- Ability to adapt
- Role and Purpose
- Connectivity
- Family and Friendship
- Love
- Exercise and Movement
- Spiritual Health
- Mental Stimulation
- Zest for Living
- Positive attitude

Theses critical factors for our health and longevity are not found in our overly medicalized, acute, and invasive disease-based system of care. The good news is that we can make a change and begin the process of creating proper environments and support systems that facilitate overall health for the older American.

For the older adult who transitions from their primary home to a senior care continuum including independent or assisted living, the move can be difficult if not traumatic. This is not a clinical matter, but a natural human adjustment that can

create feelings of loss, grief, fear, loneliness, detachment, and unfamiliarity. It is critical for proper support systems to be in place to assist the older person with this transition. They will do well with a good dose of love, compassion and ongoing encouragement to accept and to thrive once again.

Senior Living and Psychological Health for the Older Adult:

Senior Living can champion those ingredients necessary for successful aging, life transitions, and offers the following differential approach to mind-body-spiritual health and wellness:

From	To
Medical Approach to Aging	Holistic Approach to Aging
Disease	Wellness
Reactive	Proactive
Treatment Intervention	Healthy Lifestyle Promotion
Clinician Empowerment	Older adult empowerment
Talking to	Listening
Focus on the Physical Only	Mind-Body-Spirit
Acute Care Approach	Chronic Care Approach
Symptom, Treatment, Cure	Management of Condition
High Tech	High Touch
Decline	Thrive

The Importance of Psychological Health:

It is now recognized that psychological health and wellness is essential to overall health and wellbeing. There is recognition that for all adults, but particularly older adults, that psychological wellbeing must be emphasized with the same vigor as physical health. Indeed, research indicates there is value in integrating psychological health into our physical health approach and that older Americans are comfortable with such a holistic perspective where we support and reinforce the mind-body-spirit of an individual. There is reason to believe the nation has begun to accept this challenge and the time has come for this integrated mind-body-spirit wellness to continue to grow and to thrive within the entire senior care continuum.

A proper approach to overall health underscores the importance of psychological health with a belief that we all can nurture this critical part of our wellbeing through empirical and ongoing measurement, a proactive lifestyle filled with the human needs of purpose and meaning, integration in community, friendship, self-esteem, love, family and all the things our grandmother taught us as important.

Health is not simply the absence of disease and our journey to real health is not a medical issue. It is ultimately a human condition issue and the psychosocial-holistic contribution to such health is critical and necessary (PDN)

Facts of Aging in the United States:

Our nation is undergoing a significant demographic shift with an aging society. A growing number of older adults can certainly be viewed as a rich opportunity in so many ways. However, we must also be vigilant to the reality that as more individuals live longer there will be an increase in physical and psychological frailty and there is an urgent need for systems, professionals, and resources to address the challenges. The sheer demographic tsunami with all of its economic and health related implications creates an urgent call to action:

- 46 million Americans are 65 and over today (15% of population)
- 98 million Americans will be 65 plus by 2060 (24% of Population)
- Older Americans will be more racially and ethnically diverse
- Older Americans are working longer (23% men and 15% women working in 2014; 27% men and 20% women will be working in 2022)
- 25% of older Americans will have college degree by 2014
- Life expectancy 79 years in 2013 (greater for females)
- Gender gap in longevity narrowing (76.4 male vs. 81.2 female)
- Poverty rate dropped past 50 years (30% to 10%)
- Obesity rates increasing
- Economic disparities across population subgroups
- More older adults are divorced vs. prior generations
- 27% women live alone and #s increase with advanced age
- Nursing home needs increase from 1.3 million in 2010 to 2.3 million in 2030
- Persons with Alzheimer's disease (AD) 14 million in 2050 from 5.2 million today
- Social Security expenditures increase by 8 percent by 2050
- Medicare expenditures increase by 12% by 2050
- 10,000 Americans turn 65 daily
- 15 million people serve in role as caregivers and that number will increase substantially
- 33% of caregivers are depressed or experiencing symptoms of anxiety

*Population Reference Bureau (2016)

Facts of Mental Health and the Older American

Emotional and psychological frailty is often neglected in favor of physical health and frailty. The fact is that older Americans suffer mental health challenges and the number of those in need of professional care continues to grow significantly. There is an urgent need for more professionals trained in the proper approaches to care for older persons, systems of care that recognize and implement those ingredients that help older persons adapt and thrive, and a partnering of resources within senior care to meet this challenge.

- Older adults tend to be more satisfied with lives than younger peers
- Mental illness is common in the United States (20% or 44.7 million adults live with mental illness (2016)
- 25% older adults experience a mental health problem
- Those over 85 have highest suicide rate of any age group, especially older white men (6x rate vs. general population-NCOA).
- Mental Health care integrating with primary care because older adults are more comfortable getting psychological assist from PCP
- American culture values the new and pushes aside the old
- Negative attitudes towards older adults can lead to isolation and ageism
- Mental health care for older adults is not good
- Services are underutilized by older adults
- Mental health disorders for older adults are expected to nearly double by 2030
- Not nearly enough geriatric psychiatrists or psychologists-number is on decline (less than 1 geriatric specialist per 6000 patients with mental health or substance use disorders (2013 Dartmouth Study)
- Only 1.2% of psychologists specialize in Geropsychology with less than 100 board-certified Geropsychologists in the nation
- More than 20% adults over 60 suffer from a mental or neurological disorder and most common is dementia and depression (WHO)
- Dementia affects 5% between 71 and 79 and 37% over 90 (APA)
- Growing older does not mean you will suffer a mental illness, rather a longer lifespan exposes a person to mental and physical conditions that can affect a person's life and overall psyche
- 7.7% clinical depression in those over 50
- 15.7% over 50 report lifetime diagnosis of depression
- 5% clinical depression in those over 65
- 10.5% lifetime diagnosis of depression in persons over 65
- Hispanics and women most vulnerable to depression
- Anxiety also prevalent in older adults
- 50% older adults diagnosed with depression also have anxiety
- Anxiety likely underestimated in older adults because older adults complain of physical symptoms more than psychiatric
- 12.7% of those 50-64 have anxiety
- 7.6% of those over 65 have anxiety
- Hispanics and women most vulnerable

*Center for Disease Control (2008)

Mental Health in Senior Care-Assisted Living (AL)

The senior care industry is one sector with tremendous opportunity to create and operationalize the proper approach to care for the older person. This includes supporting every new resident for a healthy adjustment to recognizing and addressing the clinical needs of those with mental health issues. Indeed assisted living has emerged as a rapidly growing residential setting for older persons suffering psychological and cognitive impairment. There is a critical need to integrate expertise, trained professionals, best practices, and necessary resources into senior care-AL and to develop unique partnerships that create settings that promote mind-body-spiritual health.

- Studies of mental health in AL are limited
- As of 2014 there were over 50,000 AL residences
- As of 2014 there are over 1 million older adults living in AL
- AL primary providers of residential care for dementia
- 28% residents in AL no cognitive impairment
- 29% mild cognitive impairment (MCI)
- 23% moderate cognitive impairment
- 19% severe cognitive impairment
- 38% residents display behavioral symptoms of dementia
- Behavioral problems increase with dementia severity
- Medication utilization increases with dementia severity
- Smaller AL facilities tend to care for more residents with moderate to severe cognitive impairment
- 83% of AL facilities have no dementia care unit
- 8% have a dementia care unit
- Trend is for settings specialized for dementia care
- Majority of AL no RN (61%) or LPN (67%), however dementia units had higher rates of RNs or LPNs on staff (54%)
- 55% of facilities admitted residents with moderate or severe cognitive impairment, but only 36% admitted those with behavioral symptoms
- Behavioral problems key factor for discharging residents even compared to cognitive impairment severity
- Dementia care units more lenient in admission and discharge policies
- 69% of facilities regularly used medications to control resident's behavior and only 14% used physical restraint.
- Only 40% residents with moderate cognitive impairment and 10% with severe impairment were recognized by staff as having dementia
- Charts do not accurately reflect diagnoses, conditions, and symptoms
- No standards in documentation in AL

- ❖ Staff training, use of psychotropic medication, role of special care unit, and education about policies and practices need attention
- ❖ 38% of dementia residents display behavioral problem and 57% of them were prescribed a psychotropic (22% of all residents)
- ❖ 29% of new nursing home residents receive antipsychotic, 32% found to have no clinical indication for such

*Zimmerman, Sloane, and Reed (2014)

Depression in Assisted Living (AL)

- ❖ Studies on psychological and mental health in AL limited
- ❖ 13% of AL residents across 193 facilities were depressed and only 18% of those were on an antidepressant
- ❖ Over 33% had symptoms of depression, anxiety, or worry
- ❖ 25% displayed sad voice, expression or tearfulness
- ❖ Depression related to medical condition, social withdrawal, psychosis, agitation, length of stay
- ❖ Rates of mortality higher for those with depression
- ❖ Need to be routinely screening for depression and other mental health disorders

- Watson et al (2003)

Anxiety and Behavioral Disorders in Assisted Living (AL)

- ❖ Anxiety is a major cause for distress in older people
- ❖ Anxiety common (22%) in those with and without dementia
- ❖ Clinical anxiety found in 11% to 18% of AL residents
- ❖ Symptoms of anxiety in over 40% of residents
- ❖ 33% of residents of AL have one or more behavioral symptoms a week
- ❖ 13% display aggressive symptoms
- ❖ 20% nonaggressive behavioral symptoms
- ❖ 22% expressed verbal behaviors
- ❖ 13% resisted medications or activities of daily living care
- ❖ Behavioral symptoms related to presence of depression, psychosis, dementia, cognitive impairment, and functional dependency.
- ❖ More than 50% of those with behavioral problems were taking psychotropics and 2/3 had mental health problem indicator (dementia, depression, psychosis or other)
- ❖ Integrating mental health services within the process of care in AL is needed to manage and accommodate the high prevalence of behavioral symptoms in the evolving long-term care setting.

*Baldini, Sloane, Zimmerman (2004)

How do we bridge this gap between what older adults need for psychological health and wellbeing and what is currently provided?

Senior Care and Psychological Wellness*:*

Senior care has evolved significantly over a relatively short period of time. The early model of senior care included the nursing home, a place that was built on institutional-medical concepts and was considered the primary option for long term care.

Over time, the market demanded a less institutional environment where older adults were not subject to a medical approach to life and existence. A hospitality model based on housing and not clinical care emerged and was called Assisted Living (AL). This new option offered housing and a menu of services such as nutrition, activities, and clinical care that was added to the housing. The AL option to senior care has grown significantly in part because of its pleasing appeal and more home-like environment. While Medicaid typically funds care for the resident in a nursing home, AL is private pay. Newer models are being introduced to help create opportunity to lower income persons who can benefit from the AL approach to living.

With the demographic explosion of persons living beyond 65 and the simultaneous epidemic of those suffering AD, the AL industry has adjusted to market demand by creating "Memory Care" centers or even individual buildings using the AL concept for those with dementia. This has lead to increased staffing, specialized training of staff, attention to safe environments with detail to lighting, locked areas, and understanding of the progressive nature of dementia as needs change.

The AL industry continues to adapt and has moved further from its original housing concept to a more holistic approach to overall care. There is no doubt that the level of behavioral acuity and challenge to the staff of AL has increased in a relatively rapid time frame. More residents admitted to AL are not only experiencing physical limitation, but are also presenting with emotional and cognitive frailty. Once again, it is important to recognize the significance of the **emotional transition** for every older person moving into senior care. This is not a clinical matter, but a human concern to be recognized, respected, and comforted with a hand, hug, and compassion.

Perhaps the single greatest challenge to AL and even Independent Living (IL) is to properly identify the neuropsychological strengths and vulnerabilities of the residents who choose their facility to live. It is from such identification

that a healthy transition, proper placement, intervention, and wellness can occur (PDN).

Policy and Operational Considerations for Bridging the Gap:

1. Psychological wellbeing for the older adult and resident in **senior care** needs to be prioritized and integrated into the current and more "physical assessment and treatment approach" that presently exists. This begins by helping each resident transition to their new residence in a healthy way.

2 Psychological health and wellbeing needs to partner with the PCP of each resident to integrate best practices and provide the necessary holistic and interdisciplinary care for older persons.

3. A **proactive approach to psychological wellbeing** is needed. Such an approach involves the following:

    A. Partner with leadership of each AL facility to educate all residents and family members of the importance of emotional, cognitive, and psychological health.
    B. Provide each resident/POA the opportunity for a baseline psychological wellness screen that can empower the resident and care team with a profile of strengths and weaknesses to guide lifestyle changes and other necessary interventions.
    C. Such baseline information can help to identify, modify, and even prevent onset of problems that might occur without proper identification. It also provides support with the transition into a new residence.
    D. Promote the factors necessary to help each resident strengthen and maintain their emotional and overall psychological wellbeing.
    E. Clinical intervention can occur only as needed and as identified by being proactive and getting in front of such problems. We do not want to be reactive.
    F. Repeat the wellness screen on an annual basis to help each resident track and monitor their emotional, cognitive, and behavioral health. This is no different than the standard recommended examinations we get for other important systems in our body (i.e., mammograms, prostate, colon, hypertension, blood sugar levels, etc.).

4. Utilize Psychological Best Practices to help each facility increase the understanding, management, and promotion of mental health for all residents in the facility.

    A. Provide standardized assessments for diagnostic clarification, treatment planning, placement decisions, and family education.

B. Work as an integrated part of the resident's interdisciplinary team to help foster emotional health as part of the overall health of each resident.
C. Provide significant value to the PCP, DON, and wellness director regarding the resident's emotional, cognitive, and behavioral functioning and the psychosocial factors that can enhance psychological health.
E. Work to educate and assist the needs of the professional and family caregivers of each resident.

5. Bring a level of unprecedented expertise to the facility to manage behavioral disorders that can help to:

   A. Train staff on proper behavioral modification techniques
   B. Help to reduce unnecessary psychotropic utilization or hospital admission
   C. Assist caregivers to understand and how to intervene
   D. Work with PCP and medical team to rule out causes to confusion and behavioral dysfunction
   E. Help to reduce staff turnover through empowerment and education

6. Establish the necessary professional expertise, competence, and experience on mental health of the older adult for the facility adding value and enhanced care for the resident, family, and staff.

Benefits for the Facility:

1. Empirical support for the psychological health of the resident over time.

2. Assistance in the development of an environment in the facility that promotes psychological health and wellness (mind-body-spirit).

3. Work towards desired outcomes such as: (1) reduction in ineffective psychotropic utilization; (2) diagnostic clarification for resident, family, and facility staff; (3) assistance with staging of dementia; (4) assistance with proper placement of persons with dementia; (5) reduction in staff turnover; (6) reduction in psychiatric and general hospitalizations; (7) reduction in and enhanced management of acute agitation and behavioral disruption.

4. Ability to measure relationship between resident psychological benefits from facility-based wellness and other programs.

5. Facility leadership can have peace-of-mind in knowing they have geropsychological expertise that is present and available.

6. Facility is recognized as having committed to providing the proper and necessary care approaches for residents within the facility.

Paul D. Nussbaum, Ph.D., ABPP
Board Certified: Clinical Psychology and Geropsychology
President Brain Health Center and Adjunct Professor of Neurological Surgery
University of Pittsburgh School of Medicine
www.brainhealthctr.com
(724) 719-2833
drnuss@me.com

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