

A Mental Health Guide for Older Adults And Their Families

Produced by



**Metro Public Health Department
of Davidson County**

and

**The Mental Health and Aging
Coalition of
Middle Tennessee**

A Mental Health Guide for Older Adults And Their Families

Prepared by
Bonnie McCrickard, CMSW
Mary Lampley, CSW
Frances Clark, Ph.D., MAC

The Metro Public Health Department's mission is to provide health protection, promotion, and information products to everyone in Nashville so they can enjoy healthy living free from disease, injury and disability.

The Mental Health and Aging Coalition of Middle Tennessee promotes quality of life through mental wellness for older adults and their families.

Purpose of the Mental Health and Aging Coalition

- ❖ **Reduce the stigma of mental illness by educating older adults, family members, providers and community. Empower each to speak freely about mental health issues.**
- ❖ **Identify the unmet mental health needs of older adults in the community**
- ❖ **Advocate at the local, state, and national level for increased availability of mental health services for older adults.**
- ❖ **Increase the awareness of mental health issues effecting older adults**
- ❖ **Increase the awareness of and utilization of services available to meet mental health needs of older adults.**

Acknowledgments

We would like to acknowledge and thank all of the member organizations and individual members of the coalition.

**In addition, we want to specifically acknowledge the following individuals:
The members of the steering committee of the Mental Health and Aging coalition
Bonnie McCrickard, CMSW, Tennessee Christian Medical Center
Frances Clark, MS, MAC, Metro Public Health Department
Mary Lampley, CSW, Alive Hospice
Kansas Mental Health and Aging Coalition
Council on Aging of Middle Aging
TennCare Partners Advocacy Line
Floyd Patterson, Component Repair Services**

Table of Contents

	Page
Introduction to Mental Health and Aging	
Successful Aging	6
What is Mental Health?	8
When Mental Health Problems Occur	12
Some Common Disorders and Their Treatments	14
Depression	15
Dementias	25
Anxiety Disorders	31
Personality Disorders	37
Schizophrenia	38
Addictions Among Older Adults	42
When to Seek Treatment and Where to Find It	48
How Do I Know if Someone Needs Help?.....	48
Finding Help in Your Community	50
Who Are Mental Health Service Providers?.....	51
When You Decide to Contact a Mental Health Professional	54
Types of Treatment	57
Some Resources for Support	58
Taking Medication Safely	61
Dangers of Mixing Alcohol and Medication	63
Precautions for some medications for Older Adults	64
Making Medical or Financial Decisions	65
Medicare	65
Medicaid/TennCare	65
Declaration for Mental Health Treatment	66
Living Wills and Durable Power of Attorney	67
Housing and Services	68
Independent and Assisted Living	68
Skilled and Long-term Care	68
Home Care Related Services and Hospice	68
Resource Guide.....	69
Want to Learn More? Some Helpful Books	69
Organizations Offering Information and Self-Help Groups	71
Glossary of Terms	77
References	80

Facts and Myths about Mental Health and Aging

Introduction

If you feel stressed, do you know some easy things you can try to reduce those feelings?

If you forget someone's name, do you worry that you are developing Alzheimer's disease?

If you received treatment for depression when you were young, are you worried that it will recur late in life?

Are you concerned about a friend who can't seem to stop grieving the death of her husband and who talks of dying?

If you are worried that you, an older relative, or someone you know might be experiencing a mental health problem, do you know how or where to find help?

Do you know what Medicare, Medicaid, or private insurance coverage offer to help with the costs of obtaining mental health services?

This guide provides a practical, easy-to-use resource about mental health problems and mental health services for use by older adults in Tennessee, their families, and non-mental health service providers. It describes why people might have mental health problems, the symptoms and treatments for common mental health disorders experienced by older adults, when someone should seek treatment, the kinds of mental health services available in Tennessee and how to gain access to them, and a resource guide to assist you finding information or needed services.

What do you know about Aging and Mental Health?

Aging, by definition, means to grow old and more mature. Aging is a normal process; we are aging from the moment of birth. However, in today's society, the word "aging," like "mental health" or "mental disorder" sometimes has negative meanings. Incorrect beliefs fuel a number of myths about what it means to be an older adult, especially one who experiences a mental health problem or disorder. Answer these questions to see how much you really know about aging and mental health.

True or False?

- T F 1. All old people are crabby.
False: If you are crabby when you are 25 and 35 years old, chances are that you will be crabby at 55, 75, and 95. Our basic personalities do not change much.
- T F 2. The majority of older adults live in nursing homes.
False: At any one time, only about 5 percent of people 65+ are living in nursing homes, and the percentage is decreasing. However, a far greater percentage of people can expect a limited nursing home stay at some point in their lives. Older adults can help themselves stay healthy by living a healthy lifestyle and continuing the activities that they enjoy.
- T F 3. Isolation and hearing loss can cause paranoid thinking.
True: Paranoid thinking can develop under these difficult circumstances, when words and sounds may be misinterpreted.
- T F 4. Growing old does not really change a person's ability to learn.
True. People maintain the ability to learn throughout life unless a disease interferes. However, learning for some older adults may be slower, and there are some small changes in memory. Older adults' intellectual abilities remain much the same as when they were younger.
- T F 5. Serious mental health problems are most common in older people.
False: Only one in eight older adults have been diagnosed with a mental disorder, the lowest rate among all age groups.
- T F 6. Older adults can benefit from counseling or psychotherapy.
True: These "talking therapies" often can help older adults, and are used alone or in combination with medication.
- T F 7. Poor nutrition can produce mental health problems.
True: Poor nutrition can lead to apathy, confusion, and depression, which then can cause even worse nutrition. Some medications, dental problems, and diseases that make it difficult to cook or eat may increase the risk of poor nutrition.
- T F 8. Most older adults would prefer to be young if given the choice.
False: Most older people are satisfied with their lives. They are not eager to turn back the hands of time.

Questions adapted from The Facts on Aging and Mental Health Quiz and The Facts on Aging Quiz

Successful Aging

If aging begins at birth, when is someone an older adult? As people retire early, late, or never, and begin to receive benefits from programs such as Social Security at different ages, we no longer can use age 65 as a marker. However, most statistics provided here are for people who are age 65 and older.

There is good news for people approaching or already in their older adult years. They are likely to live longer and be healthier and more independent than people in earlier generations. We have learned that many of the challenges older people face are not necessarily part of normal or usual aging, as was often assumed, and aren't inevitable.

Research now tells us disabilities we may experience as older adults come from three things:

- Physical changes that happen as your body ages, regardless of any illnesses.
- Effects of diseases we may have.
- Lifestyle, including exercise and diet, that influences our physical fitness and our risk of disease.

“Normal” or usual aging is aging without biological or mental pathology — aging without significant illnesses. We can't do much about the influence of inevitable biological changes and family genes, but we can control the majority of factors that shape our later years.

The recipe for “successful aging” — creating the best possible situation in which to grow older — has three parts:

- Reduce risks of disease and disability.
- Maintain mental and physical function.
- Stay engaged with life.

Fact:

Sleep patterns normally change as we age. Older adults take longer to fall asleep, waken more frequently, and spend less time in deep sleep. This is normal.

People who have severe depression or anxiety may have greater sleep difficulties.

Reduce risks of disease and disability

Unfortunately, chronic diseases are likely to be a part of an individual's older years. More than 80 percent of Americans over age 65 experience one or more chronic health problems, such as arthritis. However, these health problems typically are not disabling, and most people still are able to lead active lives.

Even though the risks of some diseases increase with age, we can minimize those risks by finding out about our own chances of developing problems such as high blood pressure or diabetes, and by paying more attention to things that may put us at higher risk for such problems.

We also can take more care to reduce accidents that happen to people of all ages, such as falls and auto accidents, which are a greater risk for older adults.

Maintain Mental and Physical Function

While some decline in physical performance will occur, moderate exercise, especially in everyday activities, helps maintain the way the body functions. If the body doesn't work quite as well as it used to, a sense of humor helps!

Similarly, while some mental abilities may not be quite so sharp as at their peak, these changes don't really have a noticeable effect on everyday activities. We need to "use it or lose it" when it comes to our mental skills, as well as our physical ones.

Stay Engaged with Life

One way to stay engaged with life is to maintain relationships with people who are important — family and friends — even if they live far away. While loss of some family and friends is inevitable, we need to keep reaching out and finding new friends.

Older adults need to stay involved with our families, friends, and communities through our activities, whether we are volunteers, enjoy leisure activities, help care for a family member, or still work at farming or other employment.

Sometimes, however, older people experience serious diseases that decrease the quality of their lives in their last years. These mental and physical health problems may have begun in earlier years, or they may develop after a person reaches later adulthood. An example is someone who has Alzheimer's disease. Dealing with the consequences of such health problems is stressful for the person and those who care for him/her, especially over long periods of time. Fortunately, services and support groups are available to help both the person and caregivers deal with these challenges.

Tips for Good Mental Health

- DO be flexible and learn to adapt to changing circumstances.
- DO use your mind and stay active.
- DON'T abuse prescription or over-the-counter medications (such as tranquilizers, sleeping pills or alcohol).
- DO get regular physical checkups.
- DO set goals for yourself and work toward them.
- DO check your general attitude: positive or negative? Have you laughed recently?
- DO exercise regularly, eat nutritiously, get adequate sleep.
- DO learn and know signs of depression; it is treatable.
- DO avoid isolating yourself; isolation is a breeding ground for depression.
- DO develop and maintain good relationships with others for support.

What Is Mental Health?

Mental health is not easy to define, but aging successfully should mean good mental health. This does not mean that an older person never experiences any problems or disease, but that symptoms are treated and controlled, and do not interfere with leading a rewarding life. Unfortunately, many older people still believe the myth that mental health problems result from personal failure or weakness. This stigma means that they may not want to admit that a problem or symptom exists, and do not seek help.

Common Stressors

For many older people, later life offers many opportunities for enjoyment: travel, hobbies, volunteering, more time to spend with family and friends and to do the things they most want to do. Even older adults whose lives are filled with such rewards may experience periods of higher stress because of moving to a new location, dealing with a health crisis, or widowhood. For others, especially the frail and isolated, later life can be a time of considerable and often persistent stress. They may experience loss of mobility, financial insecurity, physical dependence, and loss of relationships with relatives and friends.

These are some of the challenges that can lead to serious physical and mental health problems. We are especially at risk if we experience:

- A great deal of stress,
- Have difficulty adapting to change in circumstances and routines,
- Do not have supportive relationships,
- Have difficulty relying on others to help cope with losses,
- Tend to have a negative outlook on life.

Checklist of Major Stressors

- Loneliness and isolation
- Loss of a spouse
- Loss of family members due to death or relocation
- Loss of friends
- Loss of a pet
- Loss of purpose, may be due to retirement
- Loss of being needed, such as no longer caring for family
- Loss of a position in community (church organist, volunteer, etc.)
- Loss of independence in transportation
- Loss of ability to drive
- Lack of transportation services
- Increased distance from family and/or friends due to moves
- Decreased financial independence
- Financial changes after retirement
- For very old adults, living longer than they planned and saved for
- Increased health care costs for self and/or family members
- Changes in health
- Deterioration in health
- Increased dependence on others
- Diagnosis of chronic or terminal disease
- Decreased physical independence
- Loss of ability to live alone
- Loss of energy
- Loss of control over daily routine
- Possible inability to do favorite activities
- Demands of caregiving
- Caring for a chronically ill spouse, parent, or other family member

If you or an older adult you know is experiencing one of more of these stressors, it's a good idea to learn to deal with the stress as well as possible. The next section gives you some stress reduction techniques to try.

Fact:

Mental health problems are common.

One in four people experience a mental health problem sometime during their lifetime.

Dealing with Everyday Stresses

Stress itself is not bad: It is sometimes our reaction to stress that may be unhealthy. Stress is the body's natural response to any change in its environment. We expect that events, such as having a house damaged by a tornado or a loved one's death, will produce stress. But even good things — having grandchildren come to visit, moving into a new home or retiring — can create stress. It is as much a part of life as eating, sleeping, and breathing.

One key to living well with life's stressors is to make sure there are enough times of relaxation to balance out the times of stress. When we are faced with one stressful situation after another with no time to relax, it can affect both physical and mental well-being. Below are some common physical and mental symptoms of too much stress. Have any or all of these troubled you or someone you know in the past month?

Checklist of Stress Symptoms

- ✓ Feeling tired, even after a good night's sleep
- ✓ Sleeplessness
- ✓ Irritability
- ✓ Unnecessary worrying
- ✓ Headaches, backaches, or chest pains
- ✓ Negative feelings or attitude
- ✓ Feeling out of control
- ✓ Feeling overwhelmed
- ✓ Poor concentration
- ✓ Frequent crying spells
- ✓ Constipation or diarrhea
- ✓ Shortness of breath

If you are having trouble with any of these symptoms, try some of the easy stress reduction techniques described in this section. If you are having trouble with several of these symptoms, consider talking with a professional health-care provider or counselor, since some symptoms may indicate health problems other than stress. The health-care provider can try to identify the cause of the symptoms and help find ways to handle or eliminate the stressful situations.

Relaxation and Breathing Techniques

1. Sit or lie down and place your hands firmly on your stomach.
2. Inhale slowly and deeply through your nose, letting your stomach expand as much as possible.
3. Exhale slowly through pursed lips as if you were going to whistle. By doing this you can control how fast you exhale and keep your airways open as long as possible.
4. Doing this exercise twice a day, for five to ten minutes at a time, will help reduce stressful feelings.
5. When time is up, sit or lie quietly a little longer, first with your eyes closed, then with your eyes open.

Easy Meditation Techniques

By allowing yourself to mentally focus on a single, peaceful word, you can create a feeling of relaxation. Try the following:

1. Reduce distractions in the room:
 - Turn off the television and/or radio
 - Close the door to help keep the room quiet.
2. Sit comfortably, and loosen any tight or restrictive clothing.
3. Close your eyes, and begin to breathe slowly and deeply.
4. Picture in your mind a peaceful word. If your mind wanders, turn your attention back to your breathing, and keep repeating your chosen word.
 - For example, if you start thinking about the shopping list, refocus onto your word. Do not worry whether you are relaxing deeply enough or getting the “right” response. If you keep doing it, stress will be reduced.

Visualization

Visualization is very simply taking a “mental vacation” to let your imagination run free.

1. Close your eyes, and picture a tranquil setting that has particular appeal to you.
2. Try to imagine all of the details. For example, if you are lying on a beach, feel the warmth of the sand under your towel and the sun on your body. Hear the waves lapping on the beach. Smell the fragrance of salt air. If the beach is not your favorite place, you can take yourself anywhere. You are only limited by your own imagination.

Exercise Can Help Mental Health

We are never too old to exercise. It's good for mental as well as physical health. Even people in their 90s (including some in nursing homes) become stronger, more independent, and have more energy when they exercise. For example, a group of healthy older adults have reported that they felt less anxious or stressed after light exercise for one year. Many community and senior centers offer exercise programs for older adults.

Tips for Exercise Success:

Older adults (or their family member if appropriate) should be sure to talk with a health-care provider to decide on the best exercise.

- Start out slowly with proper training and supervision. Be realistic about what you can do: Remember the tortoise and the hare!
- Stretch before and after exercise to improve movement and flexibility and reduce the risk of injury.

Important: If you experience sudden pain, shortness of breath, or feel ill, stop exercising immediately and check with your health-care provider right away.

- Choose enjoyable activities. If you don't like the activity you do, you'll quickly find excuses not to do it very often.
- Make small changes so that exercise is part of your daily activity. If you drive the car to do errands, park a few spaces farther away and walk a little farther.
- Exercise with a friend or a group.
- Set goals together and make it fun.

When Mental Health Problems Occur

Mental disorders are not part of normal aging, but circumstances that can contribute to the development of mental health disorders in older adults include:

- Social isolation
- Stressful living conditions
- Bereavement
- Acute and chronic health conditions
- The burden of having to take care of a seriously impaired family member

Many older people develop mental health problems for the first time when they are in their later years. It is important to remember that these problems are treatable. A smaller number of older adults have a history of serious and persistent mental health problems that began in younger years and continue to require treatment as they become older.

How Many Older Adults Are At Risk?

Approximately 35 million people in the United States are 65 and older: nearly 12.4 percent of the population, or about one in every eight Americans. In Tennessee, the number is consistent with the national percentage. The numbers are growing. From 1900 to 2000, the percentage of Americans 65+ more than tripled. In the new millennium, these changes will accelerate. The number of older Americans is increasing not only because more people reach age 65, but also because older adults are living longer. More and more people are living well past the age of 85.

Ten to 28 percent (3.5 million to 9.8 million) have mental health problems serious enough to need professional care. Twenty percent (7 million) are estimated to experience problems serious enough to put them at risk of psychiatric hospitalization or premature nursing home placement. For this group, the ability to maintain themselves in the community can become compromised as they experience serious mental, physical, social and environmental problems.

Those who are isolated, who live alone — whether in a rural or urban location — and who have mental health problems such as Alzheimer 's disease or severe depression, are especially at risk for hospitalization and nursing home placement.

Older adults (age 60+) account for a disproportional percentage of all suicides in the United States and are more likely than younger persons to die from their suicide attempts.

When we read that one in three people have a mental disorder during their lifetimes, or that 14 to 17 percent of people age 60 and older have problems with alcohol, we often don't connect these numbers to real people — ourselves, our families, and our friends. Even applying these numbers to what we know about the population of Tennesseans age 65 and older can make the problems seem distant. For example, of those 703,311 Tennesseans in 2000 (Profile of Older Americans, 2002), approximately 234,437 will have suffered a mental disorder during their lifetimes.

Treatment Facts

Research shows older adults generally respond well to mental health care in a variety of settings, including community mental health centers, nursing homes, senior centers and health clinics. However, research also shows that more than 80 percent of older adults in need of mental health services are not getting the treatment they need.

In Tennessee, about 12.4 percent of all residents are 65 or older. Clients age 65+ who receive inpatient or outpatient mental health services are underserved. A United Way needs assessment report released in September of 2003 on service gaps in Davidson County lists services for mental and emotional health for seniors as a priority.

Why? Here are some possible reasons

Many older persons at risk for serious mental disorders, including those with dementia, do not refer themselves for help or assistance.

An increasing number of at-risk older adults have no family members available to assist them in seeking services.

There is an overwhelming lack of information on the mental health needs of older minorities and foreign-born populations in the United States.

The stigma of mental health problems can prevent older adults from seeking treatment.

Fact:

Four out of five older adults who need mental health services are not getting the treatment they need. Do you know one of them?

Some Common Disorders and Their Treatments

Factors that can influence mental well-being of individuals at any age include:

- Nutrition
- Alcoholic beverages
- Prescription medications (some may cause depression or anxiety)
- Over-the-counter drugs (some may interact with prescriptions)
- Vitamins and herbal or other nutritional supplements
- Type and amount of exercise
- Stress of change and loss (common for older adults)
- Physical illness

These factors can interact with each other and lead to or escalate a mental health problem, such as anxiety or depression. If older adults take multiple medications from different physicians, or take over-the-counter drugs, they should carefully monitor how the combined medications make them feel. Be sure that every health-care provider the older person sees is informed about all prescriptions, over-the-counter drugs, herbal and/or nutritional supplements taken.

More than 200 individual mental disorders have been defined by the American Psychiatric Association. They are identified by:

- Present distress (such as a painful symptom).
- Disability (impairment in one or more areas of functioning).
- A significantly increased risk of suffering, death, disability.
- An important loss of freedom.
- They are not the same as expected responses to events, such as death of a loved one.

This section describes the most common kinds of mental disorders experienced by older people, including symptoms and effective treatment options. Types of disorders described include:

- Depression
- Dementias
- Common anxiety disorders
- Personality disorders
- Substance abuse disorders
- Schizophrenia

Because of the many biological changes, health problems and stressful life events older people face, it is sometimes difficult to separate symptoms of a mental disorder from other aging-related changes or side effects of a treatment for a medical condition. For example, changes in sleep patterns and appetite can be normal aging, symptoms of depression, side-effects of a new medication, or a combination of these things. In addition, a person may have more than one mental disorder. For example, an individual with Alzheimer's disease or other dementia may also experience depression.

Fact:

Older adults, who are 13 to 14 percent of the U.S. population, receive 40 percent of the medications prescribed by physicians.

Depression in Later Life

We all understand feeling sad or “blue” from time to time. Personal losses or crises can leave us with low energy and a sense of unhappiness. These reactions are a normal part of living. But, depression and depressive symptoms in the older individual present unique challenges. It is easy to dismiss the symptoms of depression in the older person as a normal part of aging. Sleeping problems, agitation, fatigue, isolation, loss of appetite, or a preoccupation with physical complaints may be seen as “mom just being fussy.” But depression is a serious concern that can hamper physical well-being. If properly treated, the older person with depression can live a happier, healthier life.

Depression can be a common and significant problem in elderly individuals and long-term care patients. Depressive symptoms occur in more than five million of the estimated 35 million Americans over age 65, with two million having depressive illnesses. The rate of depression in nursing homes is greater. Reports indicate that almost one in four nursing home residents may suffer from depression. In addition, approximately one-fourth (20 to 35 percent) of older adults with a significant medical illness may also be depressed. With effective therapy, however, almost 90 percent respond to treatment.

It is difficult to know how common depression really is in older persons. If it is masked by other physical problems, or if the symptoms are similar to those of dementia, physicians and other care providers — as well as the older person — may not recognize the depression. Many older persons are embarrassed at the idea of having any mental health problem, so they may describe their emotional pain as physical pain or may not report their depressive symptoms at all.

What Causes Depression?

Depression in an older person can be short-lived and could be a result of an inability to cope with **multiple stressful situations**. For example, extended grief over the loss of a loved one can develop into depression if the grief is not resolved. If an older person has a significant change in lifestyle — loss of financial security, move to a nursing home, loss of physical independence — he/she may develop depressive symptoms. Depression also can be an intense, whole-body disorder that occurs for no apparent reason. It can occur without warning, especially if there is a **family history** of depression or if a person has had a problem with depression at an earlier age.

For some older adults, depression **can be related to a physical illness**. Diabetes, thyroid disorders, Alzheimer's disease, stroke, congestive heart failure, cancer and Parkinson's disease are some examples of physical illnesses that may be associated with symptoms of depression. This is significant in older adults who may be dealing with various chronic illnesses and taking a number of medications to treat these conditions.

Medications can be responsible for causing depressive symptoms. Some over-the-counter and prescription drugs — including drugs for hypertension, Parkinson's disease, and cancer — can have depressive symptoms. Considering the number of medications an older person may take, it is important to determine whether one, or a combination, may cause the person to feel depressed.

What is Depression?

When a depressed or irritated mood goes beyond a temporary state and interferes with daily living for more than two weeks, it becomes a medical illness that needs to be treated. If several of the following symptoms occur nearly every day for two weeks or more and are affecting daily functioning, a depressive illness could be present. A person who is depressed may not always be sad.

Symptoms of Depression

- A persistent sad, anxious or “empty” mood.
- Loss of interest or pleasure in ordinary activities, including sex.
- Decreased energy, fatigue, feeling “slowed down” or an increased agitation and restlessness.
- Changes in eating habits, with significant weight gain or weight loss when not dieting.
- Changes in sleep patterns: insomnia, oversleeping, early-morning wakening.
- Difficulty concentrating, remembering, and/or making decisions.
- Feelings of hopelessness or pessimism.
- Feelings of inappropriate guilt, worthlessness or helplessness.
- Thoughts of death or suicide; a suicide attempt.
- Irritability.
- Excessive crying.
- Recurring aches and pains that don’t respond to treatment.

In older adults, these additional symptoms often are present:

- Memory and attention problems that may appear to be dementia.
- Complaints of aches and pains or other physical symptoms with exaggerated and recurring fears about physical problems.

Fact: Nine out of 10 older adults with depression can respond to treatment.

Bipolar Disorder

Bipolar disorder, also known as manic depressive illness, is another form of depressive illness experienced by a smaller number of older persons. This disorder usually starts when people are in their early twenties but continues, and must be treated, throughout life. The person has severe mood swings, from the extreme “lows” of depression to excessive “highs.” These states of extreme elation and unbounded energy are called mania.

Symptoms of Mania

- Excessively “high” mood
- Irritability
- Decreased need for sleep
- Increased energy
- Increased talking, moving, and sexual activity
- Racing thoughts
- Disturbed decision-making
- Grandiose notions
- Being easily distracted

Treatment for Depression

Medication Therapy

Medications used to treat mental health problems are referred to as psychotropic medications. More specifically, those used to treat depression are called antidepressants. Some individuals try over-the-counter supplements, such as St. John's Wort or SAM-e, to try to help their depression. If a person is already taking one of these supplements, the health-care professional must be told before antidepressant medication is prescribed.

Many new antidepressants (and some trusted older ones) may benefit the older person. A psychiatrist, especially one who has experience working with older individuals, is the best choice of medical doctor for prescribing antidepressants. In Tennessee, a Licensed Nurse Practitioner with a specialty in psychiatric medicine may also prescribe medication. It is important that the health-care provider understand the unique health problems of the older person and the combination of other medications the person takes. The older person often requires a smaller dose of medication because of the way his/her body processes the drug. Also, the older person's response to the medication may be slower than that of younger adults. The person being treated must be patient and give the medication time to work. When first prescribing an anti-depressant, the doctor will usually want to "start low and go slow" on the dosage to see how well the drug works. Medication for depression requires a few weeks or longer to build up to a therapeutic level in the body and to start improving symptoms.

The medication must be taken regularly, exactly as prescribed, and not just when a person is feeling bad. Because some antidepressants can cause tiredness, confusion, headache, nausea, or dizziness, they may be prescribed to be taken at bedtime. Some of the new medications tend to have fewer side-effects and seem to be tolerated more easily by many older persons. Medication adjustments will be needed to find out what works most effectively for each individual. Over time, the doctor may change dosages, time of day taken, or may change medications altogether until the most effective one is determined.

Once an appropriate medication and dosage are found, the older person needs to understand that he/she may continue to take it for a number of months to prevent a recurrence of the depression. If a person has a history of severe or recurring depression, lifelong medication may be needed. **It is important not to stop taking a medication without first checking with the health-care provider.**

Psychotherapy

Psychotherapy can be useful in treating older individuals with depression. Some older adults may initially view psychotherapy with suspicion and hesitation. With an understanding of the process and trust in the psychotherapist, the older person can benefit greatly from this experience. The mental health therapist is usually a clinical social worker, psychologist or nurse practitioner who has an understanding of the physical and emotional life changes an older person experiences. This talk therapy can occur individually with the older person or might include supportive family members.

Psychotherapy can be useful for older persons who are undergoing bereavement, major life transitions, or interpersonal conflicts. Sometimes older people benefit from a group therapy experience with other elders who are experiencing depressive symptoms. This can help the older person understand that the difficulties he/she is experiencing are not unusual and are shared by others.

Both Medication and Psychotherapy

Many older adults benefit from a combination of psychotherapy and medication. Short-term therapy, with the goal of changing negative self-perception and self-defeating thoughts, is very effective. In the therapy sessions, the older person is guided through behavioral and emotional problems that have contributed to the depression.

Other Treatments for Depression

In addition to medications and psychotherapy, some depressed older persons may benefit from other methods of treatment. Biofeedback, or relaxation training, has been shown to be useful in treating the older depressed person who is also agitated and irritable. With this therapy, the older person is taught techniques to increase his/her body's awareness of and control over depressive symptoms.

Electroconvulsive (shock) therapy is considered to be one of the most effective treatments for severe depression. It can be particularly helpful for severely depressed older persons for whom other forms of therapy have not been effective.

Suicide: The Risk of Unrecognized Depression

Unrecognized depression is untreated depression. When it is not diagnosed and treated, it can become more severe, putting some older persons at risk for suicidal feelings and gestures.

Older Americans who comprise 13 percent of the population are considered the group most at risk for suicide, accounting for 18 percent of suicide deaths in 2000. White men over age 65 have the highest rate of suicide in the country. It is important for family members and professionals to be willing to address concerns about suicidal risk with a depressed older person. Some may just have a wish to die but have no desire to act on this wish. Others may make verbal threats or may have made gestures.

Some older persons may not take an active step toward suicide but may quit taking important medications or may not eat properly because of a desire to fade away. It is important to seek help immediately if a person has thoughts of suicide or seems to have lost interest in taking care of her/himself.

Fact:

Free, confidential professional screening for depression is available in many communities. To locate the screening site nearest to you, or to obtain more information about depression, call the Information Line for the Campaign on Clinical Depression, sponsored by the National Mental Health Association and its affiliates: 800-969-6642.

Some Risk Factors for Suicide

- Does the older person volunteer suicidal thoughts?
- Has the older person thought through plans for suicide?
- Does the older person have access to the means of suicide? (Medications? A gun?)
- Does the older person have an exaggerated concern about a real or imagined physical illness?
- Is there evidence of a sense of hopelessness?
- Is the person an elderly white man?
- Is alcohol involved?
- Are there social contacts with whom the older person might share emotional thoughts?
- Does the older person's mental ability vary from day to day?
- Do you have reason to suspect the older person might not be taking his/her prescribed medications?
- Is someone available at home for companionship until the older person's depressed mood is controlled or improved?

Tip:

Don't be afraid to seek help immediately if you are concerned that someone may be at risk.

Grief and Depression

Like stress, grief is a part of everyone's life, but it seems to happen more often when we are older. We can grieve over any loss — the loss of independence that comes from being able to drive a car, the loss of a pet, loss of a job (even when looking forward to retirement) and, of course, the loss of friends and relatives who move away or die. Sometimes, one loss leads to others such as a recent widow who may also lose friends and financial security.

Individual responses to grief are different, and adjusting to changes from a loss takes time. Some symptoms of grief may seem similar to depression or anxiety, but they are not mental health problems unless the grief is not resolved.

People respond to grief physically and emotionally. Common responses are:

- Physical symptoms, including trouble sleeping or breathing, lack of energy or restlessness, changes in eating habits, developing minor or even more serious illnesses.
- Disbelief, by denying the pain of what has happened, becoming numb or having emotional shock.
- Anger or frustration at not being able to stop the loss or change the situation. May include blaming others or a higher power.
- Guilt that you didn't do enough, didn't do the right thing or didn't resolve a conflict.
- Sadness and a deep sense of loss.
- Anxiety or panic about the future or the feelings you are having.
- Depression, including wanting to withdraw from other people, feeling isolated, helpless, hopeless, or that no one can help.
- Relief, if the loss was anticipated and there already has been a great deal of suffering, such as after a long struggle with dementia.
- Dreams about the lost person or thing may be either comforting or upsetting, and tell you something about the dreamer's feelings.

Grief can be about any loss, not just the death of a loved one. Accepting the reality of loss takes time, even if the loss was expected. Some people say feeling the pain of the loss is the hardest part of the healing process. Both tears and laughter can help. It is important to find ways to release the many different feelings that occur — not just sorrow, but even anger and fear. Trusted family and friends, a support group, clergy, and counselors are possible sources of support. If a person tries to stay too busy to think about or feel a loss, or tries to continue to numb the pain or cut off feelings (perhaps using alcohol or tranquilizers), they are at risk for developing depression and physical illnesses.

Some Tips for Dealing with Grief

People have found many different ways to help cope with their losses. Here are a few suggestions:

- ✓ Take care of yourself: Eat nutritious meals, exercise every day, and get enough sleep.
- ✓ Talk regularly with friends. Tell them what helps you and what doesn't help.
- ✓ Structure your time alone.
- ✓ Record your feelings by writing or drawing in a journal.
- ✓ Talk about your feelings with someone you trust.
- ✓ Do something that requires you to use your hands in repetitive motions (knitting, for example).
- ✓ Spend time alone in nature, meditation, and/or prayer.
- ✓ Invite someone to be your telephone buddy. Talk daily.
- ✓ Do something to help someone else.
- ✓ Volunteer for something.
- ✓ Give yourself rewards.
- ✓ Change something in your home.
- ✓ Allow yourself to laugh.
- ✓ Allow yourself to cry.

The Difference Between Grief and Depression

Characteristic	Grief	Depression
Onset of Depressed Feelings	Caused of one or more recognizable losses (loved one, independence, financial security, pet, etc.)	May not relate to a Particular life event or loss, or a loss may be seen as punishment
Expression of Anger	May be openly angry; anger often misdirected	Irritable and may complain; does not express anger openly; anger primarily directed inwardly toward self
Expression of Sadness	Feelings of sadness, and emptiness, weeping	Pervasive feelings of sadness, hopelessness; chronic feelings of emptiness; may have difficulty weeping or difficulty controlling weeping
Physical Complaints	May have temporary physical complaints	Chronic physical complaints
Sleep	May sometimes have difficulty getting to sleep; may have disturbing dreams	Early morning waking, insomnia or excessive sleep (escape into sleep)
Insight	May be preoccupied with loss of person, object, or ability; may have guilt over some aspect of the loss; temporary loss of self-esteem	Preoccupation with self; generalized feelings of guilt; may have thoughts of suicide; longer term loss of self-esteem
Responsiveness and Acceptance of Support	Responds to comfort, support; may want not to impose grief on others	Does not accept support; tends to isolate self; may be unresponsive
Pleasure	Ability to feel pleasure varies, but can still experience moments of enjoyment	Often a persistent inability to feel pleasure
Others' Reactions Toward the Person	Tendency for others to feel sympathy for person; may want to touch or hold person who is grieving	Tendency for others to feel irritation with person; may not want to touch or hold person who is depressed

What Do You Know About Mental Disorders and Aging?

- T F 1. Cognitive impairment (memory loss, disorientation, or confusion) is an inevitable part of aging.
False: Only 5 to 15 percent of people over age 65 have any kind of dementia. For people over 85, the chances of developing a dementia increase.
- T F 2. Alzheimer's disease is the only reason older people develop cognitive impairments.
False: Although Alzheimer's disease is the most common cause of cognitive impairment for older people, many other types of dementia and health problems — such as strokes and severe depression—also cause memory loss, confusion, and disorientation. If a person develops such symptoms it is important to get professional help, since some forms of cognitive impairment are easily treated and reversible.
- T F 3. Most people with dementia act the same way.
False: Although all people with dementia experience confusion and memory loss, the degree to which they suffer from these problems varies over time. Losing things, hiding things, wandering, inappropriate sexual behavior, insulting or aggressive behavior, and repetition may occur or not, depending on the individual and the course of the disease if it is progressive (like Alzheimer's).
- T F 4. Major depression is more common among older people than younger ones.
False: Major depression is less than half as common among people over 65 than among people of all ages. However, more than a quarter of older people experience some depressive symptoms.
- T F 5. One-fourth of all suicides are committed by older persons.
True: Although the rate of suicide among women does not increase with age, for men the rate doubles between age 40 and 75. Men also tend to be more violent and to die from their attempts.
- T F 6. Most older adults who live in nursing homes suffer from mental disorders.
True: Three out of four older adults in nursing homes suffer from one or more mental disorders, including dementia, depression and anxiety.
- T F 7. More older people use mental health services than do younger people.
False: Fewer older people use mental health services, not only because this age group experiences fewer severe problems, but also because of the stigma of mental health problems. Many older adults feel strong resistance to admitting such problems and seeking help.

Questions adapted from The Facts on Aging and Mental Health Quiz and The Facts on Aging Quiz (Palmore, E.B. © 1998 Springer Publishing Inc., New York 10012).

Dementias

What is Dementia?

Dementia is a general term for several diseases that cause changes in the individual's thinking, ability to remember, reasoning, and judgment. Eventually, as a dementia progresses, it interferes with the person's ability to care for her/himself and she/he eventually becomes totally dependent on caregivers. Many years ago, such changes were often called senility, and some people assumed they were part of growing old. We now know that these kinds of memory problems are not a normal part of aging.

There are many causes for dementia, with perhaps the best known being Alzheimer's disease. Although Alzheimer's disease is the most commonly diagnosed, there are many other dementias, including:

- Vascular dementia
- Huntington's
- Pick's
- Binswanger's
- Lewy Body Dementia

Dementia also can occur with

- Parkinson's disease

There are some additional conditions that may imitate dementia. These include:

- Depression
- Brain tumors
- Head injuries
- Infections
- Drug reactions
- Thyroid problems
- Nutritional deficiencies
- Other neurological disorders.

Because many of the causes of memory problems in older adults are treatable, it is imperative that a person have a thorough diagnostic evaluation by health care professionals.

Delirium is Not Dementia

Delirium is a fluctuating level of awareness, which may vary from mild to severe confusion and/or disorientation. It is usually sudden, and can be caused by medical disorders and/or medications. Hallucinations (seeing or hearing things that are not there) and/or delusions (believing things that are not true) may be present. It is reversible when the cause is treated.

Memory Loss Check List

Not all changes in memory are caused by dementia. If detected early enough, many are reversible. Questions you should ask if you or a loved one experience memory impairment are:

- ✓ Has the change in memory happened since a new medication was started or since a medication was increased?
- ✓ Has a thorough physical been done to be sure there is no underlying medical illness that might be causing the memory problems?
- ✓ Has the doctor checked, using specific blood tests, to be sure thyroid levels, B12 levels, and others are normal?
- ✓ Has there been a recent loss — such as the death of a loved one, the death of a pet, divorce, loss of a job, financial loss, or the loss of an important relationship (due to moving away or an argument)? If so, depression could be causing the memory problem.
- ✓ Was there a recent fall, with possible head injury?
- ✓ Is nutrition adequate?
- ✓ Is the person drinking more alcohol, or taking a medication that increases alcohol's effects?

Difference Between Depression, Dementia, and Delirium				
Characteristic	Depression	Delirium	Dementia	Normal Aging
Onset	Variable	Usually sudden, caused by acute medical disorders	Variable; often gradual or unnoticed	No specific chronological pattern for symptoms
Duration	Weeks to years	Days to weeks	Months to many years	Some Changes begin mid-30's
Progression	Variable	Symptoms suddenly severe in days	Varies with type of dementia	Small changes Over long time periods
Memory	Person usually complains of Memory problems	Person often denies having problems	Person often unaware; problems noted by others	People may complain of mild losses, forgetfulness
Attention	Often impaired	Impaired	Often intact	Normal
Judgment	Variable; person often believes it is impaired	Poor	Poor; person's behavior is frequently inappropriate	Normal
Insight	Cognitive distortion likely (self-doubt, Negative Thoughts, etc.	Impairment likely, sometimes intermittent	Usually absent	Normal, consistent with personal history
Sleep	Early morning wakening common, insomnia or excessive sleep	Typically disturbed	Often normal, day-night reversals possible	Increased likelihood of intermittent awakenings
Problems in Functioning	Mild to extensive	Mild to extensive	Mild to extensive	None or a few problems
Hallucinations and Delusions	Unusual	Sometimes vivid	Sometimes present	Absent

Alzheimer's Disease

Alzheimer's is probably the most common of the diseases that cause dementia. It is estimated that Alzheimer's disease affects more than four million Americans. This disease is progressive (the effects become more severe over time). Currently we do not know how to prevent or cure the disease. However, there are medications that can help slow the disease in some people. These medications work best when started early in the disease, so it is important to talk with a health-care professional. In addition, there are medications and behavior changes that can help the older person and family deal with some of the symptoms.

The **early symptoms** of Alzheimer's disease include a very gradual change in the person's ability to remember normal things, such as appointments, names or things that happened within the recent past. As **the disease progresses**, memory of events earlier in the person's life will also be forgotten. There may be personality changes, and at times a person may become quite suspicious, depressed, hostile, or even see or hear things that are not there.

The average length of time from diagnosis to death is approximately seven years, although the lifespan range for individuals with Alzheimer's disease varies from three to 20 years. It is often said by clinicians who specialize in treating Alzheimer's patients that 90 percent of people with Alzheimer's belong at home for at least 90 percent of the illness. Some assisted living and nursing home units have environments and programs designed especially to care for individuals with Alzheimer's and other dementias. These special care facilities should have staff who are specifically trained to deal with people who have moderate to severe dementia.

Tip:

If someone seems to be making up a false story, he or she probably is not "lying" to deceive you, but rather confusing imagination with reality or trying to fill in a gap in his or her own memory. Rather than accusing the person of lying or correcting the incorrect statement, try:

Giving a noncommittal answer

Changing the focus of attention to another topic or another activity

Changing the environment to reduce anything that might increase confusion

Considering what the person might be trying to communicate. If someone insists it is winter when it is July, is the person feeling cold?

Vascular Dementia

A vascular dementia (formerly called multi-infarct dementia) results when an individual has had a number of “mini” strokes. Often the symptoms occur rather suddenly. A person may not think as clearly, may be confused, and may have difficulty functioning. The person may get better for periods of time before having another mini stroke. Recognition and diagnosis of a vascular dementia and its underlying conditions, such as high blood pressure, often lead to specific treatments that may change the progression of the disorder. It is important not to assume that all symptoms of confusion and memory loss are Alzheimer’s disease, and to obtain a thorough diagnosis.

Pick’s Disease

This rare disorder is generally confined to the front part of the brain. Changes in personality and behavior may occur even before changes in memory. Like Alzheimer’s, this is a disease that is not treatable at this time. It also progresses more rapidly than Alzheimer’s.

Lewy Body Dementia

Lewy Body dementia is another irreversible brain disease, associated with deposits of a protein substance called Lewy Bodies in the brain. This is a less common form of dementia than Alzheimer’s, and it can be misdiagnosed as Alzheimer’s, because the symptoms are similar. A person with Lewy Body dementia may have trouble remembering, may have episodes of confusion, and may have difficulty communicating clearly or following a conversation.

The person’s functioning may fluctuate substantially. For example, the person may function well for several days or weeks, and then have days or weeks where he/she is confused and has trouble remembering. Early in the course of Lewy Body dementia, the person also may see or hear things that aren’t there. (Although people with Alzheimer’s disease may develop these symptoms, they happen later in the course of their illness.)

Regardless of the type of dementia, such experiences are often frightening. People believe that what they see and/or hear is real and that others may be trying to harm them or steal things from them. Medications usually stop or decrease the hallucinations.

Binswanger's

Impairment in blood vessels deep in the brain causes this dementia. In addition to memory, early in the course of the illness Binswanger's affects the person's gait and walking ability, and emotional fluctuations. For example, the person may be laughing one minute and in tears a few minutes later, for no obvious reason. In addition, the person may lack bladder control early in the disease. Progression of the disease results in gross impairment of the individual's memory as well as the ability to communicate and function normally.

Dementia Associated with Parkinson's Disease

Parkinson's disease is a chronic, slowly progressing disease caused by a chemical imbalance of two neurotransmitters (dopamine and acetylcholine) in the brain that destroys certain nerve centers. A person with Parkinson's disease develops tremors (shaking), rigidity and slowness of movement. He or she may have difficulties with movement, balance, walking and dexterity. Some people with Parkinson's disease may experience depression, and 10 to 40 percent experience dementia. Medications are used to control the symptoms of the disease. Although there currently is no cure for the disease, many people live out their normal lifespans.

Huntington's Disease

Huntington's disease is an inherited neurodegenerative disorder that affects motor, mood and cognitive areas of functioning. Motor disturbances can result in too much (e.g., restlessness, wiggling) or too little (e.g., stiffness, rigidity) movement. Mood changes often are noticed first by family members and friends. Moods such as depression, anxiety, irritability and outbursts of temper are most common. Thinking, learning and judgment often are affected early in the disease and worsen over time. Huntington's disease also affects memory, calculation and verbal fluency. Currently, there is no cure for the disease. Treatment includes medication for relief of some symptoms and modification of the person's environment (room or home) to enhance comfort and security.

Caring For Someone with Dementia

Living with or caring for someone with dementia is a challenging job, regardless of the kind of dementia involved. It is important that caregivers learn all they can about the illness so they can recognize changes that may need to be quickly reported to health-care providers. It is also important that they learn how to approach and relate to the person with dementia, since these interactions often will determine the quality of life for everyone involved. Additional sources of helpful information about dementias and ways to cope with difficult behavior and stresses of caregiving are listed in the resource section of this publication.

Some tips for communicating with a person with dementia:

- DO talk with someone who has dementia: Talking and listening are some of the most enjoyable activities we do.
- DO look directly at the person, make eye contact, and be sure the person is paying attention to you.
- Try to be on the same eye level: Don't talk down to someone from a standing position.
- DO remember that a person may also have hearing or sight problems that make it harder for the individual to understand you.
- DO talk about the past with someone who has dementia. For some people, old photographs, memorabilia, or familiar music can trigger memories and stories about the past.

Anxiety Disorders

Everyone feels some degree of anxiety or uneasiness from time to time. We have all felt the queasy stomach or sweaty palms associated with a momentary anxious feeling. But when this feeling becomes so intense and prolonged that it interferes with daily living, it is possible that an anxiety disorder is the cause.

Anxiety can be described as a feeling of fear, unexplained nervousness or a rising sense of dread that something terrible will happen. Anxiety could be due to an underlying depression or to an emotional disorder called a generalized anxiety disorder. Both respond well to treatment with medication and psychotherapy.

Sometimes symptoms of anxiety are related to a physical illness or the medications taken for that illness. This is the case for many chronic physical illnesses older adults have. For example, people with chronic heart disease have a higher than average rate of anxiety, and Digoxin, taken for heart disease, can cause anxiety. Confusion and anxiety

are common with congestive heart failure. People with pulmonary disease often have feelings of fear, anxiety, and irritability because of an inadequate level of oxygen in their systems. Common medications for pulmonary disease — such as corticosteroids, bronchodilators, and Theophylline — can cause irritability and anxiety.

Symptoms of anxiety also are more common among caregivers for family members with chronic health problems. The stress of the responsibility of caregiving, and the caregiver's ability to cope with this stress, are significant factors in whether anxiety occurs.

Because symptoms of anxiety can be felt as physical discomfort, older adults with anxiety disorders may end up in doctor's offices or emergency rooms with complaints of physical illness. They often experience substantial medical testing before anxiety is diagnosed. Some medical illnesses and medications for chronic illness can cause symptoms of anxiety, so both may need to be treated.

Signs of Anxiety Disorder

- Feeling anxious and tense, even when there is no real danger.
- Anxious and tense feelings that cause significant distress and interfere with daily activities.
- Taking extreme steps to avoid situations that cause anxious feelings.

Some Symptoms of Anxiety Disorder

- Restlessness
- Nervousness
- Irritability
- Disturbed sleep
- Muscle tension or pain
- Headaches
- Stomachache or diarrhea
- Chills or hot flashes
- Difficulty concentrating
- Loss of energy
- Shaking, trembling or hand-wringing
- Racing or pounding heart
- Rapid breathing
- Chest pain
- Constant worry
- Unexplainable fear

Common Anxiety Disorders

Panic Disorder

Panic disorder is a diagnosable and treatable illness during which people experience sudden and recurrent “panic attacks” usually lasting between five and 30 minutes. These panic attacks can happen several times a week or within the same day. They reach their peak in about 10 minutes, but leave the person emotionally drained and frightened. Panic disorder sufferers often live in fear of having another attack because the attacks can occur without warning. They may avoid places or situations where the first attack occurred — or they become afraid to go out in public at all. Many individuals who have panic attacks also suffer from depression.

Panic Attack Symptoms

- Heart palpitations, pounding heart, or racing heartbeat
- Trembling or shaking
- Shortness of breath or feelings of smothering or choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, unsteady, lightheaded or faint
- Fear of losing control or “going crazy”
- Fear of dying
- Numbness or tingling sensations
- Chills or hot flashes

Panic Disorder Symptoms

Panic disorder occurs when at least one panic attack is followed by one month or more of at least one of the following:

- Persistent concerns about having more attacks.
- Worry about the consequences of an attack, such as losing control or having a heart attack.
- Significant change in behavior related to the attacks.

What Causes Panic Disorders?

As a medical condition, panic disorder is relatively common. Studies have shown that up to 3.5 percent of Americans will develop the disorder in their lifetimes, making it as prevalent as asthma.

The cause of panic disorder is unclear. Some people link their first attack to a specific stressful event in their lives. Others identify a physical illness or the use (or abuse) of certain medications to a first attack. There are also indications that panic disorder may run in some families (a genetic link). Sometimes, there are no clear reasons why panic disorder has developed. Researchers are studying a number of possible factors, including genetics, breathing disorders, chemical imbalances in the brain, and emotional or cognitive conditions. No matter what the cause, panic disorder is highly treatable.

Agoraphobia

Agoraphobia, which can occur in someone suffering from a panic disorder, is an anxiety about being in places or situations from which it might be difficult or embarrassing to escape—such as being in a room full of people or in an elevator. It is not unusual for people with panic disorder to develop agoraphobia because they fear that help might not be available if an attack occurs. In extreme cases, persons with agoraphobia may even be afraid to leave their homes.

Phobia

People with a phobia suffer such intense anxiety that they take extreme measures to avoid the situations or objects that make them so afraid. Being close to the object or in the situation that is so feared can cause intense feelings of anxiety or panic (as described above). Phobia may keep some people with chronic diseases from getting regular medical care.

Specific Phobia

A person with a specific phobia has a persistent, excessive or unreasonable fear that greatly limits his/her normal routine of living. This fear is related to the presence or anticipation of a specific object or situation, such as spiders, flying, or heights. When the person confronts this situation, he/she will experience immediate anxiety, with feelings of panic. Someone with a specific phobia will go to great lengths to avoid the upsetting situation.

Social Phobia

Social phobia is an excessive, persistent anxiety about social or performance situations in which the person is exposed to unfamiliar people or to possible criticism by others. When someone with social phobia confronts these situations, it can cause panic symptoms. People so fear being humiliated or embarrassed that they isolate themselves, limiting their normal routines and activity with others. Social phobia is more common than people realize: one of every eight Americans suffers from it, and it is the third most common psychiatric disorder in the United States.

Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) is caused by a chemical imbalance in the frontal lobes of the brain. It affects as many as 6 million people a year. People with OCD have distressing thoughts or impulses (obsessions) over which they feel no control. In response to these thoughts or impulses, they develop repetitive actions (compulsions) to try to prevent or reduce their obsession or prevent some dreaded event or situation from occurring. These thoughts, and the response to them, are typically not related to a real-life problem but cause significant anxiety.

People with OCD realize their obsessions and compulsions are not reasonable, but cannot stop them. They often suffer needlessly because they are too embarrassed to bring symptoms to their doctor's attention. In many cases, OCD is made worse if the person also experiences symptoms of depression.

Examples of Common Obsessions

Repeated thoughts about being contaminated with germs (e.g., from shaking hands or touching a doorknob).

Repeated doubts (e.g., about having left the door unlocked or the stove on).

Feeling that items, such as one's dishes or books, must be arranged in a particular order.

Examples of Common Compulsions

Excessively washing one's hands or showering again and again.

Excessive and repetitive cleaning or dusting.

Repeatedly checking door locks or light switches.

Arranging items in a particular, precise order for no useful reason.

Post-traumatic Stress Disorder

Persons with post-traumatic stress disorder (PTSD) have been exposed to a traumatic event that involved actual or threatened death or serious injury to themselves or another person. This event has left the person with feelings of intense fear and helplessness or horror. For example, surviving a tornado might cause PTSD. Symptoms of PTSD include continued flashbacks and reliving the event, nightmares, and intense distress when exposed to an object or situation related to the event. This leads the person with PTSD to avoid thoughts, conversations or activities that may remind them of the event.

At times the person can feel detached or estranged from others, may have difficulty forming loving attachments and may feel he/ she has no future. Often the person may have difficulty falling or staying asleep, be irritable, have outbursts of anger, have difficulty concentrating, or seem to be “on their guard” or easily startled.

Treatment for Anxiety Disorders

Researchers have found both medication and psychotherapy (counseling) effective in relieving symptoms of anxiety. Often, the two treatment methods are combined.

Medication Therapy

The use of medication for treatment of anxiety disorders is highly effective. The type of medication the physician chooses depends on the type of anxiety the older adult experiences, his/her physical condition, and the other medications being used. Because older persons metabolize medications differently than younger individuals, the health-care provider will “start low and go slow” when prescribing dosages. The older person must monitor how the medication makes him/her feel and report this to the doctor.

Psychotherapy

Psychotherapy, or talk therapy, is effective in helping the individual suffering from anxiety gain control of her/his feelings, thoughts, and behaviors. The opportunity to identify the feelings of being overwhelmed, angry, sad, or hopeless can help the individual understand the reason for those feelings and gain control over them. Often the person with anxiety thinks there is something very wrong with him/herself resulting in negative self-talk.

In psychotherapy, an older person can gain a better understanding of the reasons for self-doubt and gain a more positive attitude. Talking about feelings can help the individual react differently when an anxiety-producing situation presents itself. Relaxation therapy is also helpful. When a person feels anxious, the body tenses, creating even more anxiety. In relaxation therapy, a person learns to breathe more deeply and to relax muscles, decreasing body tension.

Personality Disorders

Webster defines personality as: “habitual patterns and qualities of behavior of any individual, as expressed by physical and mental activities and attitudes.” These characteristics are deeply rooted and enduring.

Personality disorders do not suddenly appear in older adults, but are usually a result of a person’s fundamental make-up and early life experiences. People with personality disorders are often uncomfortable with themselves. Their behavior and ways of relating to others create problems and discomfort for those around them. Personality disorders are often difficult to treat, but effective psychotherapy techniques have been developed. Medications often help reduce symptoms.

There are many types of personality disorders, with degrees of severity and dysfunction in each. The more widely known personality disorders include:

- Obsessive-compulsive
- Antisocial
- Narcissistic
- Depressive
- Dependent
- Borderline.

Examples of narcissistic, borderline, and dependent personality disorders are described below.

Someone with a **narcissistic** personality disorder is extremely self-centered, haughty, blindly assumes superiority to others, sees self and self-needs as more important than those of others, and expects to be given special favors and status without giving any in return.

An individual with a **borderline** personality disorder may be seen as having erratic moods, being impulsive and/or angry, often engaging in self-destructive acts, and having chaotic interpersonal relationships. A primary problem for people with a borderline personality disorder is a vulnerability to intense emotional reactions while

being unable to regulate their emotions. They often suffer from depression, self-hatred, and hopelessness. These people are often in crisis, and frequently injure themselves intentionally (for example, overdosing on medications or cutting themselves). Among those who engage in suicidal behavior, 10 to 29 percent die of suicide. People with this disorder may also suffer from other serious disorders, such as major depression, anxiety, and substance abuse.

A **dependent** personality disorder is exhibited by excessive need to be taken care of by others. This clinging, submissive behavior begins by early adulthood. The person has difficulty making everyday decisions without an excessive amount of advice and reassurance from others. He/she fears rejection and will go to great lengths to involve others in day-to-day activities and decisions. When a close relationship ends, the person feels alone and helpless without the nurturing, support, and control provided by the relationship, and will do anything necessary to reinstate it. A widowed person who has a dependent personality disorder may have always depended on the spouse and may try to solicit an adult child to be the major decision-maker.

Schizophrenia

Schizophrenia, among the most disabling severe mental disorders, affects one percent of the population. It is a severe, persistent mental disorder that requires long-term health care. It has a dramatic, debilitating effect on most aspects of everyday functioning, behavior, and personal experience, and it can have a devastating effect on families as well. Symptoms of schizophrenia usually begin to emerge in young adulthood.

The long-term outcome for a person with schizophrenia varies. For older people who have experienced some relief from their symptoms with improved medications and who have strong family and/or social support systems, substantial improvement in symptoms and function can occur. For older individuals who developed the disorder in their younger years, did not have the opportunity to use newer medications and community support systems, and who develop other medical problems, the outcome is more guarded.

A growing number of persons with severe and persistent mental disorders reach old age. Improvements in mental health and general medical care have resulted in more individuals with schizophrenia surviving into old age than ever before.

What Is Schizophrenia?

Schizophrenia is a syndrome characterized by disordered perceptions, thinking, and behavior that have a pervasive effect on personal, social, and work functioning. Some individuals first have difficulties in social adjustment and interpersonal relationships. Others do not show signs of significant problems until the onset of psychosis. Over a period of months, the person developing signs of schizophrenia may become socially withdrawn, depressed, and express unusual perceptions or thoughts. She/he may fail to show up for work or school and may spend long hours in seclusion. Contacts with family or friends may be punctuated by hostile, paranoid or bizarre comments.

Fully developed schizophrenia consists of a cluster of symptoms which are described as positive, negative, or affective.

Positive symptoms are the active symptoms of psychosis, such as:

- delusions (false beliefs or impressions)
- hallucinations (perceiving or sensing that something is present when it is not).

Other positive symptoms include:

- severe problems in thought processes, with illogical thinking and/or incoherent speech
- behavior problems, including bizarre, repetitive or ritualistic behavior.

Negative symptoms reflect problems in relating to others. They include:

- a lack of emotional expression
- a reduced amount of speech or speech that has no obvious content
- social withdrawal
- lack of interest or slowing down
- difficulty concentrating or performing tasks.

Affective symptoms, such as depression, are common in schizophrenia.

Approximately 60 percent of people with schizophrenia suffer a major depression during the course of the illness and are at high risk for depression in their older years. This is especially true if the person has co-existing medical problems, is taking medications that have risk of depression as a side-effect or if the person has had a history of alcohol or other substance abuse.

Schizophrenia varies in the type and severity of symptoms across different individuals. However, at some time during the course of the illness, people with schizophrenia experience problems initiating and maintaining meaningful interpersonal relationships, fulfilling responsibilities (education or employment), or engaging in caring for themselves (grooming and hygiene, managing finances, etc.).

The Older Person with Schizophrenia

Older adults with schizophrenia can be divided into two groups.

The most common group includes those with **“early-onset schizophrenia.”** People in this group were diagnosed as young adults, have endured lifelong schizophrenia, and have grown old. Several factors influence how well people in this group function in their older years. If the person is quite old, developed the disorder before the use of anti-psychotic medication, and has spent many years in a psychiatric institution, her/his ability to function will have suffered. He/she may lack the skills to live independently, have poor social skills, and depend on a structured, supervised setting to meet his/her needs. People who are comparatively younger, have been able to benefit from newer anti-psychotic medications, and have spent most of their adult lives in community treatment settings (with assistance of family or community mental health and social service supports), may be able to continue to function in this situation.

Much less common is older individuals diagnosed with **“late-onset schizophrenia.”** They may have been somewhat isolated, thought of as “odd” or “eccentric,” and may have, at times, seemed to have paranoid thoughts, but functioned independently and developed some satisfying relationships in their earlier years. The development of the late-onset schizophrenia is likely to have followed a period of severe stress or physical illness. The ability of this person to return to more routine function, with the assistance of anti-psychotic medication and family or social support, is greater than for persons with lifelong schizophrenia.

The symptoms of schizophrenia can become less intense for persons in later life. This could be due to biological changes in the brain, but may also be due to better self-management of the illness. Keeping stress low, seeking good medical care when indicated, avoiding alcohol or other substance use, and taking medications as prescribed improve the long-term functioning of any person with schizophrenia.

Older people with schizophrenia who have family or social support to assist them tend to remain independent more successfully. Managing the disorder can be difficult for older persons who have never married, who do not have supportive family members, and who have not been connected to community-based mental health services. Older adults who have schizophrenia also develop some of the medical disorders common among older persons. These medical problems can result in serious complications. In general, the physical health of individuals with schizophrenia in late middle age or early old age may be more typical of the health status of much older individuals without mental illness.

Factors that can contribute to poor physical health include frequent health-damaging behaviors such as smoking and substance abuse, limited access to good health care because of financial constraints, and delay in seeking medical treatment as a result of the high pain threshold found in many persons with schizophrenia. In addition, older

adults are more sensitive to side-effects of antipsychotic medications. One potentially serious side-effect is tardive dyskinesia, a neurological syndrome of abnormal involuntary movements.

Another problem that can occur for older adults with schizophrenia is the development of cognitive impairment or dementia. For some, the symptoms of dementia can become the primary source of problems in late-life functioning and can determine the kind of care required.

Treatment of Schizophrenia in Late Life

The most effective approach to treating schizophrenia is to address the individual's biological, psychological and social needs. This strategy is particularly true for an older person.

Medication Therapy

Effective management of psychotic symptoms through use of anti-psychotic medications is the first and most important aspect of treating persons with schizophrenia. For older adults who have a change in their metabolic system, and for those people who have life-long schizophrenia, development of the newer, atypical anti-psychotics has been important. These medications cause fewer, less intense side-effects, a particular benefit to older adults with schizophrenia who also take multiple medications for other medical problems.

Biological changes that occur as the body ages can directly affect the way medication is metabolized and can intensify side-effects. Becoming toxic from combined medications, or failure to take medications as indicated, are common problems for the older person. It can be difficult to evaluate the problems of the older person with schizophrenia if he/she is uncooperative because of delusions.

The older person with schizophrenia is already coping with difficulty in the ability to perceive and reason, which creates even more vulnerability if dementia develops. Mental health professionals must evaluate the older person's cognitive abilities, the ability to adequately perceive and understand, in order to know whether problems are due to a schizophrenic process or to a developing dementia.

If the older person is living successfully in a community situation, relying on a system of family and social supports, changes in that system can put the individual at risk. Stress from life events commonly experienced by older adults — such as the death of a loved one — can be devastating to an older person with schizophrenia. She/he may be more vulnerable to an exacerbation of the disease because of difficulty with coping and life skills. If such stressful life changes occur, it may be necessary to evaluate whether the older person is able to continue living in the community.

Community Support Services

Since family members as support persons may be limited or nonexistent, it is important that the older person with schizophrenia be connected to community support programs. Local mental health centers offer programs that can assist with medication management, crisis intervention, psychosocial programming, case management, and psychotherapy, as needed.

Addiction among Older Adults

Like adults of any age, some older adults experience problems with addiction. These problems may occur for the first time when a person is older, or may have been a concern for many years. Some such problems include compulsive gambling and alcohol abuse and dependence.

Compulsive Gambling

Problem or compulsive gambling has been called an invisible addiction because nothing is taken into the body, as in alcohol or drug abuse. Gambling often begins as a social activity. If people win at first, they may believe winnings will increase. Many gamblers enjoy the excitement of gambling, the dream of winning big, or the escape from everyday problems or stresses.

One in three probable compulsive gamblers is a woman. As a group, women tend to start later in life, often because they seek an escape from problems or stresses.

As the gambling problem increases, losses become blows to self-esteem. People may believe they can stop whenever they wish, but they have no desire to do so. They may gamble to win back losses, hide or lie about their losses, borrow money, and allow relationships to suffer. Feelings of desperation and hopelessness often increase as the amount of loss grows. Unfortunately, some problem gamblers attempt suicide before they receive treatment.

Gambling problems are more common among people who abuse alcohol or other substances. People who gamble compulsively may also experience physical symptoms: digestive problems, insomnia, headaches, high blood pressure, asthma, backaches or chest pains. They also may experience mental health problems, such as depression and anxiety disorders.

Since gambling has been legalized in Tennessee, and casinos have been developed in many states, there has been an increase in gambling problems among older persons. Casinos have turned an activity that was once socially unacceptable among older people into an enjoyable social outing with inexpensive food, free transportation and incentives for preferred customers. Most older persons are “casual, social gamblers.” Unfortunately for those older persons who are lonely, isolated, bored or depressed, gambling can be a great risk.

Facts about Gambling and Older Adults

Fact: Since 1974, the highest increase in gambling has been among adults age 65 or over.

Fact: Research shows that the third and fourth days of the month (the days that retirement checks arrive) are the busiest at casinos.

Fact: The easy access to lottery tickets as part of everyday shopping may make problem gambling more difficult to detect as it develops.

Fact: Older persons are at risk of losing everything to gambling and have few, if any, resources to start over and rebuild after a bankruptcy.

Treatment of Compulsive Gambling

Problem gambling is a treatable addiction, but relatively few treatment programs exist in comparison to those for alcohol and substance abuse problems. Few health-care professionals screen clients for gambling problems.

Treatment programs that are available may involve individual, group, and family counseling, in conjunction with developing a support network through programs such as Gamblers’ Anonymous and education about compulsive gambling. If a person also has problems with another addiction, such as alcohol, both problems must be addressed in treatment. Although women make up one-third of all compulsive gamblers, they are severely underserved in receiving treatment.

Alcohol Abuse among Older People

Alcohol abuse among older persons is a growing problem, especially as the number of persons living to an older age increases. Alcohol is the most abused substance in America, and it is the drug of choice for older Americans. Yet it can be one of the most overlooked and under-reported problems. Those who are especially at risk for physical and mental health problems related to alcohol are:

- Those who take multiple medications, have major medical problems, and also drink.
- Those who have had a long-term battle with alcohol abuse.
- Those who are isolated from family and friends and have suffered major losses in life.

It has been estimated that 2.5 to 3.7 million Americans age 65 and older are addicted to alcohol, and one in five older patients receiving treatment for medical, surgical or psychiatric difficulties is an alcoholic or problem drinker. Yet, the diagnosis of alcohol dependence/abuse is seldom made. Often health-care professionals tend to see changes in mental and physical health status but do not address the possibility of alcohol addiction as a cause of the changes. Family and friends may be too embarrassed to confront the older person about alcohol use. Often the problems go unaddressed until major health or legal problems — such as driving under the influence — occur.

The physiological changes connected with age result in a lower tolerance for alcohol and increase its toxic effects. Older persons with a variety of medical problems — including diabetes, heart disease, liver disease, and central nervous system degeneration — do not tolerate alcohol well. Some medications can intensify reaction to alcohol, leading to rapid intoxication. Some older persons use prescribed sedatives, which are potentially lethal when ingested with alcohol.

Medical problems that can develop in the older alcoholic include amnesia, delirium, convulsions, gastritis, anemia, heart problems, ulcers, unsteadiness, broken bones (especially from falls), confusion, self-neglect and depression. Excessive use of alcohol is an important factor in depression and suicide among older adults. In the United States, the older adult man who is an alcohol user or abuser is the person at highest risk for completing a suicide.

Because the effects of alcohol use and abuse in the older person can be so devastating, it is imperative that family and friends actively identify older persons with addiction problems, and direct them toward treatment programs. Older adults, especially those who have not been problem drinkers throughout their lives, have a better treatment prognosis than any other age group. They are more likely to complete their treatment and have a higher one-year sobriety rate than their younger counterparts.

Facts about Alcoholism and Older Adults

Among today's 35 million Americans age 65 and older, a growing number are addicted to alcohol. Six to eleven percent of elderly persons admitted to hospitals exhibit symptoms of alcoholism. In addition, 20 percent of this population admitted to psychiatric wards and 14 percent presenting in emergency rooms also exhibit symptoms of alcoholism. Some studies indicate as high as 49 percent of nursing home residents have problem drinking.

Early-onset alcoholism describes the addiction of people who have a history of long-term drinking. They are likely to have serious physical problems as well. Late-onset alcoholism occurs when a person begins abusive drinking late in life, often because of a dramatic change, such as retirement or loss of a loved one.

Fact: Older people are hospitalized more frequently for alcohol-related problems than for heart attacks.

Fact: The drug of first choice in the older population is alcohol. The second is tranquilizers, such as Valium, Ativan or Xanax. The mixture is potentially lethal.

Fact: Alcohol abuse creates and exaggerates medical and psychological problems.

Fact: Twenty percent of older adult patients receiving treatment for medical, surgical or psychiatric difficulties are alcoholics or problem drinkers.

Fact: The cost of alcohol-related hospital care for the elderly was estimated to be as high as \$60 billion in 1990.

Fact: Older men are about four times as likely to have alcohol problems as older women, but older women are more likely to drink alone.

Fact: Widowers over 75 have the highest rate of alcoholism in the country.

Fact: The older depressed alcoholic is the person at highest risk for committing suicide in the United States.

Fact: The number of older adults who abuse alcohol is predicted to be more than double in the next 50 years because of the projected size of the older population and because future generations of older people are predicted to have more liberal attitudes toward alcohol consumption.

The Good News...

Older people have the highest rate of success and the greatest sobriety after treatment. Thirty percent of AA members are over 50.

Physical Effects of Alcohol

Alcohol has many negative effects, which are especially dangerous in older people. For example, consider these additional facts about alcohol.

Fact: Alcohol slows down brain activity, specifically activity related to alertness, judgment, coordination, and reaction time. Therefore, drinking increases the risk of falls and accidents.

Fact: Some research has shown that it takes less alcohol to affect older people than younger people.

Fact: Over time, heavy drinking permanently damages the brain and central nervous system, as well as the liver, heart, kidneys, and stomach.

Fact: Alcohol's effects can make some medical problems hard to diagnose. For example, alcohol causes changes in the heart and blood vessels that can dull pain that might be a warning sign of a heart attack. It also can cause forgetfulness and confusion, which can seem like Alzheimer's disease.

Who Becomes a Problem Drinker?

There are two types of problem drinkers – chronic and situational.

Chronic drinkers – these are people who have abused alcohol for many years. Although many chronic abusers die by middle age, some live well into old age. Most older problem drinkers are in this group.

Situational drinkers – this term refers to people who develop a drinking problem later in life, due to “situational” factors such as retirement, lowered income, failing health, loneliness, or the death of friends or loved ones. At first, these people have an occasional drink to fill their time or ease their pain and loneliness, but this behavior can quickly become a problem if drinking becomes a regular habit and interferes with daily life.

Signs of Alcohol Misuse and Abuse

Early signs

- Sneaking drinks
- Gulping first drinks
- Unwillingness to discuss drinking
- Guilty feelings about drinking
- More frequent memory blanks

Addictive signs

- Conspicuous drinking
- Flashes of aggression
- Grandiose or “showy” behavior
- Personal relationships risked and devalued
- Decreased sexual drive
- Loss of friends due to drinking
- Unreasonable resentments
- Noticeable self-pity
- Most functioning is focused on getting and using alcohol

Chronic signs

- Regular morning drinking
- Tremors, prolonged binge or continuous drinking
- Impaired thinking
- Loss of alcohol tolerance

Treatment of Alcoholism in Older Adults

Research studies provide clear evidence that older adults with alcohol problems are at least as likely as younger persons to benefit from treatment. Outcomes are most successful for people with shorter histories of drinking problems (late-onset alcoholism). It is important that the older person receive a thorough evaluation in consultation with the primary-care provider. Many older adults with drinking problems are significantly isolated from the social support offered by friends and family members. This issue must be addressed as part of treating the alcoholism. Treatment may include individual and/or group psychotherapy in conjunction with developing social supports (including self- help groups like Alcoholics Anonymous) and education about alcohol use and abuse.

Fact:

More than half of female alcoholics report that their first symptoms occurred between the ages of 60 and 79, but older women still are significantly under-diagnosed and under-treated for alcohol problems. However, when they do receive treatment, it is highly successful.

When to Seek Treatment and Where to Find It

How Do I Know if Someone Needs Help?

“Would it help Mom to see a counselor?”

“How bad is bad?”

“How do I know if I need outside help to handle my situation?”

These are good questions, yet there is not a single answer. People differ in their needs and resources. Most people need help at some point in their lives. But needing help is not the same as wanting help. Some people are afraid to admit their difficulties. They believe seeking help means they are “weak” or “flawed.” This is not true.

Sometimes, a person can experience stress over a long period of time or have changes in physical health and well-being. As a result she/he may begin to show signs of mental distress. Sometimes a person may be vulnerable to depression, suicidal thoughts, severe anxiety, or to use/abuse alcohol. The need for mental health assessment and treatment can occur at any time, but most family members are not prepared to cope with mental disorders.

Unfortunately, many of us ignore warning signs from those close to us (or signs we see in ourselves). **The earlier these warning signs are recognized and help sought, the greater the likelihood that an effective treatment will be found and the person’s quality of life will improve.**

Warning Signs of Mental Disorders

Although there are more than 200 classified forms of mental disorders, there are some common warning signs for many of them, including:

- Confused thinking
- Prolonged depression (sadness or irritability)
- Feelings of extreme highs and lows
- Excessive fears, worries and anxieties
- Social withdrawal
- Dramatic changes in eating or sleeping habits
- Strong feelings of anger
- Delusions or hallucinations
- Growing inability to cope with daily problems and activities
- Self-neglect or abuse
- Suicidal thoughts
- Denial of obvious problems
- Numerous unexplained physical ailments
- Alcohol, medication, or gambling abuse

If an individual shows some of these signs and makes a will, gives away possessions or makes statements such as “I’m calling it quits,” or “Maybe my family would be better off without me,” the person is struggling with excessive stress or a mental disorder and would benefit from the help of a trained mental-health professional.

Often, people find themselves:

- Denying the warning signs. Some physical complaints (such as menopause) may mask signs of mental disorder. Repeated visits to a doctor with complaints of flu-like symptoms, back pain or colds may indicate an underlying mental illness.
- Worrying about what other people (even family) will think. Warning signs of mental health problems may be ignored because of the stigma that persists, especially among older adults. Some people may face ridicule or hostility from friends and neighbors. The insensitivity of others may add to feelings of loneliness and isolation and may stop someone from seeking help for him/herself or a family member.
- Wondering who’s to blame? Often, knowing what causes an illness helps people to accept the situation and move on to seeking treatment. With some mental disorders, there are no immediate answers or obvious reasons why someone becomes ill.

Research reveals many causes of mental disorders. Be alert to signs that suggest help is needed. If a mental disorder is diagnosed, find out all you can about the illness by reading and talking with mental-health professionals.

Finding Help in Your Community

When you become concerned about the mental health of an older person, it can be helpful to describe the symptoms and/or problems that concern you to a professional whom the older person trusts, such as a clergy person or the primary-care physician.

Other local professionals who can be of assistance are home health-care providers, public health nurses and aging-service case managers. They can help assess the need for assistance and inform you of mental health services in your area. The first phone call can lead to several others when searching for a mental health professional who understands the specific needs of the older person.

If the person who needs services has health insurance through a managed care provider, it will be necessary to contact that insurance company to determine whether there are restrictions on how and where mental-health services can be provided. If a person seeking admission to a nursing facility has a mental-health problem, the Area Agency on Aging will arrange for a mental health screening so appropriate services are provided.

Where Can I Go For Help?

If you have decided that warning signs indicate you or a family member could benefit from treatment for a mental health problem or disorder, the next step is to get access to that care. Here are some easy ways to find help:

Telephone the insurance carrier to see what services they provide and if they have a network of providers in your area.

Your Community Mental Health Center, Local public agencies, such as the Social and Rehabilitation Services office, the Area Agency on Aging and the Public Health Department have information on local mental health services. (See the Resource Section of this booklet for your local numbers.)

Mental-health professionals in private practice. (Consult your yellow pages) The phone book has telephone numbers for mental health professionals under such sections as “Mental Health Centers,” “Mental Health Services,” “Psychologists/ Psychotherapists,” and “Social Worker.”

Many phone books also have a section entitled “Helpful Numbers” that will lead you to information and referral phone numbers, such as the local mental-health association or a mental health hot line.

Local social services organizations — such as Catholic Charities, Jewish Family Services or other church organizations — can either provide counseling services or refer you to local mental health services.

Local hospitals may have mental health services. If not, the social services department will be able to inform you of local mental health services.

Psychiatric hospitals accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHCO).

Veterans Administration hospitals (for those qualified to receive benefits).

Mental health units of teaching hospitals, such as the Vanderbilt University.

State offices, such as Tennessee Department of Rehabilitation Services, Tennessee Department on Aging and Disabilities, or Tennessee Department of Mental Health and Developmental Disabilities have information on mental health services throughout the state. (See resource listings in the back of this book.)

Who are Mental Health Service Providers?

Community Mental Health Centers

These are public mental health centers that receive state and local funds to provide mental health services to individuals in their provider area. Most have sliding-scale fees and accept Medicaid, Medicare, private insurance and private pay.

Mental Health Professionals in Private Practice

These are therapists who provide psychotherapy services as a private business. They include psychiatrists, clinical social workers, psychologists and nurse practitioners who received specialized training and state licensing.

Not-for-Profit Mental Health or Counseling Services

These include agencies, such as Catholic Charities, Family and Children Services, Jewish Family Services, and Mental Health Cooperative, with qualified mental health providers who offer counseling services.

Private Psychiatric Hospitals

These are psychiatric hospitals that provide mental health evaluation and treatment through inpatient and/or day-treatment programs. They may have an outpatient component through referral to one of their qualified mental health providers.

Mental Health Units of Hospitals

These are specialized mental health units that provide evaluation and treatment through inpatient and/or day-treatment programs. They refer outpatient services to others in the community.

Veterans Administration Hospitals

These are full-service medical hospitals that may have mental health units as described above.

What are the Various Types of Mental Health Professionals?

Many types of mental health professionals are available to assist an older person who needs mental health care. To choose a professional, consider the symptoms and problems the person is experiencing and match them to the skills of the mental health provider. The following information will help you to understand the kinds of mental health professionals, the education each receives, the license or certification each should have, and the type of mental health services provided.

Psychiatrist: This is a medical doctor with special training in the diagnosis and treatment of mental and emotional illnesses. Like other doctors, psychiatrists are qualified to prescribe medication and have special expertise in medications for mental disorders.

Qualifications: a state license and board eligibility or certification by the American Board of Psychiatry and Neurology.

Psychologist: Therapist/counselor with a doctoral (Ph.D. or Psy.D.) or from an accredited graduate program in psychology. Trained to make diagnoses, provide individual and group therapy, and administer psychological testing.

Qualifications: state licensure; may belong to the American Psychological Association

Licensed Clinical Social Worker: Therapist/ counselor with a master 's degree in social work from an accredited graduate program. Trained to make diagnoses and provide individual and group counseling. Some Social Workers have a state certification rather than licensure.

Qualifications: state licensure; may be member of a professional social work organization.

Licensed Professional Counselor: Counselor with a master's degree in psychology, counseling or a related field. Trained to diagnose and provide individual and group counseling.

Qualifications: state licensure

Licensed Alcohol and Drug Abuse Counselor: Counselor with specific clinical training in treatment of alcohol and drug abuse. Trained to diagnose and provide individual and group counseling.

Qualifications: state licensure; may be nationally certified through the National Association of Alcoholism and Drug Abuse Counselors

Marital and Family Therapist: A therapist with a graduate degree and special training in marital and family therapy. Trained to provide individual and group counseling.

Qualifications: state licensure

Pastoral Counselor: Clergy person with training in clinical pastoral education. Trained to provide individual and group counseling.

Qualifications: Certification from American Association of Pastoral Counselors

Tip:

Therapy helps make a difference in the lives of many people, but it is a collaborative effort between you and a therapist in which you must be actively involved. You should always feel you can discuss your concerns openly and directly.

When You Decide to Contact a Mental Health Professional

Therapy helps make a difference in the lives of many people, but it is a collaborative effort in which you must be actively involved. The process is personal and intense, and may be painful at times.

You should feel that the therapist functions as a useful tool, helping you address concerns. When you call for mental health assistance, decide whether you prefer to contact your local mental health center or another mental health provider.

If you have already contacted your primary-care physician or health-insurance provider, you may already have been given a referral to a specific mental health professional or center. Since making the first contact can be a confusing process, it helps to know what to expect when you make the call.

Contacting a Mental Health Center

If you contact your mental health center, your call will be directed to a mental health professional who will gather information about the concerns you have for yourself or your family member. Although most mental health centers prefer that the proposed client make the initial call, that is not always possible.

If you are making a call for someone else, explain to the mental health professional why you are handling the task. Doing so will help the mental health professional better understand the proposed client's needs.

Be prepared to give information about who made the referral, financial status, insurance coverage, mental health symptoms, and medical concerns. You will then be given an appointment with a mental health clinician.

At the time of the first appointment, bring items listed below:

- Insurance cards
- List of medications
- Information regarding any previous mental health treatment

Be prepared to sign insurance forms, permission for treatment, and appropriate releases for exchange of information with other medical or social service providers. These tasks will most likely be handled by one of the specified office support staff.

When you meet with the mental health professional, be ready to discuss what events led to your decision to seek mental health treatment at this time. Be open about your concerns to allow the therapist to work with you to make the most effective treatment plan.

The plan could include individual therapy, group therapy, and/or family therapy. The therapist might recommend an evaluation by a staff psychiatrist or nurse practitioner to determine the need for medication therapy, which can assist in controlling some symptoms that may be of concern.

The therapist may discuss with you the possibility of hospitalization if the situation is life-threatening or if medication evaluation and management may be difficult. The therapist may also discuss the possibility of adjunct services, such as mental health case management or referral to agencies that provide supportive services, such as the local Area Agency on Aging. You should leave the first appointment with an idea of what the specific treatment program plan will include.

Contacting a Mental Health Professional in Private Practice

If you contact a mental health provider who is a private practitioner, you will need to determine the nature of his/her practice. Some providers work independently, while others work as part of a group practice that may have a variety of services.

If you feel that both medication and counseling will be needed, determine whether both services are provided by the professional you are considering. If not, find out how he/she makes referrals for those services not provided.

As described above for mental health centers, it is important to bring all pertinent information to the appointment, to understand the technical details (such as how billing is handled) and to determine the services available through this professional.

Some Questions to Ask a Therapist/Counselor

Answers to the following questions should help you feel confident in the therapist's abilities, honesty and sense of collaboration:

- What is your training? What degrees do you hold?
- What is your specialized training and experience working with older adults?
- What kind of experience do you have in treating the kind of problem involved?
- What kinds of certifications or licenses do you hold? Are you a member of _____ (the appropriate professional organization for this type of therapist)? Check state license, if required.
- What would your treatment involve?
- What length of treatment might you expect? (This will vary with the client, the problem and the approach the therapist uses.)
- How long does each session last? Forty-five to 50 minutes is common, unless it is to monitor medication, when the time may be 15 to 30 minutes.
- How often will sessions be scheduled? (Often, meetings are weekly at first and become less frequent later on.)
- What is the appointment cancellation policy? (There may be charges for missed sessions.)
- Is the therapist (or an associate) available by phone in a crisis?
- How much will it cost? Will any portion be covered by health insurance? Are different payment options available?

Are You Getting the Care You Need?

As the therapeutic process progresses, the individual in treatment should begin to feel gradual relief from distress, to develop self-assurance, have a greater ability to make decisions and be increasingly comfortable in relationships with others.

The person may feel uncomfortable or angry at times, but episodes of discomfort occur during the most successful therapy sessions. Mental health treatment should help in coping with feelings more effectively. **Always directly and openly discuss any aspects of the process that concern you.**

If you believe the person being treated is not getting adequate results from therapy, or if you do not feel comfortable with the therapist, **discuss the concerns openly**. A different approach, or even a different therapist, may be needed. Since therapy is a joint process, with therapist and client working together, it is important for the relationship to be a comfortable, trusting one. A competent therapist will be eager to discuss reactions to therapy and will respond to your feelings about the process. If medication has been prescribed, remember that it will take time for the body to make adequate adjustment. Especially with an older client, the doctor will start with a low dose and increase it very slowly, which means it may take a long time for the drug to have its full effect. **Be patient, but express your concerns.**

Types of Treatment

Psychotherapy

Psychotherapy is a method of talking face- to-face with a therapist. The following are a few of the types of available psychotherapy:

Behavior Therapy: Includes stress management, biofeedback and relaxation training to change thinking patterns and behavior.

Psychoanalysis: Involves long-term therapy meant to “uncover” unconscious motivations and early patterns to resolve issues and to become aware of how those motivations influence present actions and feelings.

Cognitive Therapy: Seeks to identify and change thinking patterns that can lead to troublesome feelings and behavior.

Family Therapy: Includes discussion and problem-solving sessions with family members. This may include several generations of the family.

Group Therapy: Includes a small group of people who, with the guidance of a trained therapist, discuss individual issues and help each other with problems.

Adjunct Therapies and Services

Movement/Art/Music Therapy: Includes the use of movement, art or music to express emotions. This type of therapy is effective for persons who cannot otherwise express feelings.

Medication Education: Includes information about what medications are prescribed. It is usually provided by the community mental health center nurse.

Mental Health Case Management: Includes assistance with coordination of services provided through the Community Mental Health Center and other community agencies. This service is provided by a mental health case manager.

Crisis Intervention: Involves evaluating the needs of a person in mental health crisis who may need more intensive assistance than outpatient therapy and/or medication.

Intensive case management services may be recommended to prevent a person from acting on impulses to harm self or others.

Psychosocial Programming: Involves activities for recreation and life skills training for persons who have limited social outlets or life skills abilities.

Medication Therapy

Medications can be beneficial to some persons with mental or emotional disorders. Before taking a medication, the person should ask about risk, possible side-effects and interaction with certain foods, supplements, alcohol or other medications. Medication should be taken in the prescribed dosage, at the prescribed intervals and should be monitored daily. (See section on Taking Medications Safely)

Electric Convulsive Treatment (ECT)

Electric convulsive treatment is a highly effective treatment for some major depressions. It has relatively few side effects, but must be carefully administered. Discuss the risks and benefits with a psychiatrist.

Some Resources for Support

Self-Help/Support Groups

Self-help/support groups bring together people with common experiences. Participants share those experiences, provide understanding and support, and help each other find new ways to cope with problems. There are support groups for almost any concern: grief, alcoholism, overeating, co-dependency, grandparenting, various mental illnesses, cancer, Parkinson's disease, Alzheimer's and many others. Support groups are offered not only for people who are coping with the problem, but in many cases for caregivers and family members as well. Sources of information about support groups in your community may be the local hospital, senior center, retirement facility, public library, and Area Agency on Aging. Also see the resource section of this directory.

Other Community Services

Finding the right treatment for a mental health disorder is important, but if the person also needs assistance with other activities (transportation, chore services or personal care, for example), other support services may be helpful. Following are some services that might be helpful for people with mental health disorders and their caregivers, and the kinds of organizations to contact in your community.

Some services are available at no charge, on a sliding scale, for a nominal fee or contribution. Some services have requirements for age and/or income levels. Case management services, which can coordinate use of other services, can be provided by agencies such as Area Agency on Aging, private care management services, employee assistance programs, etc.

Your local Area Agency on Aging is a good place to start if you are looking for information about several types of services in your community. (The Resource Section in this booklet lists services.)

Friendly Visitors/Companion Services:

Many communities have friendly visitor or companion programs, sometimes as part of a reassurance program. Contacts: Area Agency on Aging; local churches and synagogues; schools; neighborhood, social service, civic, social or volunteer organizations; home health; and hospice organizations.

Rides/Transportation:

Services provide door-to-door transportation that can accommodate wheelchairs, walkers, and other assistive equipment. Transportation can be available to medical care, senior center, grocery store, etc. Contact: Your area Transit Authority, senior center, public health department, home health or social service agencies, or religious and civic organizations.

Home Maintenance and Repair:

Services can include heavy cleaning, yard maintenance, snow removal and repairs. Contact: Area Agency on Aging, social service agencies, local neighborhood improvement or civic organizations, or community volunteer programs.

Homemaker and Chore Services:

Services help people with shopping, meal preparation, light housekeeping, and laundry. Contact: Area Agency on Aging, social service agencies, home health agencies.

Meals:

Communities have options for participating in group meals or receiving home-delivered meals, such as Meal on Wheels.

Home Health and Personal Care:

Services provide health and personal care for homebound individuals. Health care includes assistance with medications, skilled nursing care, physical therapy, etc. Personal care involves help with activities such as bathing, grooming or dressing. Some expenses of home health-care may be covered by insurance, but the person must be homebound and the care approved by her/his physician. Contact: your physician (for referral), home health services, social service and hospice organizations, health department or local hospital.

Older Adult Day and Respite Care:

Day programs offer a program of health, social and recreational services for adults who need some care and supervision. Programs often are located in long-term care or senior facilities. Some communities also have paid or volunteer respite services that offer caregivers relief for short periods or sometimes overnight. Contact: Area Agency on Aging, local long-term care facilities, home health and hospice organizations, religious groups, social service agencies.

Taking Medications Safely

People age 65 and older consume more prescriptions and over-the-counter (OTC) medicines than any other age group, according to the National Institute on Aging. Older people tend to have more long-term, chronic illnesses – such as arthritis, diabetes, high blood pressure and heart disease – than do younger people. Because they may have a number of diseases or disabilities at the same time, it is common for older people to take many different drugs.

If you are over 65, caring for someone over 65, or expect to be, now is a good time to make smart choices about medications, especially prescription drugs. It is important to tell your doctor if you have any drug allergies, to make sure your pharmacy has given you the exact drug prescribed by your doctor and to take the right dose at the right time. Something else to keep in mind: Getting older changes how you react to certain drugs, even those prescribed by doctors and those you have taken before.

For your safety, consider the following:

- ✓ Talk to your doctor. Ask Questions if you do not understand something.
- ✓ Be aware that you are at higher risk for side effects from certain drugs if you are over 65.
- ✓ Let your doctor know about all of your health problems. Some drugs should be avoided by people with specific health problems.
- ✓ Be sure you understand why the doctor wants you to take a new medicine.
- ✓ Do not hesitate to ask your doctor about a prescription drug – even one that you have been taking for years.
- ✓ Keep a list of all the medications you take. Include how much to take, how often to take it and why you take it. Be sure to include all over-the-counter medicines, vitamins, and herbal supplements. Even vitamins and supplements can interact with medications.
- ✓ Bring this list – or all your medicine and vitamin bottles – to your next doctor visit. Review it annually.
- ✓ Ask your doctor to pharmacist questions about what side effects to expect and when to call them about side effects that are serious.
- ✓ Some medications are not recommended for people over 65. Do not hesitate to check with your pharmacist if you have concerns about a particular medicine.
- ✓ Consider other options: instead of a pill to help you sleep, try a warm bath; instead of a pill to help you lose weight, exercise.
- ✓ Never stop taking a drug without asking your doctor.

Misuse of Medications

Another area of concern is the abuse or misuse of medications by older adults. Because of the number of medications an older person uses and the number of doctors the older person may see, there is a potential for confusion by health-care providers who prescribe the medications or by the patient who receives the medications. For this reason, it is important to use only one pharmacy as your pharmacist will have access to information regarding all of your prescriptions.

An older person may unsuspectingly abuse medication, increasing the risk of a potentially lethal drug-drug or a drug-alcohol interaction. Overuse of some medications, especially pain or sleeping medications, can lead to drug dependency.

Particular Concerns for Older Women

Midlife and older women in this country use a lot of medications but often don't perceive this as a concern. The problem is expected to increase with the aging of younger women drinkers and illicit drug users.

Alcohol and/or medication abuse in older women is often a reaction to fear, grief, pain, and/or loneliness. These issues must be addressed in the treatment process, along with the addiction.

Alcohol and/or medication abuse in midlife and older women is treatable, and adverse drug-drug or drug-alcohol interactions are often reversible.

Where to Look for Information

Your pharmacist or health-care provider can answer questions about whether the medications you are taking interact with each other, or interact with certain food, and can cause a bad reaction in your body. Be sure the pharmacist knows all the medications you are taking.

If you have access to the Internet, health-related and medication-related Web sites can provide information about interactions between specific medications and with certain foods. See the Resources section for some good general health Web sites.

Fact:

When someone asks about the medications you take, they need to know not only about prescriptions, but also about the over-the-counter remedies or nutritional supplements such as vitamins and herbs.

It is also important to be open about whether you drink any alcoholic beverages. Many medications do not mix well with alcohol, and in some cases the mixture can be deadly.

Some Additional Tips for Taking Medication

- Be sure you understand the directions for taking the medication. Ask about any special precautions. Check with your doctor or pharmacist.
- To be sure of the best benefit from the medication prescribed:
 - Read the label carefully and follow all the directions.
 - Establish a routine to avoid forgetting or resisting taking medication.
 - Use a pill box.
 - Do not stop taking medication without telling the doctor.
 - If you are caring for someone with dementia, be sure that the person has swallowed the medication by checking the inside of the cheek and under the tongue.

Dangers of Mixing Alcohol and Medication

Using alcoholic beverages should be avoided by anyone taking medications and by people with dementia. Alcohol may increase confusion and cause dangerous interactions with over-the-counter and prescription medications.

*****To be safe, consult your pharmacist or physician before consuming alcohol while taking any medication*****

Alcohol-medication Interactions

Alcohol, itself a drug, is often harmful when mixed with prescription or over-the-counter medicines. This is a major problem for people over 65, because they are often taking one or more prescription medicines and over-the-counter drugs. Mixing alcohol with other drugs such as tranquilizers, sleeping pills, pain killers, and antihistamines can be very dangerous – even fatal. For example, aspirin can cause bleeding in the stomach and intestines. When aspirin is combined with alcohol, the risk of bleeding is much higher.

In addition to possible interactions, older people are at risk of complications because the body's ability to absorb and dispose of alcohol and other drugs changes with age. Anyone who drinks should check with a doctor or pharmacist about possible problems with drug and alcohol interactions.

Precautions for Some Medications for Older Adults

Forty-eight medications or classes of medications to avoid in adults age 65 or older have been identified by experts who update the criteria for potentially harmful medications in older adults. The following are some of the medications that should be used with caution:

- Estrogen – a hormone replacement therapy
- Benadryl, Chlor-Trimeton, Vistaril, Atarax – antihistamines
- Elavil, Limbitrol, Triavil – Anti-depressants
- Barbiturates
- Some long-acting Benzodiazepines such as Librium, Librax, Valium, Dalmane
- Some medications for stomach disorders
- Lanoxin in doses over 0.125 mg/day – heart medication
- Demerol – a pain medication
- Miltown, Equanil - Tranquilizers
- Aldomet, Aldoril – Anti-hypertensive
- Talwin – a pain medication
- Ticlid – a blood thinner
- Incocin, Indocin SR – NSAIDS
- Most muscle relaxants

This is not an exhaustive list. For further information refer to www.hartfordign.org.

Making Medical or Financial Decisions

Medicare

If your Medicare card says "part B" or "medical insurance," you also have coverage for a doctor's care, emergency room and hospital outpatient visits, lab work, home health care visits, and durable medical equipment. You get this part of Medicare unless you tell Social Security you do not want it. It is a good idea to take it unless you have similar insurance at work or at your spouse's work. Medicare Part B does require you pay an annual deductible and a percentage of the cost of medical services as co-pay. You can save money by making sure you use doctors who accept Medicare assignment. This means that these doctors have agreed to charge no more than the amount Medicare has approved for any given service. The majority of Tennessee doctors accept Medicare assignment. Generally, Medicare does NOT cover prescription medication except if you are in a hospital or if the medicine must be given in a doctor's office, like chemotherapy.

Medicaid/TennCare

The following information on Medicaid and TennCare is provided by the TennCare Partner's Advocacy Line. The toll-free phone number is 800-758-1638.

What is TennCare?

TennCare is Tennessee's statewide managed health care program that provides health care benefits to people who qualify for Medicaid, uninsured children, and Tennesseans whose medical conditions make them uninsurable. Managed Care Organizations (MCOs) are responsible for the physical health benefits under TennCare.

What is TennCare Partners?

TennCare Partners is the part of TennCare that provides mental health and drug and alcohol abuse benefits to TennCare enrollees. Behavioral Health Organizations (BHOs) are responsible for the mental health, drug and alcohol abuse benefits under TennCare. Everyone enrolled in TennCare is also enrolled in TennCare Partners.

What benefits are covered?

There are many types of healthcare benefits available through TennCare and TennCare Partners. These may be different for each person.

Who is eligible for TennCare?

To be eligible for TennCare, you must be a Tennessee resident and meet other specific criteria.

How do I apply?

You must begin at your local Department of Human Services (DHS) office. You will complete an application and schedule an appointment with a DHS caseworker.

Can I have Medicare and still have TennCare?

The only kind of TennCare you can have if you have Medicare is TennCare Medicaid. The caseworker at DHS will screen you for Medicaid first. If you are not eligible for Medicaid, you cannot get TennCare at this time.

**Exception: Some TennCare enrollees who had Medicare AND TennCare Standard because they were uninsurable BEFORE December 31, 2001 may still have TennCare Standard.

What is TennCare Medicaid?

TennCare Medicaid is for certain people with low income who are also elderly, *or* disabled, *or* children, *or* SSI recipients, *or* pregnant women, *or* women under age 65 diagnosed with breast or cervical cancer.

What is TennCare Standard?

TennCare Standard is for people who do not qualify for TennCare Medicaid but whose medical conditions make them uninsurable.

How can I find out more?

The TennCare Partners Advocacy Line can help you learn more about **getting**, **keeping**, and **using** TennCare services.

Declaration for Mental Health Treatment

The Tennessee Mental Health and Developmental Disability law gives persons, 16 year of age and older, the right to be involved in decisions about their mental health treatment. It also recognizes that some individuals are, at times, unable to make such decisions. A **Declaration for Mental Health Treatment** allows persons receiving mental health services to plan ahead. This form describes what mental health services a person wants to receive. It describes the services the person might consider and the conditions under which the declaration will be enacted. It also gives direction on how the declaration may be revoked. For more information or to access this form go to: http://www.state.tn.us/mental/t33/DHMT_FORM.pdf

Living Wills and Durable Power of Attorney

A **Living Will** is a legal document that allows an individual to make known wishes concerning the use of life prolonging treatments This includes feeding tubes or breathing machines. A living will is written while an individual is still able to make decisions for him/herself. It is a good idea for everyone to get a living will so others will know their wishes. If you decide you want to draft a living will, discuss it with your primary care physician or your lawyer. In addition, a living will can be canceled at any time by notifying your physician.

Durable Power of Attorney for Health Care is a legal document with allows an individual to name a particular person to make decisions regarding medical care when or if they are not able to make decisions for themselves. You can also name someone to make financial decisions for you if you are ever not able to do so. This person should be someone you trust to carry out your wishes, possibly a family member. If you are interested in assigning someone to be your Power of Attorney you can also discuss this with your primary care physician or your lawyer. This also may be canceled or changed at any time, as long as the person has the capacity to do so, by notifying the named person or your physician in writing.

Both of these legal documents and must be signed by two witnesses. The witnesses cannot be relatives, your health care provider or anyone who is entitled to part of your estate upon death. Copies of these documents should be given to family or friends and your health care provider.

Advance Directives is another way to make your wishes for treatment known. This is done in writing, in advance, prior to having a disabling illness. It states you choice about treatment. It may also name someone to make such choices if you are unable to do so.

Housing and Services

Independent and Assisted Living

Assisted living communities provide help with activities of daily living (ADL), which include bathing, dressing, meals, housekeeping and toileting. In addition, assisted living staff provide reminders and assistance with taking medications. Each assisted living facility is different and has different levels of care available, so it is important to ask questions about fees for services, staffing, and resources for seniors within each community.

Skilled and Long-term Care

Nursing homes are licensed by the state and must meet specific standards of patient rights, fire safety, patient care provisions for quality of life and quality of care, etc. Specific federal regulations also apply to all nursing facilities that participate in the Medicare and/or Medicaid programs. The Tennessee Board for Licensing Health Care Facilities determines the requirements for licensure and has the authority to revoke or suspend licenses. The Board also ensures compliance with the regulations by carrying out unannounced surveys of nursing homes. It is recommended that licensure be verified by contacting the Board at **1-800-778-4504**, or visiting this Internet address: www.state.tn.us/health.

Generally, **skilled care** is paid for by Medicare or other insurances, and includes rehabilitative services such as speech therapy, physical therapy and occupational therapy. **Intermediate care**, or maintenance care, is a less intensive level of care than skilled nursing, and is **not** paid for by Medicare. Most intermediate care facilities accept both Medicaid and private pay.

Home Care Related Services and Hospice

Home health skilled medical services are provided by licensed or certified medical professionals in your home, and they may include physical, occupational or speech therapy, blood work, intravenous medications or fluids, wound care, and disease management education.

Non-medical in-home services, such as bathing assistance, errands, light housekeeping and sitter/companion care, are not paid for by Medicare or most insurances unless they are provided at the same time as a skilled service.

Resource Guide

County Health Departments in Tennessee

Each of the 95 counties in Tennessee has a County Health Department that may be able to help you identify services and resources that are available in your county. Many health departments offer flu and pneumonia shots during the fall months. Health Departments also offer education and prevention services on health related issues such as diabetes and nutrition. Check your telephone directory to find the location and phone number of the Health Department in your county. You should find it listed under your county's listing in the white or blue pages.

Want to Learn More? Some Helpful Books

- Burnham, R.W. (1994). Life's Third Act: Taking Control of Your Mature Years. New York: MasterMedia.
- Carter, R. & Golant, S. (1998). Helping Someone with Mental Illness: A Compassionate Guide for Family, Friends, and Caregivers. New York: Times Books.
- Carter, R. & Golant, S. (1994). Helping Yourself Help Others: A Book for Caregivers. New York: Random House.
- Colleran, C & Jay, D. (2002). Aging & Addiction: Helping Older Adults Overcome Alcohol or Medication Dependence. Minnesota: Hazelden.
- Golant, M. & Golant, S. (1996). What to Do When Someone You Love is Depressed. New York: Henry Holt.
- Gorman, J. M. (1996). The New Psychiatry: The Essential Guide to State-of-the-Art Therapy, Medication, and Emotional Health. New York: St. Martin's Press.
- Gwyther, L. (1985). Care of Alzheimer's Patients: A Manual for Nursing Home Staff. Washington, DC: American Health Care Association and Alzheimer's Disease and Related Disorders Association.
- Hatfield, A. (1991). Coping with Mental Illness in the Family: A Family Guide. Washington, DC: National Alliance for the Mentally Ill.
- Kuber-Ross, Elizabeth. (1969). On Death and Dying. New York: MacMillan.
- Lefley, Harriet. (1996). Family Caregiving in Mental Illness. Thousand Oaks, CA: Sage.
- Mace, N. & Rabins, P. (1999). The 36 Hour Day (third edition). Baltimore: John Hopkins University Press.

National Family Caregivers Association. (1996). The Resourceful Caregiver: Helping Family Caregivers Help Themselves. New York: Mosby

Yearbook. Research and Education Association. (1995). New Developments in the Biology of Mental Disorders. Piscataway, NJ: Research and Education Association.

Rowe, J.W. & Kahn, R.L. (1998). Successful Aging. New York: Pantheon Books.

Schiller, L. & Bennet, A. (1994). The Quiet Room. New York: Warner Books.

Smyer, M. & Qualls, S. (1999). Mental Health and Aging. Malden, MA: Blackwell Publishers.

Weiden, P., Scheifler, P., Diamond, R. & Ross, R. (1999). Breakthroughs in Antipsychotic Medications: A Guide for Consumers, Families, and Clinicians. New York: W.W. Norton

Resources for Information and Self-help Groups

More and more information is available on the internet. For those who do not have a computer, many public libraries have computers, as do some Senior Citizen Centers. New websites are developed every day and some old ones change their web address. The information below is correct as of June, 2004 but changes can be expected. If an address changes, it usually provides a link from the old address to the new one. If not, you can type the organization name in the "search" area and you will be able to access it in that manner.



Phone Information/Help Line



Referral Options and/or support



Fact Sheets/Newsletters



Self-help and/or support groups



Policy/Legislative Updates



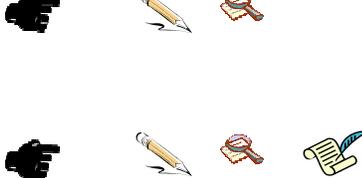
Research Updates



Bookstores, reviews, tapes, etc

General Health Web Sites

	Resources	Web Site
<p>HealthFinder A service of Health and Human Services</p>		<p>www.healthfinders.gov</p>
<p>AMA Health Insight Consumer Health Information sponsored by the American Medical Assn.</p>		<p>www.ama-assn.org/ama/pub/category/3457.html</p>
<p>National Women's Health Information Center (NWHIC) 800-994-WOMAN (800-994-9662) 703-560-6598 (FAX) TDD: 888-220-5446 Links to Federal health Clearinghouses, private sector organization resources</p>		<p>www.4woman.gov/</p>
<p>Mayo Clinic Health Oasis Men's, Women's, Alzheimer's Centers</p>		<p>www.mayohealth.org</p>

<p>Mental Health Net (Web only) (Sponsored by CMHC Systems)</p>		<p>http://mentalhelp.net</p>
<p>American Psychological Assn Phone: 202-336-5700 Psychology in Daily Life Consumer Information/Fact Sheets Mental Health Patients Bill of Rights Help Center</p>		<p>Psychology in Daily Life www.apa.org/pubinfo Help Center helping.apa.org</p>
<p>Institute of Gerontology Phone: (313) 577-2297 Fax: (313) 875-0127</p>		<p>www.iog.wayne.edu</p>
<p>American Geriatrics Society Phone: 212-308-1414 Fax: 212-832-8646 Consumer Education Page AGS Foundation for Health in Aging</p>		<p>www.americangeriatrics.org www.healthinaging.org</p>
<p>National Mental Health Consumer's Assn (NMHCA) Phone: 216-241-3400 Fax: 216-861-5067 Advocacy for patients' rights, consumer-run programs, representation</p>		
<p>National Mental Health Consumers' Self-help Clearinghouse Phone: (800) 553-4539 Fax: (215) 636-6312 Technical assistance for self-help groups</p>		<p>www.mhselfhelp.org/program.html</p>
<p>GriefNet (Web only)</p>		<p>www.rivendell.org</p>
<p>Dual Diagnosis Recovery Network (DDRN)</p>		<p>www.dualdiagnosis.org</p>

<p>Northeast/Southeast Tennessee Chapter Chattanooga, TN Help Line: 800.616.1922 Northeast Tennessee Regional Office Phone: 423.928.4080</p> <p>Eastern Tennessee Chapter Phone: 865.544.6288</p>		<p>www.tnalz.org</p>
<p>Alzheimer's Disease Education and Referral (ADEAR) Center</p> <p>A service of the National Institute on Aging Phone: 800-438-4380</p>		<p>www.alzheimers.org</p>
<p>Alzheimer's Disease Research Center - Washington University <i>The Alzheimer's Page</i> Links to many Alzheimer web pages</p>		<p>alzheimer.wustl.edu/adrc2</p>
<p>Depressive and Bipolar Support Alliance (DBSA)</p> <p>Toll free: (800) 826 -3632 Fax: (312) 642-7243</p>		<p>www.dbsalliance.org</p>
<p>Tennessee Suicide Prevention Network</p> <p>Phone: 615-297-1077 Fax: 615-383-9714</p>		<p>www.tspn.org</p>
<p>National Institute on Drug Abuse</p> <p>Phone: 301-443-1124</p>		<p>www.nida.nih.gov</p>
<p>Substance Abuse and Mental Health Services Administration General Information on Substance Abuse, Mental Health issues, HIV, Violence, etc. National Clearinghouse for Alcohol and Drug Information</p>		<p>www.samhsa.gov</p> <p>www.health.org</p>
<p>Alcoholics Anonymous Middle TN Central Office Phone: 615-831-1050 Meeting times, locations and information</p>		<p>www.aa.org</p> <p>www.aanashville.org</p>

<p>Gamblers Anonymous Phone: (213) 386-8789 Fax: (213) 386-0030</p> <p>Nashville Hotline Number: (615) 254-6454 Memphis Hotline Number: (901) 371-4083</p>	 	<p>www.gamblersanonymous.org</p>
<p>Debtors Anonymous Phone: 781-453-2743 Fax: 781-453-2745 Nashville, TN Office 615-269-3628</p>	  	<p>www.debtorsanonymous.org</p>
<p>Other Helpful Resources</p>		
<p>FirstGov for Seniors (Web only) Wealth of resources for government programs and other programs for seniors</p>	    	<p>www.firstgov.gov/Topics/Seniors.shtml</p>
<p>Administration on Aging (AoA) Phone: 202 619-0724 □ National Aging Information Center</p>	     	<p>www.aoa.dhhs.gov</p>
<p>American Association of Retired Persons (AARP) Phone: 800-424-3410 AARP Tennessee Phone: 1-866-295-7274 (toll-free) Fax #: (615) 313-8414</p>	    	<p>www.aarp.org www.aarp.org/states/tn/</p>
<p>National Family Caregivers Assn Phone: 800-896-3650 Fax: 301-942-2302</p>	     	<p>www.nfcares.org</p>
<p>Family Caregiver Alliance Phone: 800-445-1806 On-line Resource Center</p>	     	<p>www.caregiver.org</p>

Glossary of Terms

Activities of Daily Living: A term used to describe things people do on a daily basis such as bathing, dressing, cooking, walking, etc.

Acute: having a sudden onset or quickly becoming worse; lasting a short time

Adult Day Care: Supervised care and social stimulation for older adults with mental and/or physical disabilities; meals, activities, exercise and music are usually offered

Agitated: excessive motion when feeling inner tension: restless, inability to sit still, pacing, wringing of hands, pulling at clothes

Antidepressants: medications that help alleviate symptoms of depression

Antipsychotics: medications used to decrease symptoms of psychotic disorders

Anxiety: feeling of fear, unexplained nervousness or dread that something terrible will happen

Assisted Living: A retirement community where seniors have access to a variety of support services such meals, housekeeping, activities, transportation and assistance with bathing, dressing & medications

Atypical: not typical; unusual or irregular

Alzheimer's disease: illness that affects the way the brain works; damage occurs when cells are lost and nerves are damaged; causes general deterioration of mental ability

Biofeedback: training program designed to develop a person's ability to control his/her involuntary nervous system

Chronic: marked by long duration or frequent reoccurrences (as in arthritis, heart disease, asthma)

Conservatorship: A "conservator" is someone appointed by a court to legally make decisions for the care of an incapacitated adult and/or to manage his/her property. A "guardian" refers to a similar responsibility for a child under 18 years of age

Conspicuous: obvious, attracting attention, noticeable

Continuing Care Retirement Community: A residential facility offering varying levels of care: Independent Living, Assisted Living and Nursing Home

Delusion: false belief

Dementia: a general term for several diseases which cause changes in a person's thinking, ability to remember, reasoning and judgment

Durable Power of Attorney (for Health Care/Financial): The same as a regular Power of Attorney except it remains in effect should the signer become mentally incapacitated, and it includes the type of decisions that can be made for the signer

ECT: electroconvulsive therapy; use of an electric impulse to the brain to treat some cases of major depression

Elder Abuse: Physical, emotional, or sexual abuse, neglect (including self neglect), or exploitation of financial resources of an older adult

Hallucination: perception having no relation to reality and not accounted for by any outside factor; most common are hearing or seeing things no one else does

Home Care: Assistance provided in the home, such as help with bathing, dressing, healthcare, and housekeeping. Many providers also offer transportation and errand service

Hospice: End-of-life care for terminally ill patients and their families; covered by Medicare

Incoherent: unable to express one's thought in an orderly manner

Intermediate Care (nursing home): A less intensive level of care than skilled nursing (e.g. assistance with bathing/dressing/eating); not covered by Medicare

Living Will: A signed legal document expressing a person's wishes for certain medical care (i.e. artificial life support) near the end of their life

Mania: characterized by abnormal excitability, exaggerated feelings of well-being; flight of ideas, excessive activity

Medicaid: federal/state cooperatively funded and state-operated program of health benefits available to eligible low-income persons, established under Title 19 of the Social Security Act; states determine program benefits, eligibility requirements and rates of payments for agencies and institutions that provide services, as well as methods of administering the program under federal guidelines; Medicaid operates in every state except Arizona, which has a comparable program

Medicare: Federal health insurance program for persons age 65 and over who are eligible for Social Security or Railroad Retirement benefits and for some under age 65 who are disabled; program has two parts: hospital insurance (Part A) covering inpatient hospital, skilled nursing care and home health; and supplementary medical insurance (Part B) covering physician and other services, is voluntary, requires monthly premium

Medicare Plus Choice: An alternative to traditional Medicare including Health Management Organizations (HMO's) and private fee for service plans

Medigap insurance: private health insurance purchased to cover the gaps, and often some additional services, not covered by Medicare

Metabolic system: chemical and physical changes that take place within human cells

Neurotransmitters: chemical substances in the brain (such as dopamine, serotonin) that transmit nerve impulses across a synapse

Power of Attorney: A signed, legal document giving a designated person the right to fully or partially manage the signer's financial affairs

Psychosis: mental disorder marked by impairment in person's ability to think, remember, interpret reality and behave appropriately

Psychotherapy or Therapy: therapy involving talking with a professional about problems and issues in an individual's life

Respite Care: Short term or overnight care for an elderly person so that the caregiver can have "time off"

Schizophrenia: brain disorder characterized by disordered perceptions, thinking and behavior that has a comprehensive effect on personal, social and work functioning

Skilled Nursing Care (nursing home): Level II care that includes care provided by a nurse, physical therapist, speech therapist, or occupational therapist

Social Security: A government program offering financial assistance due to retirement, death of a wage earner (survivor), or disability

Stigma: mark of disgrace or reproach

TennCare: Tennessee's health insurance for low income or uninsurable residents. Qualifying seniors can be insured by both TennCare and Medicare, with TennCare serving as a Medicare supplement

Testamentary: capacity and ability to make a will

References

The information presented in this guide reflects the contributions of many individuals and organizations. Some of the resources used include:

Kansas Mental Health and Aging Coalition: A Mental Health Guide for Older Kansans and Their Families

The following references are some of those sited in the Kansas guide: Administration on Aging. (1998). Administration on Aging
[<http://www.aoa.gov/prof/Statistics/Census2000/2000pop/2000pop.asp>]

Adult Development and Aging Division 20. (1999). Self-Help Materials for Older Adults [www.iog.wayne.edu/apadiv20/clingd4.htm] (9/15/99)

American Association of Retired Persons. Washington, D.C.: American Association of Retired Persons.

(1991) "So many pills and I still don't feel good."

(1993) Late Life Depression and Suicide Potential.

(1989) "I wonder who else can help."

(1989) "If only I knew what to say or do..."

(1990) Backgrounder: Stress in Later Life.

(1991) Is Drinking Becoming a Problem?: Older Women and Alcohol.

(1991) "If only I could get a good night's sleep!"

(1993) Backgrounder: Depression in Later Life.

(1994) Backgrounder: Alcohol Abuse among Older People.

American Association of Retired Persons and Hazeldon Foundation. (1995). Alcohol, Medications and Older Adults. Washington, D.C., Center City MN: American Association of Retired Persons.

American Bar Association (ABA). (1991). Patient Self Discrimination Act: State Law Guide. Washington, D.C.: ABA Commission on Legal Problems of the Elderly.

American Heart Association. (1994). How Strokes Affects Behavior. Dallas Texas: American Heart Association.

American Medical Directors Association. (1997). Understanding Depression in the Elderly. Plainsboro, NJ: Multi-Media Health Care/Freedom, LLC.

American Psychiatric Association. (1994). DSM IV: Diagnostic and Statistical Manual of Mental Disorders (4th). Washington, D.C.: American Psychiatric Association.

Anderson, E., & White, D. (1988). *Good Grief: Healing the Pain of Loss*. Wisconsin: Wisconsin Clearinghouse.

Arapakis, M. (1998). *Staying Young at Heart*: Denver, CO: SoftPower Resources, Inc.

Bender, P. (1992). Deceptive Distress in the Elderly. *American Journal of Nursing*, (October), 29-32.

Blume, S.B. (1992). *Compulsive Gambling: Addition without Drugs*. Harvard Mental Health Letter: February, 1992.

Bristol-Meyers Squibb Company. (1992). "Profiles of Persistent Anxiety." Princeton, N.J.: Bristol-Myers Squibb Company.

Bristol-Myers Squibb Company. (1998). *What is anxiety?* Princeton, N.J. Bristol-Myers Squibb Company.

Brown University Long-Term Care Quality Advisor. (1999). 11(2).

Bruce, M. (1997). *The Cost of Depression in Late Life*. *The Decade of the Brain*, (vol. 8). Arlington, VA:

The National Alliance for the Mentally Ill. Caregiving. (1999, 7/18). Caregiving - Online Support: Help
[www.caregiving.com/support/html/helpyou.htm] (7/18/99).

Carman, M. (March 1997). *The Psychology of Normal Aging*. Philadelphia, PA: The Psychiatric Clinics of North America.

Davis, E., et. al. (1996). *A Caregiver's Guide for Alzheimer's and Related Disorders*. Manhattan Kansas:

Kansas Department on Aging and Kansas State University Agricultural Experiment Station and Cooperative Extension Service.

Federal Council on Aging. (1995). *Federal Council on Aging's Annual Report*. Washington, D.C.

Federal Council on Aging. (1995). *Mental Health and Aging*. 1995 White House Conference on Aging. Washington, D.C.: Federal Council on Aging.

Haber, D., (1999). *Health Promotion and Aging*. Springer Publishing Company.

Harris, H.W. (1997). *Pharmacological Treatment of Depression Late in Life*. *The Decade of the Brain*, (vol. 8). Arlington, VA: The Alliance for the Mentally Ill.

- Hoffman, R.S. & Koran, L. (1984). Detecting physical illness in patients with mental illness.
- Katz, I. (1997). Biology of Late Life Depression. *The Decade of the Brain*. (vol. 8). Arlington, VA: The Alliance for the Mentally Ill.
- Lebowitz, B.(1997). Depression in Late Life:Progress and Opportunity. *The Decade of the Brain*, 8(summer). Arlington, VA: The National Alliance for the Mentally Ill.
- Massachusetts Council on Compulsive Gambling. (1999). What is Compulsive Gambling? [www.masscompulsivegambling.org] (9/1).
- Martin, M. (March 1997). Late-Life Psychiatric Diagnosis in DSM-IV. Philadelphia, PA: The Psychiatric Clinics of North America.
- Million, T. with Davis, D. (1991). *Disorders of Personality: DSM-IV and Beyond*. New York: Wiley & Sons.
- National Institute of Mental Health. (1980). Fact Sheet: Depression in the Elderly. Rockville, MD: U.S. Department of Health, Education, and Welfare.
- National Institute of Mental Health. (1990). If You're over 65 and feeling depressed. Washington, D.C.: U.S. Department of Health and Human Services.
- National Mental Health Association. (1990). *The 50 Plus Experience. Depression: How to Understand and Deal with it*. Alexandria, VA: National Mental Health Association.
- National Mental Health Association. (1990). *Answers to Your Questions About Clinical Depression*. Alexandria, Virginia: National Mental Health Association.
- Organon Inc. (1998). *Anxiety: A Symptom of Depression*. U.S.A.: Organon Inc.
- Palmore, E.B. (1998). *The Facts on Aging Quiz (second edition)*. New York: Springer Publishing, Inc.
- Preskorn, S., (1999). *Outpatient Management of Depression: A Guide for the Primary-Care Practitioner,* Second Edition: Professional Communications, Inc.
- Rando, T.A. (1988). *Grieving: How to Go on Living When Someone You Love Dies*. Massachusetts: Lexington Books.
- Rando, T.A. (1984). *Grief, Dying and Death: Clinical Interventions for Caregivers*. Champaign, Illinois: Research Press.

Reynolds, C., Small, G., Stein, E., & Terri, L. (1994). When Depression Strikes the Elderly Patient. *The Practical Journal for Primary Care Physicians*, 28(February), 1-16.

Rowe, J.W., M.D. and Robert L. Kahn. (1998). *Successful Aging*. New York: Pantheon Books.

Sadavoy, J., Lazarus, L., Jarvik, L., & Grossberg, G. (Eds) (1996). *Comprehensive Review of Geriatric Psychiatry-II*(second edition). Bethesda, MD: American Association of Geriatric Psychiatry.

SAMHSA. (1998). *Drug Abuse by Senior Adults Is an Epidemic Says CSAT/SAHMSA Report* [www.health.org:80/pubs/elderly/TRENDS2.htm] (7/7/99).

SmithKline Beecham Pharmaceuticals. (December 1998). *Social Anxiety Disorder: Is it More Than Just Shyness?* Philadelphia, PA: SmithKline Beecham Pharmaceuticals.

SmithKline Beecham Pharmaceuticals. (March 1998). *Anxiety Disorders: You Don't Have to Live in Fear*. Philadelphia, PA: SmithKline Beecham Pharmaceuticals.

Smyer, M. & Qualls, S. (1999). *Aging and Mental Health*. Malden, MA: Blackwell Publishers.

The National Institute on Aging. (1995-1999). *Age Pages*. U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health.

Wolfelt, A. (1988). *Death and Grief: A Guide for Clergy*. Muncie, Indiana: Accelerated Development.

Zarit, S. H., & Knight, B.G. (1985). *The hidden victims of Alzheimer's disease: Families under stress*. New York: New York University Press.

In addition to the above references, the following references were used to assemble this directory:

Beers, MH, et al. Explicit criteria for determining inappropriate medication use in nursing home residents. *Archives of Internal Medicine* 1991;151(9):1825-1832. Last Updated June 16, 2003

[<http://mqa.dhs.state.tx.us/QMWeb/MedSim/MedSimTable1.htm>]

Colleran, C. & Jay, D. (2000). *Aging & Addiction: Helping Older Adults Overcome Alcohol or Medication Dependence*. Minneapolis: Hazelden.

Ensuring Solutions to Alcohol Problems. (2004). *How Alcohol Complicates Medication Use*. Washington, DC. [www.ensuringsolutions.org]

GoErie.com. (2003). *Taking Medications Safely*. Prime Life Styles.

Hartford Institute for Geriatric Nursing. (1999). Understanding the HCFA Guidelines for Potentially Inappropriate Medications in the Elderly – Optimizing Prescribing in Long-Term Care (Merck & Co.) [www.hartfordign.org]

HealthGate Data Corp. (2003). Alcoholism in the Elderly. Warren, MI [www.stjohn.org/healthinfolib]

Jackson, T, MCG. (2003). Criteria for medications to avoid in the elderly updated. EurekaAlert. Medical College of Georgia.

Molony, S, MS, APRN. Beer's Criteria for Potentially Inappropriate Medication Use in the Elderly. Best Practices in Nursing Care to Older Adults. Issue Number 16. Hartford Institute for Geriatric Nursing.

National Institute on Alcohol Abuse and Alcoholism. (1998) Alcohol and Aging. Alcohol Alert. Number 40.

National Institute on Mental Health. (2003). Older Adults: Depression and Suicide Facts. NIH Publication No. 03-4593

Tennessee Department of Mental Health Developmental Disabilities (2001). Declaration for Mental Health Treatment: A Document to Help People Make Choices About Their Mental Health Treatment & A Guide for Providers. State of Tennessee. U.S Food and Drug Administration. (1997). Medication and Older People. FDA Consumer Magazine, Publication Number FDA 03-1215C.

United Way of Middle Tennessee (2003). Community Needs Assessment.