Issues in Aging: A Clinician Primer
Part II

Overview

- Late Life Stressors
  - Role change/Loss/Grief
- Mental Health
- Substance Abuse
- Suicide
- Mild Cognitive Impairment
- Delirium
- Dementia
- Capacity Issues

Demographics

US
- Increase from 13-20% of the population
- 5% decline of working age adults
- Adults age 85 and over will more than double
- Majority of older adults will be ages 65-74
- Minority population of elderly population will grow from 16% to 25%
Late Life Stressors

- Chronic physical health condition(s)
- Death of a loved one
- Retirement and subsequent role change
- Loss of social status
- Caregiving
- Social isolation/lack or loss of social support
- Significant loss of independence
- Change of residence, relocation
- History of mental health problems

Stressors: Changes in Health

- Hearing losses
- Vision losses
- Slowed response times
- Functional losses
- Chronic medical conditions

- These can lead to loss of ability to drive, loss of independence, loss of residence, and loss of autonomy.

STRESSORS: CHANGES IN ROLES

- Older people typically leave work and social roles that provided economic rewards, status
- After retirement, spouses may find themselves in significantly greater contact with each other
- Grandparenthood and great-grandparenthood provide both new demands and opportunities
- Functional losses may place older persons in help-seeking rather than help-providing roles
- Another’s losses may place one in a caregiving role
STRESSORS: LOWER SOCIAL STATUS

- Factors associated in the US with negative psychosocial and physical outcomes:
  - Race other than white
  - Female gender
  - Being poor or poorly educated (a surrogate for being poor)
- Treatment may need to include or rely principally on culturally-specific options

Coping With Transition

- Planning for retirement
- Meaningful activities (paid or volunteer work, physical or creative activities)
- Relationships (family, friends, intimate—including sexual—relationships)
- Spiritual matters
- Locating and paying for help when needed:
  - Home care
  - Elder care
  - Assisted living and life care communities
  - Psychotherapy/support groups

Stressor: Coping with Loss

- Bereavement is the loss or deprivation experienced by a survivor when a loved one dies.
- Grief is a state of mental distress that occurs in reaction to significant loss.
- In disenfranchised grief, a person experiences a loss that cannot be openly acknowledged, publicly mourned, or socially supported.
- Mourning refers to culturally prescribed and accepted time periods and behavior patterns for the expression of grief.
What Is Normal Grief?

- Acute grief syndrome often includes
  - periodic waves of physical distress lasting 20 minutes to an hour.
  - a feeling of tightness in the throat.
  - choking and shortness of breath.
  - a frequent need to sigh.
  - a feeling of emptiness in the abdomen.
  - a sensation of muscular weakness.
  - intense anxiety.

Signs/Symptoms (Suggesting) Mental Health Problems

- Noncompliance with medications
- Memory problems
- Vague complaints with frequent visits
- Multiple somatic c/o disproportionate to examination
- Multiple grief/loss issues associated with aging
- Chronic pain
- Depression/anxiety
- Relationship problems
- Suicidal thoughts
- Isolation/loneliness

THE NUMBER OF OLDER ADULTS WITH MENTAL ILLNESS IN THE UNITED STATES WILL DOUBLE FROM 2000 TO 2030.

Projected Growth of 65 and Over Population with Mental Disorders: 2000 to 2030

Most common mental disorders in 65+

- Depressive disorders, cognitive disorders, anxiety disorders and alcohol use disorders
- Psychiatric disorders other than depression are found in lower prevalence among the elderly than at any other stages of the life cycle
- Suicide risk in the elderly is higher

Impact of Gender on Mental Health

- Women outlive men; greater numbers of older women means they will outnumber men in most settings, including mental health care
- Women are more likely to seek help for mental health concerns than men at all ages
- Men can be harder to diagnose with depression than women.
- Twenty percent of men over 50 are estimated to have depression or chronic low mood
- Only 30 percent of men with depression who seek treatment for their condition

Special Issues in Identifying and Working with Older Persons with Mental Illness

- Older persons who have mental illness are more likely to:
  - Present with generalized physical complaints rather than emotional distress
  - Use numerous medications that can affect each other and can contribute to some forms of mental illness
  - Have a strong sense of stigma about mental illness
  - Have a brittle support system
  - Have long term untreated or under-treated mental illness.
Treatment of Mental Illness Among Older Adults

- 7 million All Older Adults with Mental Illness
- 1.5 million Receive Treatment
- 1.93 million Treatment from Primary Care Physicians
- 1.57 million Treatment from Mental Health Professionals

Source: U.S. Department of Health and Human Services, Older Adults and Mental Health: Issues and Opportunities (Rockville, MD: 2001).

Treatment Barriers For Seniors For Mental Health Services

- Stigma of mental illness
- Lack of awareness of mental health problems
- Denial or underreporting of symptoms
- Attribute problems to medical illness
- Under diagnosis of problems and underutilization of mental health services
- Challenges in accessing free standing mental health clinics e.g. transportation
- Financial-larger co-payment mental health

Substance Abuse

- 17% have substance use problems
- 3% of older adults have diagnosable substance abuse disorder
- Very few heavy, lifelong alcohol or illegal drug abusers survive into old age
- Lifelong addiction vs. addiction in late life
- Methadone
- Mostly alcohol and/or medications – especially to manage pain
- Use of illegal substances expected to rise as more baby boomers merge into “elder boom”
Alcohol and Drug Interactions in Older Adults

Scope of the Problem

- 25% of community dwelling older adults at risk for alcohol-drug interactions
- 36% of older people in retirement communities were drinkers who used alcohol-interacting drugs
- 60% of older people referred for prescription drug abuse showed evidence of alcohol use
- 77% of older adult prescription drug users were exposed to alcohol-interacting drugs; 19% of those taking alcohol-interacting drugs reported concomitant alcohol use

An Invisible Epidemic

Substance Issues in Older Adults:
- Hard to detect under routine circumstances
- Mimic symptoms of other health problems
- Symptoms perceived as part of normal aging
- Shame, guilt, stigma
- Family and others ignore or enable
- Absence of previous consequences

Effects on Older Adults

Physical, psychological, social impacts:
- Falls, injuries, accidents, medical conditions worsen
- Anxiety, mood lability, depression, personality changes
- Relationships deteriorate, isolation increases, cycle repeats and reinforces itself
**Risk Factors**

- Gender
  - Older men more likely to have the problem
  - Women more likely to be widowed, divorced, problem with drinking spouse and depression
  - Major treatment issues for women (isolation or homebound)
- Loss of Spouse-divorced or widowed (men)
- Other Losses-death of family members, friends, income or job
- Co-morbid Psychiatric Disorders-depression, especially among women
- Family History-genetic factors
- Limited education
- Low income
- History of substance abuse

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**Prescription and OTC Drug Use**

- Evolution of Prescribing
  - 65+ consume more prescribed and OTC drugs than any other age group
  - Most are for mood-changing or psychoactive
  - Most don’t intend to abuse
- Patterns of Use
  - Unintentional misuse
  - Misunderstood directions and multiple prescriptions contribute to problem
- Differences in dosage for elders may not be understood
  - Sleep disturbances common complaint
  - May be related to other conditions of aging (depression, Alzheimer’s)
  - OTCs: not much known about interaction, lack of research.
Barriers to Identification and Treatment

- Ageism
- Lack of awareness
- Provider Attitude (not worth treating, lack of understanding or geriatric experience)
- Co-morbidity with conditions such as cognitive impairment, depression, sensory deficits, and mobility issues
- Lack of age specific programs
- Complications with overall health
- Medication management
- Transportation (rural setting)
- Support systems (family and self-help)
- Not a “sexy issue”
- Lack of expertise
- Financial / Reimbursement

Screening

- Who and When to screen—everyone over 60, presence of risk factors
- Introducing the topic—mass screenings, health screening by medical personnel
- Cognition and Collateral Reporting—use when cognitive impairment is present
- Positive Screening Results
  - Describe impact
  - Provide options to current medications
  - Detox
    - May be needed
    - Likely to be in-patient
  - Full Assessment
    - Medical
    - Social
    - Psychological

Suicide in Older Adults

- 65+: highest suicide rate of any age group
- 85+: 2x the national average (CDC 1999)
- Peak suicide rates:
  - Suicide rate goes up continuously for men
  - Peaks at midlife for women, then declines
- Approximately 1/3 of older men saw their primary care physician in the week before completing suicide; 70% within the prior month
Characteristics of Elderly Suicide

- Fewer warnings of intent
- Attempts are more planned, determined
- Less likely to survive a suicide attempt due to use of more violent and immediate methods
- More likely to have suffered from a depressive diagnosis prior to their suicide compared to younger counterparts
- Suicidal ideation less common in elderly (studies range from 1 to 36%)
- Ratio of attempts to completed suicide range from 4:1*
  - Note: Ratio for younger female population is 200:1


Risk Factors

- Suicide attempt
- Psychiatric disorders (77% of suicides, 63% of those were depressed)
- Physical illness, pain, and functional impairment
- Social isolation and decreased social support
- Marital status (single, divorced, widowed)
- Recent bereavement (some studies show)
- Access to means (especially firearms)
- Financial burdens may or may not be a risk factor for the elderly
- Sex (male)
- Age (older) – (beginning at age 60)
- Depression
- ETOH/SA
- Organized plan to commit suicide
Cognitive Impairment

- Cognitive Impairment means there is a change in how a person thinks, reacts to emotions, or behaves.
- Can range from mild memory problems to an inability to think independently.

Causes of Cognitive Impairment

- Can be present at birth
- Can be caused by abuse of prescription medications, alcohol, street drugs or other chemicals
- Can be caused by a disease
- Can be a side effect of some medications
- Can be caused by a trauma

Functional Consequences

- Forgetting
  - Things already learned, Appointments, Self-care (including medication)
- Getting Lost
- Following Commands/Instructions
- Mood
  - Depression, Anxiety
- Unpleasant Interpersonal Behavior
  - Anger, Paranoia, Inappropriate Sexual Remarks/Actions
- Capacity Limitations
  - Decision-Making: Financial, Medical
- Communication Deficits
  - Receptive, Expressive
Mild Cognitive Impairment

- Problems with memory, language, or another mental function severe enough to be noticeable to other people and to show up on tests, but not serious enough to interfere with daily life.
- Person does not meet criteria for dementia diagnosis
- Amnestic MCI is most frequently studied
- Increased risk of developing Alzheimer's Disease over next few years

Criteria for MCI Diagnosis (AAN, 2001)

- An individual's report of his or her own memory problems, preferably confirmed by another person
- Measurable, greater-than-normal memory impairment detected with standard memory assessment tests
- Normal general thinking and reasoning skills
- Ability to perform normal daily activities

Types of Cognitive Impairment

- Amnestic Disorder
- Delirium
- Dementia
- Cognitive Disorder NOS
Diagnosis

• Diagnosis of Cognitive Impairment is made according to the type of impairment.
• Diagnosis is made according to the Diagnostic and Statistical Manual-IV criteria for the specific condition.

Differential Diagnosis

• All types of cognitive impairment are treatable and many are reversible.
• Treatment for each is unique, although some overlap.
• Early identification can lead to early intervention and treatment.

Amnestic Disorder

• Development of memory impairment: the ability to learn new information or recall previously learned information
• Significant social or occupational impairment, a significant decline from previous low functioning
• Not due to delirium or dementia
• Subtypes: Transient (≤ 1 month), Chronic
• Examples: herpes simplex encephalitis, Korsakoff’s
Cognitive Disorder, NOS

- Cognitive dysfunction presumed due to the effect of a general medical condition
- Does not meet criteria for deliriums, dementias, or amnestic disorders
- Examples:
  - Mild neurocognitive disorder
  - Postconcussional disorder

Delirium

- Features
  - Disorientation
  - May have hallucinations and delusions
  - Incoherent speech
  - Increase/decrease in metabolic activity
  - Agitation or lethargy
  - Easily distracted

DSM-IV Criteria for Delirium

A. Disturbance of consciousness (reduced clarity of awareness of the environment) with reduced ability to focus, sustained, or shift attention
B. Change in cognition (memory deficit, disorientation, language disturbance) or development of perceptual disturbance not better accounted for by dementia
C. Develops over a short period of time (usually hours/days) and tends to fluctuate
D. Etiologies: substance induced, general medical condition, metabolic, multiple
**Types of Delirium**

- Wernicke's Encephalopathy
- Medications
- Pain
- Infection
- Toxic and Metabolic Disturbance
- Post-surgery

**Delirium versus Dementia**

- Features of Delirium
  - Rapid onset
  - Short duration
  - Mood shifts from lethargy to agitation
  - Patients with dementia are at increased risk for delirium

**Dementia**

- Organic mental disorder with slow loss of intellectual abilities that interfere with functioning
- A clinical diagnosis
  - Memory loss + dysfunction in other cognitive domains
  - Gradually progressive decline from previous cognitive abilities
  - Affects daily function
  - No disturbance of consciousness
  - Absence of systemic disorders that could account for deficits in memory and cognition
Prevalence of Dementia Doubles Every 5 Years Beginning at 60


DSM-IV Criteria for Dementia

A. Development of multiple cognitive deficits:
   • Memory impairment, plus
   • One or more Cognitive Disturbances:
     • Aphasia: disorder of language
     • Apraxia: impaired motor activities
     • Agnosia: inability to recognize or identify objects
     • Dysexecutive: defective initiation, planning, organization/abstraction

B. Cognitive deficits cause significant impairment in social/occupational functioning and are a decline from previous level of functioning

Dementia Subtypes

• Vascular Dementia: sudden onset, fluctuating course, focal neurological signs/symptoms
• Alzheimer’s Disease: gradual onset, progressive course
• Those secondary to General Medical Conditions: Huntington’s, Parkinson’s, Lewy-Body, Creutzfeldt-Jakob, AIDS dementia, Pick’s, Normal Pressure Hydrocephalus, hypothyroidism, B-12 deficiency
• Substance-Induced Persisting Dementia
Dementia Types

- AD + Vascular 27%
- AD 25%
- AD + Lewy Body 12%
- AD other 4%
- Hippocampal/Sclerosis 3%
- Lewy 4%
- Vascular 7%
- Normal 7%
- Other 11%

Neuropathological Diagnosis in 124 Community-based Incident Dementia Cases;
Adapted from slides from Stephen Thielke, Puget Sound VA GRECC

Dementia Behaviors

- Paranoia, delusions, illusions, hallucinations
- Wandering, insomnia, undressing
- Incontinence
- Increased risk of delirium
- Harm self or others, yelling or screaming
- Repeating questions
- Inappropriate sexual behaviors

Recognizing Dementia

- Memory problems are often not the primary complaint
  - Difficulties may be noted in
    - Short-term memory, planning, judgment
    - Word finding (language)
    - Taking medication correctly (executive function)
    - Driving (visuospatial)
    - Balancing checkbook (calculation)
  - Spouses or children are often more concerned than patients
  - Good verbal skills and living independently should not preclude evaluation of cognition
  - Conduct additional workup whenever patient or family describe problems or when cognitive problems are observed

Adapted from slides from Stephen Thielke, Puget Sound VA GRECC
**Dementia vs. Age-related changes**

<table>
<thead>
<tr>
<th>Signs of Dementia</th>
<th>Typical Age-Related Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor judgment and decision making</td>
<td>Making a bad decision once in a while</td>
</tr>
<tr>
<td>Inability to manage a budget</td>
<td>Missing a monthly payment</td>
</tr>
<tr>
<td>Losing track of the date or the season</td>
<td>Forgetting which day it is and remembering later</td>
</tr>
<tr>
<td>Difficulty having a conversation</td>
<td>Sometimes forgetting which word to use</td>
</tr>
<tr>
<td>Misplacing things and being unable to retrace steps to find them</td>
<td>Losing things from time to time</td>
</tr>
</tbody>
</table>

www.alz.org

**Alzheimer’s Association’s 10 Warning Signs**

- Memory loss that affects job skills
- Difficulty performing familiar tasks
- Problems with language
- Disorientation to place and time
- Poor or decreased judgment
- Problems with abstract thinking
- Misplacing things
- Changes in mood or behavior
- Changes in personality
- Loss of initiative

**Evaluation Process**

- Interview
- History
- Medical Record Review
- Observation
- Assessment
- Evaluation should be multidisciplinary
Domains

- Attention
- Executive Functioning
- Verbal Ability
- Visuospatial and Visuoconstructional Function
- Memory
- Affect
- Psychological Functioning

Treatment of Dementia

- Early and differential diagnosis is critical
- New medications may slow deterioration due to dementia (Aricept, etc)
- Effective treatment of depression or anxiety can improve cognitive functioning
- Support for family caregivers helps them and delays nursing home placement

Principles for Managing Dementia

- Screen for depression and treat prn
- Adjust medications that may worsen memory (anticholinergics- OTC & Rx)
- Review appropriateness of FDA-approved pharmacotherapy (consider VA standards)
- Engage in advance care planning
- Assess and reassess:
  - Dementia-related behavioral symptoms
  - Delirium and distressing physical symptoms
  - Functional capacity. Discuss support services
- Assess caregiver burnout
- Watch for signs of abuse or neglect
- Address general health maintenance, especially hypertension and diabetes
**Capacity - Legal Definition**

A judge determines legal capacity – that an individual lacks capacity according to a standard, removing rights of self determination for a specific matter, altering the individual's legal status, and assigning the authority for the decision making to another

Exception is that lawyers can determine legal capacity for transactional matters

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**Capacity - Clinical Definition**

A clinician provides an opinion about clinical capacity, describing the diagnosis, cognitive, and functional abilities that may be used as evidence, but does not alter legal status

Quasi-exception is medical consent capacity, when a clinician’s opinion allows a proxy’s authority to take effect (but it does not alter legal status); should hold up in court

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**Competency**

- Legal Competency – Incompetency
  - Denotes a legal status determined by a judge
  - Judgment based on clinical/lay evidence, case/statutory law, principles of justice, and other non-clinical factors
  - Judgment of “incompetency” alters legal status by removing rights of self determination for specific matter
  - Judgment of “incompetency” requires transfer of decisional authority to a court appointed proxy (guardian/conservator).
**Capacity**

- Capacity – Incapacity
  - Denotes a clinical status determined by a clinician
  - Clinician makes clinical capacity judgment based on patient’s functional, cognitive, and behavioral abilities
  - Clinical judgment is “evidence” of legal competency
  - Clinical judgment does not alter legal competency status
  - Clinical judgment does not permit transfer of authority for decision making to another (except in DPOAs)

**Legal capacity vs. Clinical capacity**

- Has capacity
  - Has capacity
  - Diminished capacity
  - Lacks capacity
  - Lacks capacity

**Capacity vs. Competency**

- Competency – historically the legal term
- Capacity – historically the clinical term although many in healthcare still use competency
- But now, capacity used legally because of the law’s interest in capacities rather than all-or-none
- Legal capacity v. clinical capacity
- Always need to clarify context and domain when evaluating
- Don’t use “competent” or “deemed”
Ten Myths About Decision-Making Capacity

1. Decision-making capacity and legal competency are the same.
2. Lack of decision-making capacity can be presumed when patients go against medical advice.
3. There is no need to assess decision-making capacity unless patients go against medical advice.
4. Decision-making capacity is an “all or nothing” phenomenon.
5. Cognitive impairment equals lack of decision-making capacity.
6. Lack of decision-making capacity is a permanent condition.
7. Patients who have not been given relevant and consistent information about their treatment lack decision-making capacity.
8. Patients with certain psychiatric disorders lack decision-making capacity.
9. Patients who are involuntarily committed lack decision-making capacity.
10. Only mental health experts can assess decision-making capacity.

(National Ethics Committee of the Veterans Health Care Administration, 2002)

Multiple Capacities

- Capacity to live independently
- Capacity to manage financial affairs
- Contractual capacity
- Donative capacity
- Testamentary capacity
- Treatment consent capacity
- Research consent capacity
- Driving capacity
- Voting capacity

Things to Remember....

- Multiple Capacities
  - Capacity is not a unitary concept
  - Task specific capacities instead
- “Capacity” to do what?
- And in what context?
- Capacity can fluctuate and can recover
- Diagnosis does not constitute incompetency
- Cognitive impairment does not constitute incompetency
- Have to examine functional abilities constituent to the specific capacity
Process for Capacity Evaluation: What is different?

Capacity assessment is different from psychological assessment in key ways:

- Do more up-front inquiry
- Modify informed consent process
- Know law, surrogate dm, aging services
- Know/add functional assessment
- Outcome is a clinical judgment – not a test interpretation, weighing of ethical factors

Forming a Clinical Judgment

Clinical Judgment

Diagnosis
Cognitive, Psychiatric, and Everyday Functioning

Values and Preferences

Risk Considerations
Means to Enhance Capacity

Legal Standard

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