

MEETING THE MENTAL HEALTH CHALLENGES OF THE ELDER BOOM

by

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America is aging. The number of adults who are 65 or older in the United States will more than double between 2010 and 2050, and they will increase from 13% of the population to 20% (Grayson & Velkoff, 2010).

This has fueled great concern about the viability of the Social Security system, about the sustainability of Medicare, and about the availability of a workforce to provide health and social services for older people. There is also widespread concern about the physical health of older adults and about Alzheimer's disease.

But for the most part, other mental health needs are overlooked. This is unfortunate for five basic reasons.

First, contrary to the underlying ageist assumptions of our culture, people can live well in old age, but mental illness is a barrier to well-being. Mental health promotion and effective treatment of mental illness are, therefore, critical to successful aging.

Second, approximately 20% of older adults have diagnosable mental and/or substance use disorders, including dementia (U.S. Department of Health and Human Services, 1999). Over time, the most common mental disorder is dementia—the prevalence of which doubles every five years beginning at age 60 (U.S. Department of Health and Human Services, 1999; Cummings, & Jeste, 1999). But the range of behavioral health problems also includes:

- anxiety and mood disorders, which often co-occur with dementia in its early and middle stages
- psychotic conditions, such as schizophrenia and severe mood disorders
- substance use disorders.

Some of these mental and substance use disorders begin early in life; some become more severe later in life; others emerge in old age.

Third, mental illness can have terrible impacts on physical health. People with mental disorders are more likely to have physical disorders, and people with co-occurring physical and mental and/or substance use disorders are at higher risk for disability, premature death, and far higher medical costs than those with physical disorders alone (Kilbourne, et al., 2005; Husaini, 2000; Katon, & Ciechanowski, 2002).

Fourth, untreated mental and/or substance use disorders contribute to avoidable placements in institutions, such as nursing homes, probably driving up the costs of long-term care (Friedman, 2009). They also contribute to social isolation and high suicide rates among older adults (Centers for Disease Control and Prevention, 2007).

Fifth, all older adults face emotional, developmental challenges, including: social and occupational role changes, diminished—but not lost—physical and mental abilities, losses of family and friends, and the inevitability of death.

In order to achieve the major goal of community mental health, which is to help people with mental disorders avoid institutionalization and live where they prefer in the community, a number of key changes are needed in the systems of care for older adults. These include: (1) supports for family caregivers, who provide 80% of the care (Spillman, & Pezzin, 2000) for adults with disabilities, (2) housing alternatives to institutions for those who cannot remain at home without extensive support, (3) improved access to mental health and substance abuse services in community settings, (4) improved quality of services in community-based and institutional settings, (5) a larger and more clinically, culturally, and generationally competent workforce, (6) increased integration of physical and mental health care, (7) home-based services for those who are able to live in the community but are physically or psychologically homebound, (8) increased collaboration with the aging services system, (9) enhanced outreach and mental health education in the community, and (10) increased and restructured mental health financing, and more.

This chapter focuses on the behavioral health challenges of old age. Part 1 provides an overview of demographic shifts and epidemiological data. It also includes information about the major mental and substance use disorders of old age and about interventions that are helpful to people with such disorders. Part 2 addresses the failure of mental health policy in the U.S. to anticipate the elder boom and identifies key policy changes needed to meet its mental health challenges.

Part One: Mental and Substance Use Disorders in Old Age

The March of Demography

Over the first half of the 21st century, the number of adults 65 and older in the United States will more than double from 35 million in 2000 to 88.5 million in 2050. The greatest growth will take place between 2010 and 2030, when the population of older adults will increase from 40 million to 72 million (Grayson & Velkoff, 2010).

More important than the growth in numbers is the growth of older adults as a proportion of the population from 13% to 20% (Grayson & Velkoff, 2010). Because the working age population will decline by 5% as a proportion of the population (Grayson & Velkoff, 2010), there are great concerns about the viability of Social Security pensions and Medicare. There are also concerns about whether there will be enough workers in the helping professions to provide the care that disabled older adults will need.

In addition, during the first half of the 21st century there will be a vast increase in both the number and proportion of minorities. The Census Bureau projects that by 2042, minorities will outnumber whites in the United States. For older adults, the Census Bureau projects that the minority proportion of the older population will grow from about 15% in 2000 to 20% in 2010 to nearly 30% in 2030 and 42% in 2050 (Grayson & Velkoff, 2010). Although the Asian population will grow at the fastest pace, Latinos will be by far the largest portion of the minority population.

This demographic change makes issues of cultural competence increasingly important. Can the systems of care for older adults in the United States, which currently are not adequately responsive to the needs of minorities, develop the capacity to meet the needs of an ever larger population?

Mental and Substance Use Disorders Among Older Adults

Approximately 20% of older adults have one or more diagnosable mental and/or substance use disorders in any given year (U.S. Department of Health and Human Services, 1999). This does not include people with emotional distress that does not meet the criteria for a diagnosis as a mental illness or substance **misuse** that does not meet the criteria for **abuse***.

Assuming that the prevalence of mental and substance use disorders among older adults remains constant, the number of older adults with diagnosable mental illnesses in the U.S. will more than double from 8 million in 2010 to 14 million in 2030 to 18 million in 2050 (Kessler & Wang, 2008; Grayson & Velkoff, 2010).

Given the shortage of geriatric mental health services now, it is doubtful that so much growth can be handled without higher than proportional growth of mental health professionals, as well as restructuring provider roles so as to get the most possible from other professionals, such as physicians and social workers, from paraprofessionals such as recreation workers and companions, and from volunteers, including retired older adults. (Bartels, Pepin, & Gill, 2014).

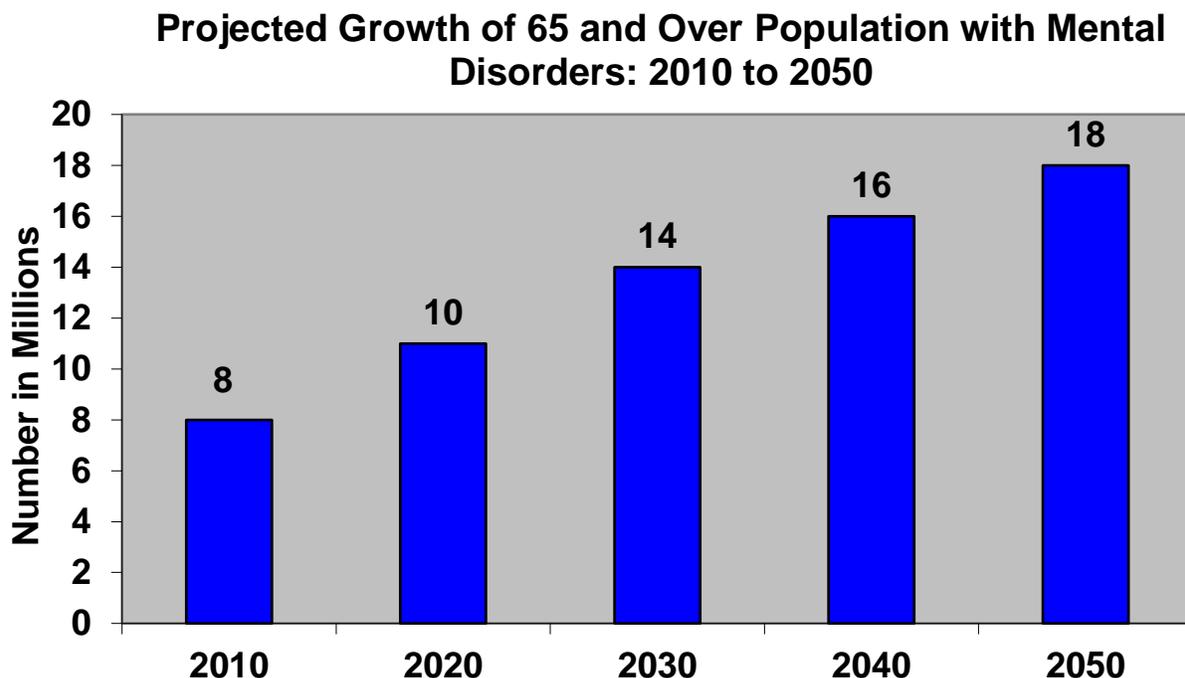
Older adults with mental disorders are a heterogeneous population, most of whom live, and want to remain, in the community. They include:

- ❑ People with long-term psychiatric disabilities who are aging
- ❑ People with psychotic conditions that develop in late life
- ❑ People with dementia, most commonly Alzheimer's disease
- ❑ People with mild to severe mood and/or anxiety disorders
- ❑ People with substance use problems, primarily alcohol and prescription drug misuse, but also some abuse of illegal substances including some people with lifelong addictions
- ❑ People whose behavior is challenging to their caregivers

* For example, 17% of the population of older adults drinks excessively (U.S. Department of Health and Human Services, 2009) but less than 2% have a diagnosable alcohol or drug use disorder (U.S. Department of Health and Human Services, 2009).

- People with emotional problems adjusting to old age.

GRAPH 1



Prevalence of Mental and Substance Use Disorders Among Older Adults

PREVALENCE OF MENTAL DISORDERS AMONG YOUNGER AND OLDER ADULTS
(U.S. Department of Health and Human Services, 1999)

Type of Disorder	Ages 18-54	Ages 55+
Any Disorder	21%	19.8%
Any Anxiety Disorder	16.4%	11.4%
Any Major Mood Disorder	7.1%	4.4%
Schizophrenia	1.3%	.6%
Severe Cognitive Impairment (Mostly dementia)	1.2%	6.6%
Anti-social Personality	2.1%	-

While the overall prevalence of mental disorders is roughly the same among older and younger populations, the mix of disorders varies significantly. The prevalence of anxiety and mood disorders and of psychotic conditions declines in old age; dementia increases.

The prevalence of alcohol and substance abuse is hard to estimate because different studies use different age ranges and different definitions of substance misuse and

abuse. Common estimates in the 20% range include arguable misuse of alcohol that is clearly not a substance use disorder. Diagnosable alcohol and drug abuse disorders are much less common. Whatever the number, it is clear that the use and misuse of alcohol and illegal drugs has declined with age in the current generation of older adults. Abuse of prescription and over-the-counter medications, however, rises—in part because of chronic pain. (Friedman, MB & Williams, K. 2015)

Lifelong and Late Life Disorders

It is useful to distinguish older adults with lifelong mental and/or substance use disorders from those with late life disorders. With the exception of dementia, most people with mental illness in old age have had mental illness earlier in life as well (Kessler, et al., 2005). Often, it has not been severe enough to be a major problem. Typically, something happens in later life that exacerbates the disorder or precipitates its reoccurrence after remission, such as the death of a spouse, job loss, or serious physical illness or injury.

In addition, it is very important to distinguish between people with long-term psychiatric disabilities and people with diagnosable mental and/or substance disorders that do not cause severe disability.

People With Long-Term Psychiatric Disabilities Who Are Aging

Mr. C., who just turned 79, has suffered from severe mental illness since his early 20's. He lived in a state hospital for many years, moved to a single room occupancy hotel (SRO) during deinstitutionalization, became homeless when SROs were converted to luxury housing, but eventually was housed in an apartment where case managers check in as needed. In the beginning his parents provided extra supports and advocated on his behalf, but they died ten years ago, and his siblings do not live nearby. As he has aged, he has become increasingly obese. Now he has diabetes and arthritis and the beginnings of dementia. His case manager has been unable to arrange good medical care or to find appropriate housing in the community. He has begun to consider referring him to a nursing home. Mr. C's fate will become increasingly common as more people with serious and persistent mental illness become elderly.

The population of adults with serious long-term psychiatric disabilities who are 65 or older is a very small portion of the general population—about 1% (McAlpine, 2003). But these are the people who have been the traditional, primary responsibility of the public mental health system. They include people with schizophrenia and people with severe mood disorders, such as bipolar disorder, which are "treatment refractory", i.e. do not respond to treatment. Many--if not most--of this population have had (or currently have) co-occurring substance use disorders. Most people with severe, persistent mental disorders experience functional disabilities related to their illnesses. Over time, a significant number of people with long-term psychiatric disabilities "recover" (Anthony, 1993). Some become asymptomatic, while others may continue to experience symptoms of schizophrenia or a major mood disorder but become more able to function independently and develop lives that they find satisfying and meaningful. Some of those who have experienced "recovery" have become important leaders in the field of mental health.

One of the reasons that the prevalence of serious and persistent mental illness declines with age is that the life expectancy of people with serious mental illness is considerably lower than the general population. Reports range from 6 to 32 years (Colton & Manderscheid, 2006; Dembling, Chen, & Vachon, 1999; Piatt, Munetz, & Ritter, 2010; Walker, McGee & Druss, 2015). A major reason for lower life expectancy is poor health. People with serious mental illness are at high risk for obesity (related in part to their anti-psychotic medications (Tiihonen, 2009)), hypertension, diabetes, heart disease, pulmonary conditions (many are heavy smokers), and communicable diseases, particularly hepatitis and HIV/AIDS, that are related to histories of drug abuse, of hard and dangerous periods of homelessness, and of being victims of crime. They are also at high risk for suicide and for accidental deaths, especially overdoses of their medications, as well as falls.

The greatest need of people with long-term psychiatric disorders is support to live in the community, especially stable housing as well as cash and in-kind public assistance. Parents provide housing, financial assistance, and other supports for many younger adults with long-term psychiatric disabilities; but as the parents age, become disabled, and ultimately die, they can no longer provide for their now aged children. Supplemental needs trusts can help, but usually to a limited extent; and, unless a sibling is willing and able to take over for the parents, older adults with continuing psychiatric disabilities will need supports to remain in their homes or alternative supportive housing arrangements to avoid institutionalization.

A broad range of mental health services organized into a comprehensive system is also necessary for this population. This includes psychiatric rehabilitation (especially activity and social interaction); outpatient treatment in clinics and day programs; inpatient treatment (preferably in local general hospitals); specialized crisis services (mobile crisis teams as well as emergency rooms); outreach programs such as assertive community treatment (ACT) and intensive case management.

A "recovery" orientation is as essential to work with older adults as with younger populations (Anthony, 1993). Often, however, recovery goals for older adults should not emphasize employment, because for many (but not all) older people employment is no longer a personal goal (Friedman, MB and Williams, K, 2006). Older adults with psychiatric disabilities do, however, have other important goals such as serving as volunteers, enhanced socialization, improved relationships with their families, intimate romantic relationships, enhanced connections with houses of worship, improved management of their physical health conditions, and stable housing in the community that addresses declines in physical and cognitive capacity.

The critical point is that older adults with long-term psychiatric disabilities can lead lives that they find satisfying and meaningful, and services should be organized in ways that help them do so.

Anti-psychotic medications are useful for many people with long-term serious mental illness, including those in "recovery". However, the side effects of these medications can be particularly dangerous for older adults--especially to those who also develop

dementia (Schneider LS, Dagerman KS, Insel P: 2005; Nowrangi MA, Lyketsos, CG, & Rosenberg, PB, 2015).

Because this population is somewhat more likely to develop depression, anti-depressant medications may also be helpful, although also have their risks (Alexopoulos GS, Katz IR, Reynolds CF 3rd, Carpenter D, Docherty JP, 2001).

Typically, older adults react differently to medications than younger adults. For this reason, doses of psychiatric medications for older adults must be monitored very carefully and adjusted (usually down) as reactions to them change. (Coupland, C, Dhiman P, Morriss R, Arthur A, Barton G, and Hippisley-Cox 2011).

As they age, people with psychiatric disabilities are even more likely than other older adults to develop serious, chronic physical conditions for which routine treatment is necessary (Osborn, D. P., Levy, G., Nazareth, I., Petersen, I., Islam, A., & King, M. B. 2007). Eventually many develop physical disabilities and/or dementia, which will result in their needing additional care--including home-based care and specialized community residences--to be able to live in community settings (Friedman, M & Williams K 2008). As a result, many older adults with psychiatric disabilities end up in long-term health care programs not designed to meet their mental health needs, including adult medical day centers, assisted living, and nursing homes.

Late Life Psychotic Conditions

Ms. F. had lived with her mother all her life and never had a significant love relationship, but she had had a responsible job and many friends despite occasional periods of major depression. She became depressed more frequently after she was forced to retire but continued to have an active social life and took good care of her mother, who was in her 90s and increasingly disabled. When Ms. F. was 70, her mother died. Shortly after that she became acutely psychotic for the first time, experiencing both hallucinations and delusions. After a brief stay in psychiatric unit of a local general hospital, she recovered and returned home. Over subsequent years she had similar psychotic breaks from time-to-time. She had good home health aides, but they were not prepared to deal with her mental condition, and the nephew who took responsibility for her care simply burned out after too many crises in the middle of the night. Ultimately, she could not manage in her home and was placed in a nursing home, where she lived unhappily until she died 5 years later.

People of any age, including older adults, can develop psychotic conditions, extreme disruptions of mental functioning that usually make people incapable of carrying on life as they ordinarily do. Hallucinations, delusions, loss of a sense of reality, and irrational thinking processes and behavior are all characteristic of psychotic episodes.

Psychotic conditions can be (1) transient, a one-time event that never recurs, (2) recurrent, characterized by relatively short periods of psychosis and normal functioning in between, or (3) chronic, shifting between acute phases and phases of poor functioning.

Older people who experience transient or recurrent psychotic episodes need the same sort of treatment that younger people do, including crisis management and outpatient and inpatient services. Transitional services such as partial hospitalization and a stay in a community residence may also be helpful, although it is generally best for people to return to their homes as rapidly as possible and to provide supports there. This is easier said than done, however, because of the shortage of in-home workers with competence regarding mental illness. Often, family members must be caregivers during the process of recovery, creating considerable family burden. Support for these caregivers is often key to avoiding institutionalization. (Dunkin, J. J., & Anderson-Hanley, C. 1998; Mittelman, M.S., Haley, W.E., Clay, O., & Roth, D.L. 2006).

Older people for whom late onset psychotic conditions become chronic are virtually indistinguishable from people with long-term psychiatric disabilities and, like them, need integrated physical and behavioral health services. They also can often benefit from the kinds of rehabilitation programs that serve those with lifelong psychiatric disabilities. Unfortunately, eligibility rules for these programs often exclude people who have not had a long history in the mental health system. This is one reason why it is not uncommon for older adults who develop long-term psychotic conditions to be treated in the long-term health care system, often rapidly ending up in nursing homes.

Psychotropic medications are generally used during a psychotic episode and sometimes continued in the hope of preventing relapse. For older adults special care must be taken with regard to dosage, especially for those who also have dementia, for whom anti-psychotic medications can be lethal. (Nowrangi MA, Lyketsos, CG, & Rosenberg, PB, 2015).

Dementia

Mr. V. began to experience confusion when he was 80, but he was able to hide it from his family and friends. He loved woodwork and made almost daily trips to the hardware store. Once he forgot where he was going, got lost, and became very frightened. It happened again. He began to make excuses for not going out at all. Over time he found it impossible to do crossword puzzles and began to display angry frustration. The family doctor diagnosed him as in the early stages of dementia. In fact, Mr. V. was also depressed. With treatment for the depression, he might have overcome some of his cognitive impairment and recovered a better quality of life.

Dementia, of which Alzheimer's' disease is the most common form, is the most feared of all the possible mental disorders of old age, in part because it is increasingly common as people age, in part because it takes such a terrible toll on people's lives, and in part because there is no recovery. There are medications that can slow the process of deterioration in some people; but so far, that process is inexorable. The greatest hope for the moment is that deterioration can be slowed enough so that older people die of other conditions before they reach the end stage of dementia.

In 2012, the U.S. Department of Health and Human Services established a National Alzheimer's Plan that focuses on biomedical research with a goal of developing a cure

or effective preventive intervention by 2025. Unfortunately, the plan and associated research neglects the psychosocial aspects of dementia, including the mental disorders that are common concomitants of dementia (Friedman, MB & Lyketsos, CG, 2012).

During the early and mid-stages of dementia when normal functioning is possible, though to a decreasing extent, it is not unusual for people to develop depression and/or anxiety disorders. Fortunately, both depression and anxiety are treatable in people suffering from dementia (Draper, 1999; Snowden, Sato, & Roy-Byrne, 2003; Kraus, et al., 2008; Pellegrino LD, Peters ME, Lyketsos CG, Marano CM 2013). And, since both depression and anxiety produce cognitive decline, successful treatment may temporarily, improve the functioning of the person with dementia. It will not cure or stop the decline due to dementia, but it will help people to lead better lives in the time they have.

Many people with dementia exhibit "behavior problems," such as refusal to follow through on treatment, wandering, verbal abuse toward caregivers, dangerous forgetfulness, and more. In general, non-pharmacological interventions based on a sense of the humanity of the person with dementia can be helpful and are preferable because of the risks of psychiatric medications for this population. Unfortunately, there is considerable evidence that anti-psychotic medications are overused to control behavior (Gill, 2007), and this should be monitored carefully wherever people with dementia get care. When psychiatric medications must be used for the treatment of psychotic, mood, or anxiety disorders, medication monitoring to ensure appropriate dosage is critical (Nowrangi MA, Lyketsos, CG, & Rosenberg, PB, 2015).

In addition, it is important to understand that the dread of dementia is, in part, in the mind of the beholder. There are those who find people with dementia to be more emotionally open and more willing to take interesting creative risks (Zeisel & Raia, 2000; Zeisel, 2009). People with this perspective about those with dementia can help them make different, but meaningful, lives for themselves. In addition, some developmental psychologists have suggested that it is valuable to regard dementia as a developmental stage rather than solely as a disease. They note that some people with dementia enjoy life while others don't, and they point out that the state of mind characteristic of dementia—lack of memory, lack of sense of time and place, and living in the moment—is similar to the state of mind that is sought as the ultimate achievement of human life by Buddhists. They refer to this state as "gerotranscendence" (Erikson, E and Erikson J, 1997). This perspective can be helpful to caregivers trying to help people with dementia get the most out of life (Waldenstein, B. & Carlsson, M., 2003), and it can help to reduce the terror with which most of us regard dementia.

Finally, it is important to keep in mind that family members are the primary caregivers of older adults with dementia, and they are at high risk for mood and anxiety disorders, as well as for physical illnesses. They frequently "burn out" because of the stress; and, as a result, a significant number of older adults go to nursing homes who could remain in the community if their families were given appropriate supports—including individual counseling at convenient times and places, crisis intervention, family counseling, access to caregiver support groups, and respite care. Studies indicate that providing this kind

of support for family caregivers can defer placement in nursing homes 18 months or longer (Mittelman, et al, 2006).

Depression

Mrs. S was 81 when she stopped playing bridge and going to theater with her friends. It just wasn't fun anymore. She became more and more withdrawn and did not take much interest in her children or her grandchildren. Her daughter persuaded her to go to a psychiatrist, whom she told that she did not have the energy she used to have and that she had trouble concentrating. She said that she did not think she was useful to anyone and that "it's all downhill from here." With anti-depressants and behavioral activation therapy, she soon resumed cards and theatre and other pleasurable activities. She was lucky. Many older adults refuse to seek psychiatric help because they are embarrassed, because of their lack of knowledge about mental illness, or because they cannot find good treatment due to shortages of geriatric mental health professionals, cost, travel, and other obstacles.

It is widely believed that depression is common in old age. In fact, however, a majority of older adults probably never experience major depressive disorder (MDD), and epidemiological studies consistently show a decline of MDD in old age (Blazer, 2009; Byers et al., 2010).^{*} It may or may not be that older adults are more likely to experience sadness or apathy, but sadness and apathy are not necessarily MDD. A diagnosis of major depression requires the presence for a period of at least two weeks of one of two cardinal symptoms and a total of five symptoms altogether. The cardinal symptoms are (1) profound sadness with a sense of hopelessness and (2) a lack of interest or pleasure in people or activities that have been a source of interest or pleasure in the past. While persistently sad mood is the symptom most commonly associated with depression, there can be depression without sadness, in which the predominant symptom experienced is the loss of the capacity to experience interest or pleasure in activities formerly enjoyed (Gallo & Rabins, 1999). Additional symptoms of depression include: disturbances of activity, eating, or sleep; rumination or inability to concentrate; irritability, and others. The most dangerous symptom is recurrent thoughts of death and/or suicide. Older adults are more likely to complete suicide than the general population. (See section on suicide below).

Fewer than 5% of older adults who live in the community have a major depressive disorder in any given year (Blazer, 2009, Byers et al, 2010). Minor depression is more common, affecting 8%-20% of older adults each year (U.S. Department of Health and

^{*} There are three major theories about the apparent decline in major depression. One is that there isn't really a decline. The apparent decline is due to inappropriate diagnostic standards for older adults or reflects the fact that epidemiological studies are done only with people who live in the community and don't include institutionalized populations. A second theory is that the prevalence of depression varies from generation to generation. The current generation of very old people has weathered very tough times—The Depression, World War II, and more. Will the next generation of older adults have as much resilience as the current generation? A third theory to explain the apparent decline of major depression as people get older is that people with serious health conditions who are also depressed are at higher risk for disability and/or premature death than those who are not depressed. A significant number of people with depression just don't live to be old or are in institutions.

Human Services, 1999). The likelihood of having major depressive disorder is greater among those with chronic physical conditions, still greater among those needing home health care (Hybels & Blazer, 2003), and greater still among those in institutions, such as nursing homes (Blazer, 2009).

Although not as prevalent as widely believed, depression is dangerous. It has a negative impact on physical health, is correlated with premature disability and death, contributes to social isolation, and also contributes to the high rates of suicide among older adults.

Depression appears to be highly treatable. An extensive evidence base indicates that the use of medications and psychotherapy together is most effective, but that the use of medications or psychotherapy alone can also be effective. (DeRubeis RJ, Hollon SD, Amsterdam JD 2005). Psychotherapies with research support include cognitive therapy, cognitive-behavior therapy, problem solving therapy, interpersonal therapy, and behavioral activation therapy (Bartels, SJ, et al. 2002; Friedman, M, Furst L, Williams K, 2013).

For those with severe or psychotic mood disorders, electroconvulsive therapy (ECT) and/or inpatient care may be necessary. (Kellner CH, Greenberg RM, Murrough JW, Bryson EO, Briggs, MC and Pasculli RM, 2012)

Some recent research raises questions about the effectiveness of anti-depressants for the treatment of mild or moderate major depressive disorder (Fournier, JC, et al. 2010) and about the adverse consequences of anti-depressants in older adults, including headaches, stomach upset, insomnia, electrolyte imbalances, and falls, which are the most common cause of disability and premature death in older adults (Ferguson JM 2001; Coupland, C, Dhiman P, Morriss R, Arthur A, Barton G, and Hippisley-Cox 2011). In addition, there are serious questions about the benefits of treatment for patients with mild depression or subclinical mood disorders. Unfortunately, a significant proportion of elderly patients are prescribed anti-depressants for these milder mood deficits. Although they show no more improvement than placebo, they do suffer the same risk of side effects. (Pagura J, Katz LY, Mojtabai R, Druss BG, Cox B, Sareen J., 2011)

Many people with mild or moderate major depressive disorder get treatment from primary care physicians, who--unfortunately--provide minimally adequate care for less than 15% of the people they treat (Wang et al., 2009). However, there are a number of evidence-based approaches to providing effective treatment of depression in older adults in primary care practices, including Improving Mood: Promoting Access to Collaborative Treatment (IMPACT) (Unützer et al., 2002) and Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E) (Bartels, et al., 2004), among others (Oxman, Dietrich & Schulberg, 2005). All of these approaches provide a care manager to follow up with the patient to be sure they are adhering to treatment and, in some cases, to provide brief counseling such as problem-solving therapy as well.

Non-clinical interventions are also helpful for older adults with major depression. Being active and involved with other people can make a big difference. Physical exercise also

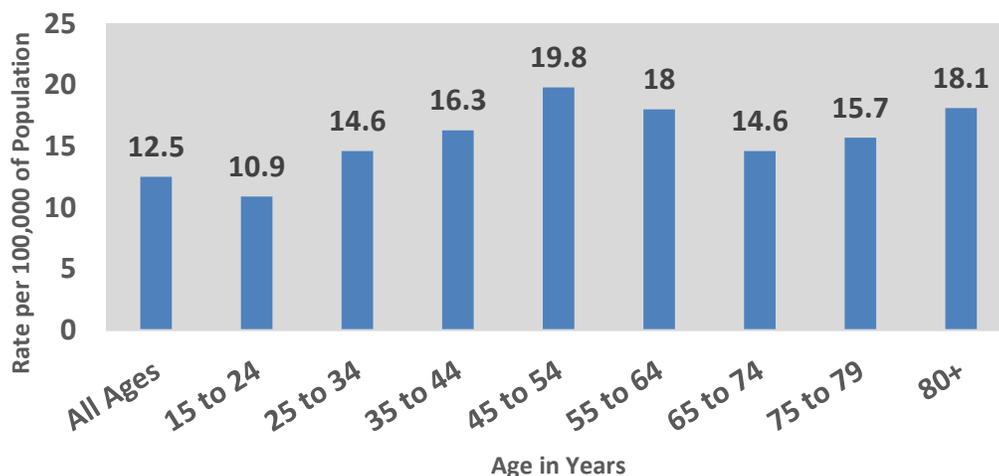
seems to be helpful. And for many people depression is linked to concrete or psychosocial problems, such as lack of adequate income, isolation and loss of a loved one. Addressing these external "causes" of depression can also be enormously helpful. (Bartels, SJ, et al. 2002)

Suicide:

Mr. A, who was 86, shot himself to death shortly after his wife died and he was diagnosed with cancer. He had seen a doctor a few days before, but the physician did not notice that he was depressed, let alone that he was at risk for suicide. Routine screening, unfortunately, was not part of this physician's practice. Had the screening revealed the possibility of depression, the physician might also have asked whether Mr. A. owned a gun, a very common antecedent of suicide in the United States.

The rate of suicide among older adults is high. Older adults 65 and over complete suicide 26% more than the general population and 44% more than teenagers and young adults. Over the past decade suicide has risen among working age adults; it is now higher than the rate of suicide among retirement age adults (65 to 79). It rises again in the population 80 and above. Suicide among older adults is primarily a white male phenomenon, and white men 85 and older complete suicide at a rate of 51.3 per 100,000, more than three times as often as the general population. (CDC, 2015)

Suicide Rates Per 100,000 By Age (2010-2014)



In addition to depression, other risk factors for suicide among older adults, co-morbid medical conditions, particularly those which cause pain and decline in physical, social and/or occupational functioning, social dependency or isolation, family discord or losses, inflexible personality or rigid coping styles, and access to firearms. Those who have a history of suicide attempts are at particularly high risk, especially if their suicide attempt has been planned rather than impulsive (Conwell, 2001).

Most older adults who take their own lives have seen primary care physicians shortly before they complete suicide (Schmutte, O'Connell, Weiland, Lawless & Davidson, 2009). Therefore, suicide prevention efforts should include improved identification of risk

by primary care physicians and others who come in contact with older adults seeking help for one reason or another. This is not easy, because people with depression are often very skilled at hiding their emotions. The use of effective screening tools for depression--such as the PHQ-2 or 9--is preferable to relying on a physician's perception alone. (Berman J & Furst L 2010; Mojtabai R. 2014; Jin, J. 2016.)

Providing treatment for those who are depressed can be helpful as a measure to prevent suicide. Additional effective prevention efforts to target high risk groups include optimizing functioning and minimizing physical pain in primary care and home health as well as decreasing social isolation and increasing social supports.

Crisis call centers can play an important role in efforts to prevent suicide (Gould, Kalafat, Munfakh & Kleinman, 2007; De Leo, Buono & Dwyer, 2002; Mishara et al., 2007). The National Suicide Prevention Lifeline (NSPL) provides a single telephone number that connects to over 160 call centers around the country. It should be well-publicized everywhere--**1-800-273-TALK (1-800-273-8255)**. NSPL has also introduced a number of on-line tools, using the power of social networks to reach people considering suicide. They probably do not reach many older adults now, but the next generation of older adults will undoubtedly be more computer savvy than the current generation.

Mass public education campaigns can also be useful in improving awareness and reducing shame about seeking help (Conwell, 2001).

Anxiety

Mrs. P is 76 years old. She has been a “worry wart” all her life, but since her husband died, she has become so anxious that it is difficult for her to manage the basic routines of her life. She can’t concentrate or make day-to-day decisions. She feels restless almost all the time. She has trouble sleeping because her mind fills with worries. She goes to her doctor frequently with complaints about headaches and stomach problems. There is no physical explanation for her symptoms; and she spends much of her time with the doctor talking about her many worries. These include her feeling that no one will enjoy her company, that she’s just not fun. She doesn’t want to burden people with her presence and so has become increasingly socially isolated. Left alone with her thoughts, she becomes even more worried. This form of “generalized anxiety” is not uncommon among older people.

Mrs. C lived alone in the apartment in which she and her husband had raised their children. She had always been a bit distrustful. The butcher put his thumb on the scale. A teacher had it in for a daughter who wasn’t doing well in school. After her husband died, her suspiciousness grew into paranoia. (Many serious mental disorders in old age are exacerbations of an underlying character trait or minor mental illness that are triggered by an adverse event such as the death of a spouse or poor health.) Mrs. C came to distrust even her daughter, accusing her, for example, of stealing her diamond ring, which she had simply misplaced. Her daughter was tolerant, to a point, but eventually arranged for help in the home, in part so she didn’t have to face her mother’s abuse every day. “You say my daughter sent you,” the mother yelled through the door. “I don’t believe you.” She did not open the door. Eventually, Mrs. C had to go to the hospital for treatment of pneumonia. Her daughter and the social worker agreed that, given her growing physical disabilities and the difficulties she presented at home, she should be in a nursing home. Mrs. C never went home again, a not uncommon fate for people who cannot accept help in the home.

Anxiety disorders are the most prevalent mental illnesses among older (and younger) adults, affecting over 10% of those 65 and older (Byers, et al., 2010). There are a number of different types of anxiety disorders, including generalized anxiety, social anxiety, phobias, obsessive-compulsive disorder, panic disorder, and post-traumatic stress disorder. Many anxiety disorders are treatable in much the same way that depression is treated, including psychotherapy, supportive interventions, and psychotropic medications.

Although anxiety disorders can be relatively mild and cause limited disruption in an older person's life, too often they are major causes of social isolation and unnecessary institutionalization. This is particularly true when anxiety takes the form of paranoia, which can range from suspiciousness to paranoid delusions* such as the belief that a neighbor is a terrorist. Such paranoid ideation can lead to a rejection of help, increasing the likelihood of institutionalization.

Social Isolation

Severe anxiety and depression, which frequently co-occur, often contribute to social isolation. In research studies and policy reports, living alone is frequently a proxy for social isolation, but that is a mistake. Social isolation does not mean living alone; it means being largely cut off from the outside world. People who are socially isolated have generally lost their relationships with family and friends, do almost nothing that gives them pleasure, and may not leave their homes except for doctors' visits or perhaps to buy groceries. Of course, some people are isolated because of physical problems, but many people are isolated because they are too depressed to rouse themselves or too frightened to leave their home. Frequently they are caught in a vicious cycle. Contact with people and activity would lift their spirits and calm their fears, but they are too depressed or anxious to do what would help them most. And they become increasingly depressed and/or anxious because of their isolation. Breaking the cycle of isolation is exceedingly difficult. Often it requires persistent outreach and great patience (Brennan, Vega, Garcia, Abad, & Friedman, 2005). And this is made all the more difficult because outreach services of this kind are usually not funded.

Substance Use Problems

Alcohol and Medication Misuse and Abuse

Mrs. J. is 75 years old. She has lived alone since her husband died. At first she kept up the relationships she and her husband had had together, but over time she began to feel like a third wheel and stayed alone more and more. She began to drink in the evenings to comfort herself and to help her fall asleep. One night she fell and broke her hip.

* Technically, paranoid delusions are a symptom of a psychotic condition and not of an anxiety disorder, and treatment for such delusions is different from the treatment for less severe fears.

Mr. L. retired with nothing to do and barely enough money to live on. Travel and other retirement activities were not financially possible for him. He began hanging out with his friends at the local bar. Over time a couple of beers sipped slowly became a pitcher or two. He got drunk often and became a hazard to the highway when he drove home from the bar. His relationship with his wife became more and more troubled.

Mrs. S had arthritis and was in constant pain. It was intolerable, and she would do anything to make the pain go away. She went to different doctors and got different prescriptions for painkillers. She bought whatever she could over-the-counter. She became addicted to opioids and damaged her stomach with the excessive doses of aspirin, Tylenol, and ibuprofen.

Lifelong Addiction

Mr. R had been a hardcore drug addict most of his life. He had robbed people to support his habit, been in and out of prison several times, and had been on the verge of death more than once from injuries and illnesses that are a typical part of a life on the street. But somehow he survived. When he turned 65, he looked back on his life with horror. He saw lost opportunities to have a meaningful life as well as lost relationships with his parents, siblings, and his own children. He wanted to redeem himself; he wanted to resurrect long lost relationships. Some people like Mr. R manage to revive relationships with their family and to begin a different way of life. Some burned their bridges long ago.

Misuse and abuse of alcohol is the major substance use problem among older adults. The misuse or abuse of prescription and over-the-counter medications is also a significant problem. Both are more common than misuse or abuse of illegal substances. According to the study most often used in policy reports, 17% of older adults consume more alcohol than recommended by the U.S. National Institute on Alcohol Abuse and Alcoholism (NIAAA) and/or misuse medications (Blow, 1998). But substance abuse or dependence is far less common. SAMHSA reported that in 2014 2.2% of adults 65 and older experienced alcohol abuse or dependence. .4% experienced dependence or abuse of illicit drugs, most often marijuana* (Substance Abuse and Mental Health Services Administration, 2015).

Although illegal drugs have not been used much by the current generation of older adults, it is widely expected that when the baby boomers (the generation of “drugs, sex, and rock and roll”) become the elder boomers, there will be increasing use of illegal substances among the elderly. (Kuerbis, A, Sacco,P, Blazer, D, & Moore A, 2014). And, because physical changes in the body as one ages reduce tolerance for alcohol and other substances that are used recreationally, the potential growth of older people who have been recreational drug users is a matter of concern.

Many older adults who misuse or abuse substances under or over-utilize medications. Some people can't afford medication, so they take less of it. Some people can't remember to take their medication and end up under or over-dosing. Some people just don't like to take medications. Some people cannot tolerate incessant pain or other physical suffering and medicate themselves with anything they can get their hands on

* Recently a number of states have legalized the use of marijuana for medical and, in some states, recreational purposes. As a result, it will become necessary to change the category of “illicit” drugs over time.

that seems to help, often creating significant iatrogenic health and mental health problems for themselves.

Among older adults the onset and course of substance misuse or abuse varies. Some older adults began abusing substances earlier in life and have been using most of their lives. Some early-onset abusers are hard core substance abusers who survive into old age, curtailing their addictions as they age. This includes people in methadone programs who are aging, and it also includes survivors who find new hope as they age and who want to make restitution and to build new lives for themselves. Except for those who abuse prescription and over-the-counter medications, few older adults are late-onset substance abusers. Rather, most are intermittent abusers who misused a substance when they were younger and are now returning to that substance in their later years, perhaps to cope with developmental challenges. In addition, there are older adults who were recreational users when they were younger, and the 'use' of alcohol and/or drugs becomes misuse/abuse in later life due to age related physical changes.

A number of different types of services are useful for people who misuse or abuse substances. Brief interventions, including counseling and public education (especially regarding reduced tolerance for alcohol, medications, and illegal drugs), particularly in primary care has shown to be effective. An evidence-based approach called Screening, Brief Intervention, and Referral to Treatment (SBIRT) is fundable through Medicaid. It can be used in emergency rooms and primary care practices as well as in mental health and substance abuse clinics. (SAMHSA-HRSA Center for Integrated Health Solutions. 2011.)

Motivational interviewing is an important component of SBIRT. It is also useful for primary care providers who identify substance use issues and want to help their patients change their behavior or lifestyle. (Britt E & Blampied NM, 2004; Case Western Reserve Center for Evidence-Based Practices, 2016.)

Other types of useful services include outpatient treatment, outpatient and residential detoxification, outpatient and residential rehabilitation, and mutual aid/self-help groups such as Alcoholics Anonymous (Ruiz P, Strain EC, 2007). Integrated treatment for those with co-occurring mental and substance use disorders (Drake RE, Mercer-McFadden C, Mueser KT, McHugo GJ, and Bond GR ,1998) and for those with co-occurring physical and/or behavioral disorders is especially important but not widely available.

There are a number of medications for addiction that appear to be helpful. These are targeted to the drug of abuse, such as Antabuse (disulfiram) or naltrexone specifically for alcohol, methadone or Suboxone (buprenorphine) maintenance for opiate addiction, or bupropion for nicotine, and are particularly effective when used as part of a therapeutic substance abuse program including group therapy (Jarosz J, et al, 2013)

Substance abuse programs need to be tailored for older adults (Bartels, SJ Pepin, R, Gill, LE, 2014). But while age-specific treatments, including peer self-help groups such as Alcoholics Anonymous, appear to be particularly helpful for older adults, they should

be given a choice of being in programs only for people of their age or with younger people as well.

Whether confrontation style interventions work for older adults is a matter of controversy. And whether the goal of treatment is abstinence or harm reduction is extremely controversial.

Behavioral Problems

Mr. B was fortunate enough to have a home health aide who visited him every day to be sure he took his medications, ate regularly, and otherwise managed activities of daily living. But one aide after another refused to continue to visit him because he would stubbornly resist taking medications, frequently accuse them of theft, and ask insistently for sexual favors. Ultimately, the agency gave up, and there was no choice but to move him to a nursing home, despite his desire to remain in his own home.

Mrs. S. was a “hoarder”. Her apartment was beyond cluttered. Old newspapers, old clothes, mementos of her 81 years were everywhere. It was so crowded that she, a very small, thin woman, could barely walk from bedroom to bathroom to living room to kitchen. All the rooms were filled. She stopped cleaning and stopped washing dishes. Cockroaches took over the apartment, and a stench developed that was so bad that her neighbors called the police, who called the Health Department, which ordered her to clean up. When she didn’t, Mrs. S was referred to Adult Protective Services (APS). The worker tried to persuade her to clean up and threatened to have it done for her. She did nothing. A cleaning service came in and took away the stuff of Mrs. S’s life. She became emotionally distraught. Mrs. S was lucky a good worker from a mental health organization got involved and helped her weather what she experienced as an assault on her life. Often, people like Mrs. S. get moved to nursing homes because APS workers have no other resources.

Older adults with dementia or other forms of mental illness often have “behavior problems”. These include refusal to accept, resistance to, or inability to follow treatment regimens; verbal, or occasionally physical, abuse of family and/or paid caregivers; sexually inappropriate behavior; wandering; dangerous behaviors such as smoking in bed or not turning the stove off; and maddeningly annoying behaviors such as constant complaining, asking the same question over and over again, or refusing to bathe. (Friedman, MB, 2010)

Older adults with such problems frequently become socially isolated and alienate caregivers. Many end up in nursing homes because home-based care becomes impossible. And in institutions, the people most difficult to the staff are often restrained chemically or physically because appropriate non-pharmacological interventions are not available.

Understanding that behavior problems are not solely in the person said to have the problem but in the relationship between the person and his/her caregivers is key to being able to help them. Sometimes finding a good match is all that is needed, but special training for both formal and informal caregivers is very important. This should include information about mental disorders, behavior management techniques, and practical methods of humane intervention based on appreciation of the individuality of each person whose behavior is troublesome to caregivers.

In extreme cases, non-sedating medications from the antidepressant class have been shown to treat anxious and aggressive behaviors in dementia (Porsteinsson AP, et al, 2014.)

Emotional Problems Adjusting To Old Age

Dr. A had been the Chairman of the Department of Cardiac Surgery at a major medical school. He believed that he should not continue to operate after the age of 60 and that, if he did not practice, he could not be an effective chairman, so he retired at 63. He had consulting work that kept him busy. He had very close family and friends, but he missed day-to-day contact with colleagues and ultimately he realized, as he put it, "I'm not a star anymore." He wanted the admiration and respect of others. He became depressed. Over time, Dr. A found a role as a mentor to students at a nearby community college who were interested in careers in health care. This helped him to weather the often painful transition to retirement. Increasingly, "civic engagement" is being recognized as a way to support the mental health of older adults and to provide help to younger and older people that otherwise would not be available.

Mr. F. had lost many family members and friends by the time he was 67. He had other people in his life and did not become isolated, but he found that people popped up in his mind like ghosts when he passed a restaurant where they used to meet for dinner or on the tennis court where they used to play or on the highway when he passed a town he used to go to for family get-togethers. The ghosts were bittersweet. He felt happy to be in their presence again but sad that they were just figments of his own imagination. Sometimes he felt called to join them, and more and more he thought that he too soon would be dead. It always made him a little tearful, though the tears were as invisible to others as his ghosts. Sometimes he worked at being ready to die; usually, however, he was so involved in real life that the idea of death surprised him. He, like all older adults, needed to come to terms with the fact of mortality. Some do it through their religious or spiritual experiences. Others do it without religion. It is often not an easy process.

Old age is a stage of life that, like all stages, has its emotionally difficult developmental challenges. People with or without mental illness have to face these challenges (Erikson, EH and Erikson, JM, 1997). Most people make the emotional transition with some pain but without developing a diagnosable mental disorder; others develop diagnosable disorders or live in an unsettled state between an earlier phase of life and old age.

The major developmental challenges of old age are: major role changes such as retirement, loss of status (common in Western cultures but not in some others where elders are revered for their wisdom), reduction (but usually not complete loss) of physical and mental capacities, the development of chronic health problems often with severe pain, loss of family and friends, and coming to terms with death.

Many people react to this list with the sense that getting old must be depressing. Not so. Most older people find new sources of satisfaction, ways to cope with physical and mental decline, and ways to handle mortality without denial.

Weathering the transition to old age successfully depends on good retirement planning; keeping active and involved with others; having access to good health care and to recreation, among other things. For many, a connection with a religious group is important. In addition, during this time of life, group and individual counseling is useful to many people.

The range of what is needed to promote "positive aging" has led to a number of different models for "age-friendly" or "livable" communities, efforts to make neighborhoods/towns/villages better places for older people to live. Unfortunately, attention to mental health and substance use issues is rarely included in these models. The Geriatric Mental Health Alliance of New York has developed a guide to help community planners to include mental health promotion and treatment (Williams & Friedman, 2010).

Part Two: Needed Policy Changes

The American society is poorly prepared to respond to the social needs that will emerge due to the vast growth of the population of older adults over the next two decades. It is particularly poorly prepared to meet the mental health challenges of the elder boom. Changes are needed in the size and structure of the mental health and substance abuse systems in both the public and the private sector. Changes are also needed in the health system--in primary care, specialty care, and long-term care. The aging services system also needs to pay considerably more attention to issues of mental illness and substance misuse among older adults, as well as to take advantage of opportunities to promote good mental health in old age.

What follows is the 12 Point Agenda for Improved Geriatric Mental Health Policy developed by the Geriatric Mental Health Alliance of New York.*

A 12-POINT AGENDA FOR IMPROVED GERIATRIC MENTAL HEALTH POLICY

1. **PROMOTE MENTAL HEALTH:** Pursue opportunities to promote mental health and to prevent the development or exacerbation of mental and substance use disorders in old age. It is particularly important to build this goal into the health care delivery system and into the efforts to modernize the aging services system and to develop "age-friendly" communities.
2. **SUPPORT AGING IN THE COMMUNITY:** Provide supports to enable older adults with mental disorders to live where they choose—usually in the community. It is particularly important to provide housing alternatives to institutions for older adults with co-occurring serious physical and mental disorders, including supportive housing and in-home care.

* We also recommend that readers review the proposals included in "The Paradox of Scarcity in a Land of Plenty" (Bartels, SJ, Pepin, R, Gill, LE, 2014).

3. **PROVIDE FAMILY SUPPORT:** Provide support for family caregivers, including those who care for aging spouses or parents with mental disorders, older adults who care for grown children with mental disabilities, and grandparents raising grandchildren. This should include tax benefits as well as services such as counseling, psycho-education, support groups, and respite.
4. **IMPROVE ACCESS TO MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES:** To improve access to these services, it will be necessary (a) to increase the amount of service available in both the public and private sectors. In addition, (b) it will be very important to make services more affordable, mobile, and available in home and community settings such as senior centers, senior housing, naturally occurring retirement communities (NORCs), and houses of worship.
5. **IMPROVE QUALITY:** The quality of mental health and substance abuse services for older adults needs vast improvement in both community and institutional settings and in both the public and the private sectors. This must include improved identification and treatment of mental health and substance use problems by health and aging services providers as well as mental health and substance abuse providers.
6. **INTEGRATE MENTAL HEALTH, PHYSICAL HEALTH, AND AGING SERVICES:** (a) It is important to integrate screening for and treatment of mental and substance use disorders into primary and specialty health care if only because those with these disorders are likely to also have chronic physical health conditions and to be reluctant to go to specialty behavioral health settings. The emphasis on the development of comprehensive "medical homes" and "accountable care organizations" in federal health care reform creates an opportunity to focus on real integration of meaningful behavioral health services in primary care. (b) It is particularly important to improve identification and treatment of mental, substance use, and behavioral disorders in long-term care, i.e., in home health care, adult medical day care, assisted living, and nursing homes. (c) Aging services settings such as senior centers, senior housing, naturally occurring retirement communities (NORCs), meals-on-wheels, case management, etc. should routinely engage in screening for and treatment of mental and substance use disorders in partnership with mental health, substance abuse, or health care organizations. They should also emphasize mental health promotion.
7. **PROMOTE CULTURAL COMPETENCE:** Minority elders will increase from 15 to 25% of the older population over the next two decades. Services need to be adapted in response to cultural differences. It is particularly important for services to be provided in their native languages.
8. **WORKFORCE DEVELOPMENT:** The current shortage of clinically, culturally, and generationally competent (Friedman, MB., 2016) providers will almost certainly get worse as the elder boom takes place. There are two distinct issues to address--size and quality. (a) To build a bigger workforce there need to new incentives to attract new workers. (b) The workforce of the future needs to include professionals such as physicians and social workers who do not specialize in mental health but who can do much to maintain and improve the mental health of those they serve. (c) There should also be more initiatives to develop both paid and volunteer helping roles for older adults themselves. (d) Enhanced professional and paraprofessional education and training are also critical to building the workforce of the future.
9. **PROVIDE PUBLIC EDUCATION:** (a) More extensive efforts are needed to combat stigma, which causes reluctance to acknowledge or get help with mental or substance

use disorders. (b) Education is also needed about mental illness, the effectiveness of treatment, and where treatment is available. Expanded information and referral services specifically related to older adults would be of great value. (c) It is particularly important to combat ageism, which results in the expectation that depression and other mental disorders are unavoidable among older adults

10. **ADDRESS SOCIAL/ECONOMIC ISSUES:** Older adults with mental or substance use disorders often face social and economic problems such as social isolation, inadequate income, and poor housing. It is important to help them address these kinds of problems as well as to provide treatment for their mental and physical disorders.
11. **DESIGN NEW FINANCE MODELS:** Currently (a) there is not enough funding for geriatric mental health services in both the public and the private sectors. In addition, (b) financing models need to be restructured so as to support services in home and community settings, support integrated service delivery, encourage the use of state-of-the-art practices and service innovation, go beyond the medical model, broaden Medicare coverage to include essential services such as case management, and to facilitate pooling funding across service systems.
12. **PROMOTE PUBLIC AND PRIVATE SECTOR READINESS:** (a) Neither plans nor structures have been created in government agencies to prepare for the mental health and substance abuse challenges of the elder boom. Planning and the clarification of responsibility for developing needed services should happen immediately. (b) The workplace can play an important role through programs to promote mental health among older workers and those who about to retire and through efforts to support workers who are responsible for the care of older adult family members.

Conclusion

In the first half of the 21st century, the population of older adults (65 and over) in the United States will more than double. Overall about 20% of this population has a diagnosable mental or substance use disorder, and this rises to about 50% by age 85 because of the significant increase in dementia as people age. Thus, increasing longevity will result in disproportionately large increases in the numbers of older adults with mental health and/or substance use problems, creating an alarming challenge to the community mental health system, which is not prepared to meet this challenge; the current and projected workforce is much too small and is not adequately educated or trained in geriatric mental health and/or substance use problems.

Time has run out for our nation's service systems to prepare in advance for the elder boom. Now we will have to confront the challenges of this vast demographic change while it is underway. We hope that our nation is up to the task.

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References

Alexopoulos GS, Katz IR, Reynolds CF 3rd, Carpenter D, Docherty JP, (2001) Expert Consensus Panel for Pharmacotherapy of Depressive Disorders in Older Patients Postgrad Med. 2001 Oct; Spec No Pharmacotherapy():1-86

Anthony, W.A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal*, 16 (4), 12-23.

Bartels, SJ, et al. (2002). Evidence-Based Practices in Geriatric Mental Health Care. *Psychiatric Services*. Vol. 53, No. 11. November 2002.

Bartels, S.J., Coakley, E. H., Zubritsky, C., Ware, J.H., Miles, K. M., Arean, P. A., Chen, H., Oslin, D. W., Llorente, M. D., Costantino, G., Quijano, L., McIntyre, J.S., Linkins, K. W., Oxman, T. E., Maxwell, J., & Levkoff, S.E. (2004). Improving access to geriatric mental health services: A randomized trial comparing treatment engagement with integrated versus enhanced referral care for depression, anxiety, and at-risk alcohol use. *American Journal of Psychiatry*, 161, 1455-1462.

Bartels, SJ., Pepin, R., Gill, LE. (2014). The Paradox of Scarcity in a Land of Plenty: Meeting The Needs of Older Adults with Mental Health and Substance Use Disorders. *Generations: Journal of the American Society of Aging*. Fall 2014. Vol 38, No.3.

Berman, J and Furst, L. (2010). *Depressed Older Adults: Education and Screening*. Springer Publishing.

Blazer, D.G. (2009). Depression in late life: review and commentary. *Focus: The Journal of Lifelong Learning in Psychiatry*, 7, (1), 118-136.

Blow, F. C. (1998). *Substance abuse among older adults treatment improvement protocol*. (DHHS Publication No. (SMA) 98-3179). Retrieved from <http://www.ncbi.nlm.nih.gov/books/NBK14467/>

Brennan, M., Vega, M., Garcia, I., Abad, A., & Friedman, M. (2005). Meeting the mental

health needs of elderly Latinos affected by depression: Implications for outreach and service provision. *Care Management Journals*, 6 (2) 98-106.

Britt E, Hudson SM, Blampied NM (2004) Motivational interviewing in health settings: a review. *Patient Educ Couns* 53:147, 2004.

Byers, A., Yaffe, K., Covinsky, K.E., Friedman, M.B., & Bruce, M.L. (2010). High occurrence of mood and anxiety disorders among older adults: The National comorbidity survey replication. *Archives of General Psychiatry*, 67 (5), 489-496.

Case Western Reserve Center for Evidence-Based Practices. (2016.) Motivational Interviewing. <https://www.centerforebp.case.edu/practices/mi>

Centers for Disease Control and Prevention. National Center for Injury Prevention and Control. (2007). *WISQARS injury mortality reports, 1999-2014*. Retrieved from http://webappa.cdc.gov/sasweb/ncipc/mortrate10_us.html

Chin, E., Hedberg, K., Higginson, G.K., & Fleming, D.W. (1999). Special report legalized physician-assisted suicide in Oregon-The first year's experience. *New England Journal of Medicine*, 340, 577-583.

Colton, C., & Manderscheid, R. (2006). Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing Chronic Disease*, 3 (2), A42.

Conwell, Y. (2001). Suicide in later life: A review and recommendations for prevention. *Suicide & Life - Threatening Behavior: National Suicide Prevention Conference Background Papers*, 31, 32-47. Retrieved December 14, 2010, from Research Library. (Document ID: 72665323).

Conwell, Y., Duberstein, P.R., Cox, C., Herrmann, J.H., Forbes, N.T., & Caine, E.D. (1999). Relationships of age and axis I diagnoses in victims of completed suicide: a psychological autopsy study. *American Journal of Psychiatry*, 153, 1001-1008.

Coupland, C, Dhiman P, Morriss R, Arthur A, Barton G , and Hippisley-Cox. (2011) Antidepressant use and risk of adverse outcomes in older people: population based cohort study" *The BMJ*, August 2, 2011. <http://www.bmj.com/content/343/bmj.d4551>

Cummings, J.L., & Jeste, D.V. (1999). Alzheimer's Disease and its management in the year 2010. *Psychiatric Services*, 50 (9), 1173-1177.

De Leo, D., Buono, M.D. & Dwyer, J. (2002). Suicide among the elderly: The long-term impact of a telephone support and assessment intervention in northern Italy. *British Journal of Psychiatry*, 181, 226-229.

Dembling, B., Chen, D., & Vachon, L. (1999). Life expectancy and causes of death in a population treated for serious mental illness. *Psychiatric Services*, 50 (8), 1036-1042.

Draper, B. (1999). Practical geriatrics: The diagnosis and treatment of depression in dementia. *Psychiatric Services*, 50, 1151-1153.

Drake RE, Mercer-McFadden C, Mueser KT, McHugo GJ, and Bond GR (1998). Review of Integrated Mental Health and Substance Abuse Treatment for Patients with Dual Disorders. *Schizophrenia Bulletin* (1998) 24 (4): 589-608.

Dunkin, J. J., & Anderson-Hanley, C. (1998). Dementia caregiver burden A review of the literature and guidelines for assessment and intervention. *Neurology*, 51(1 Suppl 1), S53-S60.

Erikson, EH and Erikson, JM (1997). *The Life Cycle Completed*. WW. Norton and Company.

Ferguson JM: SSRI Antidepressant Medications: Adverse Effects and Tolerability. *Prim Care Companion J Clin Psychiatry* 3:22, 2001 [PMID:15014625]

Fournier JC, DeRubeis, RJ, Hollon SD, Dimidjian, S, Amsterdam JD, Shelton RC, and Fawcett, J. (2010) Antidepressant Drug Effects and Depression Severity: A Patient-Level Meta-analysis. *JAMA*, January 6, 2010.

Friedman, MB and Williams, K (2006). *Meeting the Challenges of Aging People with Serious, Long-term Psychiatric Disabilities: Report of a Workgroup Co-Sponsored by The Geriatric Mental Health Alliance of New York and the Urban Institute for Behavioral Health*. Published by The Mental Health Association of New York City.

http://michaelbfriedman.com/mbf/images/stories/geriatric_MH_policy/Reports_and_Background_Material/Meeting_the_Challenges_of_Aging_People_with%20Serious,%20Long-Term%20Psychiatric%20Disabilities.pdf

Friedman, MB and Williams, K (2008). *Housing in the Mental Health System for Aging People with Serious Psychiatric Disorders: Report of a Consensus Workgroup*. Published by The Mental Health Association of New York City.

http://michaelbfriedman.com/mbf/images/stories/geriatric_MH_policy/Reports_and_Background_Material/Housing_Aging_People_with_Serious_Psychiatric_Disabilities.pdf

Friedman, MB (2009). *Behavioral health is key to long-term care reform [PowerPoint slides]*. Retrieved from

http://michaelbfriedman.com/mbf/images/stories/mental_health_policy/Finance_and_Managed_Care/BH_and_LTC_UHFWeb.pdf

Friedman, MB (2010). Behavioral Health Challenges in Home Health Care. *Focus* Vol 7, No. 1.

<http://www.nyshcp.org/assets/0/72/300/302/7864/bf884042-ea9a-43bb-9ae0-dbb194c37ff5.pdf>

Friedman, MB and Lyketsos, CG (2012). Draft National Alzheimer's Plan Is Disappointing. *Huffington Post*, April 9, 2012. http://www.huffingtonpost.com/michael-friedman-lmsw/alzheimers_b_1412260.html

Friedman, MB, Furst, L, Williams KA (2013). Behavioral Activation Targets Depression. *Today's Geriatric Medicine*, Vol.6 No. 5 P.24 September/October 2013.

Friedman, MB and Williams, K (2015). Substance Abuse and Misuse Among Older Adults. *Behavioral Health News*. Winter 2015.

http://michaelbfriedman.com/mbf/images/Substance_Abuse_In_Older_Adults_Print-Friendly.pdf

Friedman, MB. (2016). A Behavioral Health Workforce for an Aging America. *Behavioral Health News*, Spring 2016.

http://michaelbfriedman.com/mbf/images/A_Behavioral_Health_Workforce_for_An_Aging_America.pdf

Gallo, J., & Rabins, P. (1999). Depression without sadness: Alternative presentations of depression in late life. *American Family Physician*. 60, (3), 820-6.

Gill, S. S., Bronskill, S. E., Normand, S. T., Anderson, G. M., Sykora, K., Lam, K., & Rochon, P. A. (2007). Antipsychotic drug use and mortality in older adults with dementia. *Annals of Internal Medicine*, 146 (11), 775-W180. Retrieved from EBSCOhost.

Gould, M., Kalafat, J., Munfakh, J., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes: Part 2: Suicidal callers. *Suicide & Life-Threatening Behavior*, 37(3), 338-352. Retrieved December 21, 2010, from Research Library

Grayson, V., & Velkoff, V. (2010). *THE NEXT FOUR DECADES, The Older Population in the United States: 2010 to 2050, Current Population Reports, P25-1138*. Washington, DC: U.S. Census Bureau. Retrieved from: <http://www.census.gov/prod/2010pubs/p25-1138.pdf>

- Husaini, B.A., et al (2000). Prevalence and cost of treating mental disorders among elderly recipients of Medicare services. *Psychiatric Services*, 51, 1245-1247.
- Hybels, C., & Blazer, D. (2003). Epidemiology of late-life mental disorders. *Clinics in Geriatric Medicine*, 19 (4): DOI: 10.1016/S0749-0690%2803%2900042-9
- Jarosz J et al (2013). Naltrexone (50 mg) plus psychotherapy in alcohol-dependent patients: a meta-analysis of randomized controlled trials. *Am J Drug Alcohol Abuse* 39:144, 2013
- Jin, J. (2016). Screening for Depression. *JAMA* January 26, 2016.
- Katon, W., & Ciechanowski, P. (2002). Impact of major depression on chronic medical illness. *Journal of Psychosomatic Research*, 53, 859-863.
- Kellner CH, Greenberg RM, Murrugh JW, Bryson EO, Briggs, MC and Pasculli RM. (2012). ECT in Treatment-Resistant Depression. *American Journal of Psychiatry*. Vol. 169 Issue 12 December 2012, pp. 1238-1244.
- Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K., R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication, *Archives of General Psychiatry*, 62 (6):593-602.
- Kessler, R., & Wang, P. (2008). *The Descriptive Epidemiology of Commonly Occurring Mental Disorders in the United States. Annual Review of Public Health*. Volume 29, Page 115-129. Retrieved from: <http://www.arjournals.annualreviews.org>
- Kilbourne, A.M., Cornelius, J.R., Han, X., Hass, G.L., Salloum, I., Conigliaro, J., & Pinous, H.A. (2005). General-medical conditions in older patients with serious mental illness. *American Journal of Geriatric Psychiatry*, 13 (3), 250-254.
- Kraus, C., et al. (2008). Cognitive-behavioral treatment for anxiety in patients with dementia: two case studies. *Journal of Psychiatric Practice*, 14 (3), 186-92.
- Kuerbis, A, Sacco, P, Blazer, D, and Moore A. (2014). Substance Abuse Among Older Adults. *Clin Geriatr Med*. 2014 August ; 30(3): 629–654. doi:10.1016/j.cger.2014.04.008
- McAlpine, D. (2003). Patterns of care for persons 65 years and older with schizophrenia. In C. Cohen (Ed). *Schizophrenia Into Later Life* (pp.3-17) Washington. DC: American Psychiatric Publishing, Inc.
- Mishara, B. L., F. Chagnon, Daigle, M., Balan, B., Raymong, S., Marcoux, I., Bardon, C., Campbell, J., & Berman, A. (2007). Which helper behaviors and intervention styles are related to better short-term outcomes in telephone crisis intervention? Results from a silent monitoring study of calls to the U.S. 1-800-SUICIDE network. *Suicide and Life Threatening Behavior*, 37, 308-321.
- Mittelman, M.S., Haley, W.E., Clay, O., & Roth, D.L. (2006). Improving caregiver well-being delays nursing home placement of patients with Alzheimer disease. *Neurology*, 67, 1592-1599.
- Mojtabai R. (2014). Diagnosing Depression In Older Adults in Primary Care. *N Engl J Med*. 2014 Mar 27;370(13):1180-2. doi: 10.1056/NEJMp1311047.PMID: 24670164
- Nowrangi, MA, Lyketsos, CG, and Rosenberg, PB. Principles and Management of Neuropsychiatric Symptoms in Alzheimer's Dementia. *BioMed Central*. DOI 10.1186/s13195-015-0096-3
- Osborn, D. P., Levy, G., Nazareth, I., Petersen, I., Islam, A., & King, M. B. (2007). Relative risk of cardiovascular and cancer mortality in people with severe mental illness from the United Kingdom's General Practice Research Database. *Archives of general psychiatry*, 64(2), 242-249.

- Oxman, T. E., Dietrich, A., & Schulberg, H.C., (2005). Evidence-based models of integrated management of depression in primary care. *Psychiatric Clinics of North America*, 28 (2005), 1061–1077.
- Pagura J, Katz LY, Mojtabai R, Druss BG, Cox B, Sareen J. (2011). Antidepressant Use in the Absence of Common Mental Disorders in the General Population. *J Clin Psychiatry*. 2011 Apr;72(4):494-501. doi: 10.4088/JCP.09m05776blu. Epub 2011 Jan 25.
- Pellegrino LD, Peters ME, Lyketsos CG, Marano CM. (2013). Depression in Cognitive Impairment. *Curr Psychiatry Rep*. 2013 Sep;15(9):384. doi: 10.1007/s11920-013-0384-1. Review. PMID:
- Piatt, E., Munetz, M., & Ritter, C. (2010). An examination of premature mortality among decedents with serious mental illness and those in the general population. *Psychiatric Services*, 61 (7), 663-668.
- Porsteinsson AP, Drye LT, Pollock BG, Devanand DP, Frangakis C, Ismail Z, Marano C, Meinert CL, Mintzer JE, Munro CA, Pelton G, Rabins PV, Rosenberg PB, Schneider LS, Shade DM, Weintraub D, Yesavage J, Lyketsos CG; CitAD Research Group (2014). Effect Of Citalopram On Agitation In Alzheimer Disease: The Citad Randomized Clinical Trial. *JAMA*. 2014 Feb 19;311(7):682-91. doi: 10.1001/jama.2014.93.
- Ruiz, P., Strain, E.C., Langrod, JG (2007). *The Substance Abuse Handbook*. Lippincott Williams and Wilkins.
- SAMHSA-HRSA Center for Integrated Health Solutions. (2011.) SBIRT: Screening, Brief Intervention, and Referral to Treatment. <http://www.integration.samhsa.gov/clinical-practice/SBIRT>
- Schmutte, T., O'Connell, M., Weiland, M., Lawless, S., & Davidson, L. (2009). Stemming the tide of suicide in older white men: A call to action, *American Journal of Men's Health*, 3, 189-200, doi:10.1177/1557988308316555.
- Schneider LS, Dagerman KS, Insel P: Risk of death with atypical antipsychotic drug treatment for dementia: meta-analysis of randomized placebo-controlled trials. *JAMA* 294:1934, 2005
- Snowden, M., Sato, K., & Roy-Byrne, P. (2003). Assessment and treatment of nursing home residents with depression or behavioral symptoms associated with dementia: A review of the literature. *Journal of the American Geriatrics Society*, 51(9), 1305-1317. doi:10.1046/j.1532-5415.2003.51417.x.
- Spillman, B. & Pezzin, L. (2000). Potential and actual family caregivers: Changing networks and the "sandwich generation". *Milbank Quarterly*, 78 (3), 347-374.
- Substance Abuse and Mental Health Services Administration. (2005). *The NSDUH report: Substance use among older adults: 2002 and 2003 update*. Retrieved from <http://www.oas.samhsa.gov/2k5/olderadults/olderadults.htm>
- Tiihonen, J., Lönnqvist, J., Wahlbeck, K., Klaukka, T., Niskanen, L., Tanskanen, A., et al. (2009). 11-year follow-up of mortality in patients with schizophrenia: A population-based cohort study (FIN11 study). *The Lancet*, 374 (9690), 620-627. Retrieved from www.scopus.com
- Unützer, J., Katon, W., Callahan, C.M., Williams, J.W. Jr, Hunkeler, E., Harpole, L., Hoffing, M., Della Penna, R.D., Hitchcock Noël, P., Lin, E., Areán, P.A., Hegel, M.T., Tang, L., Belin, T.R., Oishi, S., & Langston, C. (2002). Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. *Journal of the American Medical Association*, 288(22), 2836-2845. doi:10.1001/jama.288.22.2836.

U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Washington, DC: Author.

U.S. Substance Abuse and Mental Health Services Administration (2015). *Behavioral Health Barometer, United States 2015*. HHS Publication No. SMA-16-Baro-2015.

Waldenstein, B and Carlsson, M. Theory-Driven Guidelines for Practical Care of Older People, Based on the Theory of Gerotranscendence. *Journal of Advanced Nursing* Vol 41, Issue 5 pages 462-70, March 2003.

Walker, ER, McGee, RE, & Druss, BG. "Mortality in Mental Disorders and Global Disease Burden Implications: A Systematic Review and Meta-Analysis." *JAMA Psychiatry*. 2015 Feb 11. doi: 10.1001/jamapsychiatry.2014.2502.

Wang, P.S., Lane, M., Olfson, M., Pincus, H.A., Wells, K.B., & Kessler, R.C. (2005). Twelve-month use of mental health services in the United States: Results from the national comorbidity survey replication. *Archives of General Psychiatry*, 62(6), 629-640.

Williams, K.A., & Friedman, M.B. (2010). Addressing the mental health needs of older adults in *Age-Friendly Communities: A guide for planners*. A Geriatric Mental Health Alliance Publication, Mental Health Association of New York City. Retrieved from: <http://www.mhanyc.org/media/1251/agefriendly.pdf>

Zeisel, J. (2009). *I'm still here: A breakthrough approach to understanding someone living with Alzheimer's*. New York, NY: Penguin.

Zeisel, J., & Raia, P. (2000). Nonpharmacological treatment for Alzheimer's disease: A mind-brain approach. *American Journal of Alzheimer's Disease and Other Dementias*, 15, 331-340.