TCHP Education Consortium

Mental Health

Issues in ElderCare

Part of the

ElderCare: Healthcare for the Aging Series

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Introduction/Purpose Statement

It is estimated that approximately one-fourth of the elderly in the community and more than half of those in nursing homes have symptoms of serious mental health problems.

***Mental health is the capacity to cope effectively with and manage life's stresses in an effort to achieve a state of emotional well-being.*[1]**

The purpose of this home study is to review what the cognitive and mental changes of aging normally are, what is not normal with aging, and how to assess and work with the elder who is experiencing disturbances in mental health. Delirium, dementia, depression, alcohol/substance abuse, hypochondriasis, paranoia, and elder abuse are covered.

Target Audience

This home study was designed for health care professionals with little to no familiarity with caring for elderly patients with mental health issues.

Content Objectives

1. Review normal changes of aging related to cognitive, mental, and behavioral health.

2. Discuss the causes, symptoms, diagnosis, and management of mental illness in the elderly patient

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Please see the last page of the packet before the post-test for information on submitting your post-test and evaluation for contact hours.

Normal Changes with Aging

Many people believe that loss of mental functioning, confusion, memory loss, and behavioral problems are an expected part of aging – this is not true! Changes in learning occur with normal biological aging. These changes do not reflect declining intelligence or ability to learn, but rather, slowing down in the speed of learning.

Simple recall declines, but verbal ability and learning skills are maintained. A concern that many of us think about is: *how will I age?* Statistics show that we tend to become "more of ourselves" as we grow older. So, if you have always been outspoken and opinionated or fun-loving and sociable, you will likely act the same way when you are older.

Cognitive function in later life is very individualized, based on personal resources, health status, and experiences in the individual's life.

Delirium

Delirium is very common among the elderly, especially in the hospital setting. Prompt treatment of delirium can prevent permanent damage.

Of general medical patients greater than 70 years of age admitted to the hospital:[2]

- 10-20% are delirious at the time of admission
- 10-20% become delirious during hospitalization
- 15-25% have delirium after elective procedures
- 35-65% experience delirium after emergency procedures.

Delirium is:

A clinical state characterized by an acute, fluctuating change in mental status, with inattention and altered levels of consciousness.[3]

Some health care practitioners use the terms delirium and acute confusional state synonymously.

The hallmark of delirium is acute cognitive dysfunction with impaired attentiveness, which develops suddenly, or over a short time (usually hours to days). Delirium alters the level of consciousness, whereas dementia does not. Delirium is often precipitated by a physical illness and manifests as a psychiatric complication. Symptoms of delirium generally include either:

- Extreme sleepiness, lethargy, or partial consciousness ***or***
- Hallucinations, delusion, and excitability

In some cases, patients have a mixture of these features.

Causes of Delirium

The causes of delirium appear to lie outside the central nervous system (CNS). The causes of delirium are widespread, and could include:

- Medications
- Sensory deficits
- Metabolic disorders
- Rectal impaction
- Urinary bladder infections
- Alcohol abuse or overuse

Management of Delirium

It is important for health care providers to look for the underlying causes of delirium. Providers should get a complete medication history, including prescription, over-the-counter, and herbal medications. Sensory deficits, such as loss in vision and hearing, should be assessed. Metabolic disorders, such as hypothyroidism, diabetes, and nutritional disorders, can be detected through lab tests and physical exams. Electrolyte disturbances can also be diagnosed through lab tests.

Treatment is based on treating the cause, not the symptoms, of the delirium. Treating the symptoms rather than the cause, or thinking of the symptoms as being normal for an elderly patient, can result not only in worsened mental status, but also in the worsening of a physical condition, which could become life-threatening.

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During the acute stage, interventions are aimed at supporting the patient and maintaining safety. Management of the delirious patient includes:

- decreasing stimulation and maintaining consistency in care
- controlling behavior to ensure patient comfort and promote safety. Placement of a delirious patient in a room/bed near the nursing station is recommended. Encouraging family members to stay with the patient or having a patient "sitter" is usually preferred to physical or chemical restraints.
- helping to orient or re-orient patients (i.e. clocks, calendars)
- assisting patients who need glasses and hearing aids to wear them
- mobilizing and repositioning to reduce the risk of atelectasis, deconditioning, and pressure sores
- paying close attention to nutritional intake and assisting with feeding as necessary

Inform the family that delirium is usually reversible but cognitive deficits often take weeks or months to return to their baseline after resolution of the acute illness.

Less commonly, drugs can be used to treat delirium directly. For example, delirium caused by alcohol withdrawal can be treated with benzodiazepines, and anticholinergic drug toxicity, if severe, can be treated with physostigmine.

Discontinuing drugs or treatments known to precipitate delirium is recommended. Psychoactive drugs may then be used to treat agitation associated with delirium. If psychoactive drug treatment is required, documentation and assessment of the target symptoms and the response to treatment are necessary. There are three drugs or types of drugs which may be used:

1. For most patients, low doses of high-potency antipsychotics (e.g. haldol 0.25 – 1 mg po, IV, IM) are preferred.
2. Use of risperidone (0.25 to 1 mg) has recently been suggested to treat the agitation of hyperactive delirium.
3. Benzodiazepines (e.g. ativan 0.25 – 1 mg po, IM, IV) are the treatment of choice for patients with delirium secondary to alcohol or sedative withdrawal or for patients with Parkinsonism who cannot tolerate the extrapyramidal effects of an antipsychotic.

Keep in mind that all drugs used to treat agitation can produce oversedation, and their use sometimes prolongs delirium and increases the risk of complications.

Dementia

Dementia is a deterioration of intellectual function and other cognitive skills, leading to a decline in the ability to perform activities of daily living.[4]

Dementia is one of the most serious disorders affecting the elderly. The risk of developing dementia increases with age; the number of people developing dementia doubles every five years after the age of 60. Dementia affects only 1% of people between the ages of 60 – 64, but 30-50% of people over 85 years. Currently, dementia is the leading cause of nursing home placement in the United States, accounting for 60 – 80% of the elderly living in nursing homes.[5]

Alzheimer's Disease (AD)

Alzheimer's disease is the most common form of dementia affecting the elderly (approximately 50% of dementias). AD is characterized by the following changes in the brain:[6]

- Presence of neuritic plaque, which contains deposits of beta-amyloid protein (excess amounts are also found in people with Down's syndrome)
- Neurofibrillary tangles in the cortex
- Loss or degeneration of neurons and synapses
- Marked reduction in brain weight

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The diagnosis for AD is done by performing a thorough clinical workup. The patient and his/her family should be involved in obtaining a comprehensive history. The history should include information on the patient's social, cultural, ethnic, and family background. The patient should have a physical examination including laboratory tests to rule out other problems.

Lab Test	Differential Diagnosis
Blood glucose	HHNK, DKA, hypoglycemia
BUN/creatinine	Kidney failure
Liver function tests, including ammonia	Liver failure
Hgb, Hct	Anemia
WBC, differential	Infections
T3, T4, TSH	Thyroid dysfunction
VDRL analysis	Syphilis
HIV test	AIDS-related dementia

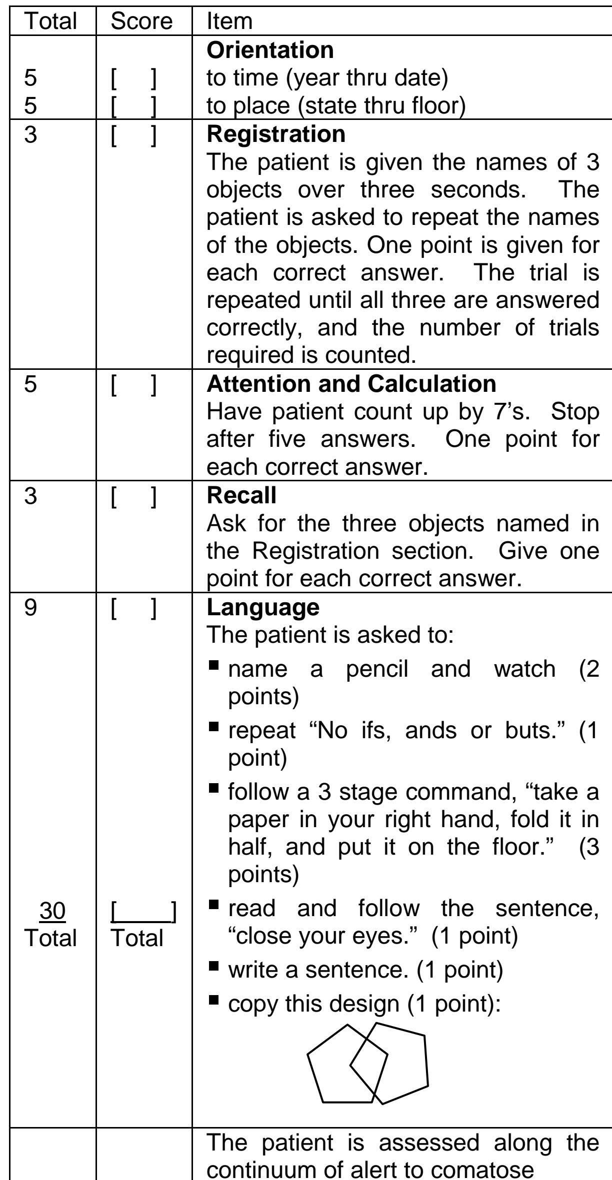
A past health history, including all medications the patient is currently on or has recently been on, is also very important. Any specific tests indicated by the patient's history and psychological evaluation should be done, for example, an MRI of the brain.

There are new developments that could allow doctors to detect and possibly treat the illness years before symptoms develop. The most notable, presented in July 2002, in Stockholm, is the use of PET scans of the brain. "For the first time we can actually see the physical evidence of the disease in the living patient," says Dr. Gary Small, a principle investigator in the UCLA Alzheimer's research looking at this strategy.[7] These scans may not be available to the public for several years; thus Alzheimer's disease continues to be diagnosed by the process of elimination and can be confirmed by autopsy upon death.

It is important to rule out illnesses that can mimic AD or dementia. A mental status examination, such as the "Mini-Mental State Examination" is used to determine the current level of cognitive function.

(An adapted version of this test follows)

Mini-Mental State Examination



Total	Score	Item
 5 5	 [ ] [ ]	**Orientation** to time (year thru date) to place (state thru floor)
3	[ ]	**Registration** The patient is given the names of 3 objects over three seconds. The patient is asked to repeat the names of the objects. One point is given for each correct answer. The trial is repeated until all three are answered correctly, and the number of trials required is counted.
5	[ ]	**Attention and Calculation** Have patient count up by 7's. Stop after five answers. One point for each correct answer.
3	[ ]	**Recall** Ask for the three objects named in the Registration section. Give one point for each correct answer.
9 30 Total	[ ] [____] Total	**Language** The patient is asked to: ■ name a pencil and watch (2 points) ■ repeat "No ifs, ands or buts." (1 point) ■ follow a 3 stage command, "take a paper in your right hand, fold it in half, and put it on the floor." (3 points) ■ read and follow the sentence, "close your eyes." (1 point) ■ write a sentence. (1 point) ■ copy this design (1 point):
		The patient is assessed along the continuum of alert to comatose

Adapted from Folstein, M., Folstein, S., & McHugh, P. (1975). Mini Mental State: A practical method for grading the cognitive state of patients for the clinician. Journal of Psychiatric Research, 12(3), 189-198. Copyright 1975.

Thought to ponder: would you want to know if you had a genetic predisposition toward AD?

Environmental factors play a role in possible causes of AD; genetic factors do increase the risk of AD. Chromosomal abnormalities have been identified, a connection with Down syndrome.

Staging of Alzheimer's disease provides some information for practitioners on how far the disease has progressed. The course of AD involves a gradual deterioration over one to twenty years. Early signs and symptoms are often vague, and may last up to fifteen years. Usually, the younger the person is when AD occurs, the more severe the disease becomes.

Reisberg, et. al. developed a screening scale in 1982 to assess an individual's stage of the dementia. This scale has seven stages which are summarized below:

Global Deterioration Scale

1. **Normality** – no complaints by the adult

2. **Forgetfulness** – normal in the aging adult, the person may have some difficulty in word-finding and locating objects. They are typically concerned about this.

3. **Early confusional** – the adult becomes anxious while having difficulty handling complex job tasks. This may be the earliest stage of Alzheimer's, and lasts on average seven years.

4. **Late confusional** – the person needs help in tasks that are more complex, such as handling finances or planning large events. The person's affect becomes flat, and the person may emotionally withdraw, deny, or have tearfulness. This is mild AD and will last about two years.

5. **Early dementia** – in moderate Alzheimer's, the person needs assistance for many things, rendering them unable to function independently. This stage is characterized by an increasingly flat affect, sometimes anger and tearfulness. It may last about 18 months.

6. **Middle dementia** – agitation and psychotic symptoms may accompany this stage, where the adult needs assistance with all ADL's. Later, the person will become incontinent of bowel and bladder. This stage may last 30 months.

7. **Late dementia** – this is the most severe stage of Alzheimer's, and is characterized by pathologic passivity. The person gradually loses speech, the ability to walk, sit up, smile, and hold up head. This stage may last up to five years. When the ability to hold up the head is lost, survival time is variable.

Management for Alzheimer's Disease

The management for Alzheimer's disease is the same as for any and all dementias. Currently, there is no cure for AD, but there are medications that are available that help slow the progression of the disease. Exelon, Aricept, Reminyl, and Cognex slow acetylcholine's breakdown in the blood. In AD, the level of acetylcholine, a chemical in the brain linked to impaired memory or intellect, is deficient. Research shows that by taking these drugs early enough, you can help relieve serious symptoms of AD.

There are also ways to help prevent AD. We are learning about the relationship between cardiovascular risk factors and later development of AD. By getting hypertension, diabetes, high cholesterol, smoking, and weight under control, people may be able to reduce their risk of AD. There is evidence that the use of antioxidant vitamins like C, E, and folic acid may be helpful. There is talk of taking ibuprofen (an NSAID) regularly to reduce your risk of AD. In females with a family history of AD, it is recommended to take hormone replacement at the time of menopause.

Other Dementias

While 50% of all dementias are classified as Alzheimer's dementia, 10-20% are due to vascular disorders, such as multi-infarct dementia, and another 20% may be a combination of AD and multi-infarct dementias.[8] Other less common, progressive, degenerative dementias include the following:

- Korsakoff's psychosis or syndrome related to chronic alcoholism and Vitamin B_1 deficiency
- Parkinson's disease
- Huntington's chorea
- Pick's disease, clinically similar to AD, but very rare
- Creutzfeldt-Jakob disease, a slow-acting viral infection influenced by a genetic predisposition
- AIDS-related dementia (10% of patients with AIDS are more than 50 years old, and dementia can be related to AIDS or Alzheimer's disease)

Management of Dementias

The irreversible nature of dementia and its progressive deteriorating course can have devastating effects on affected individuals and their families. The majority of care required for people with dementia falls under the scope of nursing practice, with safety being the biggest consideration.

A safe, structured environment is essential. Items to trigger memory are useful (i.e. photographs). Noise, activity, and lighting levels can overstimulate the patient and further decrease function; this is especially important with sundowners.

The physical care needs of patients with dementia are at risk of being overlooked. These individuals may not complain that they are hungry; they can not remember to drink water; many are incontinent; they fight their bath so strongly that they are left unbathed; and pressure ulcers on their buttocks go unnoticed. It is important to watch for non-verbal cues since many patients are unable to communicate their needs.

Special attention must be paid to maintaining and promoting *Individuality, Independence, and Dignity*; persons with dementia continue to be valued human beings who are members of families and communities.

Depression

Depression is a disorder characterized by feelings of sadness and despair and ranging in severity from mild to life-threatening.[9]

Depression is the most frequent problem that psychiatrists treat in the elderly, and it increases in incidence with age. It is estimated that 10-25% of the elderly in the community and 12-16% of the elderly that live in long-term care facilities are diagnosed with depression. Another 20-30% that live in long-term care facilities are not diagnosed, even though they display symptoms of depression.[10]

It is not uncommon for depression to be a new problem in old age, while some elders have dealt with it on and off throughout their life. It's not surprising when you stop and think about why. Elderly people are faced with many losses, such as the independence of their children; retirement; changes or losses of roles; and reduced income. Loss of money affects the elders' leisure activities and may affect their ability to meet basic needs. Elders also face decreasing efficiency of the body and the death of family and friends, which reinforces the reality of one's own life. Drugs may also cause depression.

The most common signs and symptoms of depression are:

- Insomnia
- Fatigue
- Anorexia
- Weight loss
- Constipation
- Decreased interest in socializing
- Decrease in regular hygiene practices
- Decreased interest in sex

Symptoms of depression can mimic those of dementia; however, a decline in the intellect and personality is usually indicative of dementia, not depression. It is important to watch for suicidal symptoms – suicide is a real and serious risk among depressed persons. The suicide rate increases with age and is highest among older white men.

Management of Depression

It is necessary to look at the relationship of life events to the depression. The approach for a person depressed from the side effects of a medication will differ from that of a person who has just been diagnosed with a chronic or terminal illness or a person who has just lost a loved one. The underlying problem should be addressed. Depression tends to last longer in the elderly; thus it is important to treat as soon as possible.

The most common treatments are psychotherapy and antidepressants. There are many different antidepressants on the market – when my dad was put on the antidepressant Paxil, his doctor told him, "If I had my way I would have Paxil put in the water towers." Some herbs have been shown to help depression too; St. John's Wort, gotu kola, ginseng, skullcap and lavender. It is important that the physician knows about use of herbal medications because of drug interactions.

Electroconvulsive therapy has been shown to be effective for serious depressions that have not responded to psychotherapy or antidepressants.

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Acupressure, acupuncture, guided imagery, and light therapy in conjunction with psychotherapy can be helpful. Proper diet and regular exercise are good for one's mood as well.

Alcohol and Substance Abuse

The use of alcohol to such an extent that it causes physical or psychosocial harm. Physiologic dependence implies tolerance (example: increasing amounts are needed to get the same effect) and withdrawal symptoms when consumption ceases.[11]

Abuse, dependency, and addiction to alcohol affects roughly 15% of the elderly. The prevalence of heavy drinking and alcoholism declines after the age of 65 for many reasons:[12]

- The current elderly population has lower lifelong drinking habits than its predecessors
- The female to male population ratio increases with age, and women are less likely to consume alcohol
- Declining health or functional impairments, which accompany aging, often lead to a decrease in alcohol intake
- Alcohol-related illnesses and injuries prevent may alcoholics from surviving to old age

Alcoholics come in many forms and often do not fit the stereotypical profile. Some elderly alcoholics have been heavy drinkers throughout their lives. Others start in old age because of situational factors such as poor health, being widowed, or retiring.

Complications develop secondary to alcoholism, such as:

- Cirrhosis
- Magnesium deficiency
- Pancreatitis
- Hypertension
- Heart failure
- Hepatitis
- Chronic infections from a suppressed immune system
- Polyneuropathy
- Irregular heart beat
- Impaired cognition from loss of brain cells and enlargement of cerebral ventricles

These signs should be noted during an assessment and trigger questions regarding the patient's drinking pattern. It is often good to have family involved in getting a history, but keep in mind sometimes family members cover-up for their loved one. It is important to look at what medications the person is taking; many, if mixed with alcohol, can be dangerous to the patient. Signs and symptoms of alcohol abuse can be:

- Drinking to calm nerves
- Drinking fast
- Memory blackouts
- Malnutrition
- Confusion
- Social isolation
- Anxiety
- Irritability
- Depression
- Mood swings
- Lack of motivation or energy
- Injuries/falls
- Insomnia
- GI distress

One of the most useful screening tools is the "CAGE" questionnaire, which asks the following:

1. "Have you ever felt you should **C**ut down on your drinking?"
2. "Does criticism of your drinking **A**nnoy you?"
3. "Have you ever felt **G**uilty about drinking?"
4. "Have you ever had an '**E**ye opener' to steady your nerves or to get rid of a hangover?"

Two or more "yes" responses indicate a probable diagnosis of alcoholism. However, some heavy drinkers are not detected by the CAGE questions, so the questions regarding quantity and frequency of alcohol use should be asked. The National Institute on Alcohol Abuse and Alcoholism recommends asking the following three questions:

1. *"On average, how many days per week do you drink alcohol?"*
2. *"On a typical day when you drink, how many drinks do you have?"*
3. "*What is the maximum number of drinks you had on any given occasion in the past month?"* [13]

Other substance abuse and dependence

Use of illegal drugs is uncommon among elderly patients, although this may change as the baby boom

generation ages. What is seen in the elderly would be abuse of prescription and OTC medications. Alcoholics are at a greater risk of misuse of other medications. Benzodiazepines and opiates are the categories of drugs most likely to cause trouble in the elderly. Alcohol use and abuse is more common in men; benzodiazepine use is more common in women.

Tobacco dependence is the only substance-related disorder more common among the elderly than alcoholism. Tobacco-related illnesses cause tremendous suffering, and the benefits of smoking cessation have been proven. Physician counseling is very effective in helping people quit smoking and should be done at every opportunity.

Management of Alcohol Abuse

For severe abuse or dependence, the long term goal is sobriety; this can only happen if the patient acknowledges he or she has a problem and takes responsibility for doing something about it.

For some, a brief discussion with their primary care physician can greatly reduce alcohol consumption. Some individuals are helped by seeing test results that confirm what their drinking has done (example: elevated liver function test results). Keeping a diary of alcohol consumption is also helpful for many patients.

Look at the reasons as to why they drink and address the issues. For persons with severe abuse or dependence, formal treatment is often necessary. Family involvement can be very important to the success of the treatment plan because sometimes the outcomes can be negatively affected by loved ones denying or enabling the drinking problem. Alcoholics with dementia can rarely maintain abstinence until their access to alcohol is restricted (must have support of family/friends for this).

Alcohol treatment programs are often not geared toward the elderly. It is important to inquire if the staff knows about the unique needs of the older alcoholic. It is important that the nurses competently address their needs. For example, benzodiazepines, commonly used for detoxification, can cause toxicity in older people at the same dosage levels that are prescribed for younger adults. Dosage adjustments are necessary, as is a close assessment for complications.

Elderly patients have about the same success rate as younger patients in structured programs; about 50% remain abstinent one year after treatment. Great support and success can come from attending Alcoholics Anonymous (AA), either following a treatment program or instead of one.

Hypochondriasis

A disorder characterized by physical symptoms that suggest, but are not fully explained, by a physical disorder, by the direct effects of a psychiatric disorder, or by drug abuse. Hypochondriasis is the preoccupation with the fear of having or the idea that the patient has a serious disease.[14]

Diagnosis with hypochondriasis as a mental illness indicates that the person has been reassured by health care professionals that no medical condition exists, but the physical symptoms persist for more than six months. Hypochondriasis is often associated with depression.

For some elderly, complaints about physical illnesses may be an attention-getting mechanism. Some older people may use it as a socialization tool. Their peers will probably have similar ailments, which provides a common theme for conversation if they do not have travels, professions, or interests that they share with others.

Management of Hypochondriasis

First, the physician needs to rule out the possibility of a physical disorder before assuming that the patients' complaints are part of hypochondriasis. Even if the patient is known to be a hypochondriac, the complaints need to be evaluated.

Once any physical diseases have been ruled out, it is beneficial to help the patient find alternatives to their obsession with their bodily functions.

It is valuable to involve the family so they understand the problem and reinforce positive behavior and not get manipulated. Usually, the best treatment is a calm, firm, supportive relationship with a physician who offers symptomatic relief and protects the patient from aggressive diagnostic or therapeutic procedures.

Paranoia

Suspiciousness, persecutory delusions, and paranoid delusions occur often in cognitively impaired or emotionally distressed elderly persons.[15]

Paranoia does not seem that unrealistic considering the following:

- Sensory losses can cause the environment to be misperceived
- Illness, disability, living alone, and a limited budget promote insecurity
- Society gives the message that it's not desirable to be old
- Older people are often seen as easy targets/victims of crime and scams

Paranoia as a mental illness, however, indicates that the suspiciousness, distrust, and preoccupation with motives of others are not based on reasonable evidence.

Management of Paranoia

Assess the cause of their insecurity and misperception. Often glasses, hearing aides, more money/supplemental income, new housing, and a stable environment can reduce or eliminate the paranoia.

If the patient is diagnosed with paranoid personality disorder, psychotherapy and medications can be used.

Do not overlook the patient's general health and well-being. Watch nutritional status; some people think their food is being tampered with and refuse to eat. Others might be sleep deprived, thinking someone is in their house and so they do not sleep much, and some may not seek medical attention when necessary because they think the doctor is the enemy. The best way to handle paranoid individuals is to be honest and give basic and simple explanations to their misperceptions; never support delusions.

Elder Abuse

Definition: physical or psychosocial mistreatment, neglect, or financial exploitation of the elderly.[16]

The most common types of abuse are physical, psychological, neglect, and financial. Each type may be intentional or unintentional. The perpetrators are usually spouses or adult children, but may be other family members, as well as paid or informal caregivers.

Physical abuse is the use of force that results in physical or psychological injury. It includes striking, shoving, shaking, beating, restraining, and improper feeding. It may include sexual assault.

Psychological abuse is the use of words, acts, or other means that cause emotional stress or anguish. It includes issuing threats (example: institutionalization), insults, and harsh commands; remaining silent; and ignoring the person. It also includes treating the elder as a child and encouraging the victim to become dependent on the abuser.

Neglect is failing to provide food, medicine, personal care, or other basic needs.

Financial abuse is the exploitation of or inattention to a person's possessions or funds. It includes swindling, pressuring a person to distribute assets, and managing a person's money irresponsibly.

Risk factors for abuse include impairment from chronic diseases, functional impairment, cognitive impairment, and social isolation.

It is difficult to detect abuse; often the signs are subtle, and the victim is not willing to discuss the situation. Sometimes when abuse victims seek help, their complaints are not taken seriously because others may think that the patient is confused, demented, or paranoid. A physician or other health care practitioner may be the only other person an abuse victim has contact with other than the abuser. All health care providers should be vigilant for spotting risk factors and signs of abuse.

Management of Elder Abuse

If the patient is in immediate danger, the physician, in consultation with the patient, should consider hospital admission, law enforcement intervention, or relocation to a safe house. If the patient is not in immediate danger, steps to reduce risk should still be taken, but are less urgent.

Interventions need to be tailored to each situation. An interdisciplinary team approach (physicians, nurses, social workers, psychiatrists, and other

practitioners) is essential. If the victim has decision-making capacity, he/she should determine their own intervention. If the victim does not have decision-making capacity, the interdisciplinary team, ideally with a guardian or objective conservator, should make most decisions. Often, there is no single correct decision, and each case must be carefully followed up.

Nurses and social workers, as members of the interdisciplinary team, play an important role; assessing patients at risk and reporting of suspected or confirmed abuse is mandatory in all states if the abuse occurs in an institution, and in most states if it occurs at home.

In more than three quarters of US states, including Minnesota, the agency designated to receive abuse reports is the state social service department (adult protective services). At times, family who care for their elderly relative do not even realize their behaviors could be bordering on abusive. Family members or caregiver should be informed of services to help them, including adult day care, respite programs, and home health care.

Summary

Mental health problems are not uncommon in the aging population, and the ability of the elder to successfully cope with mental health issues declines with age. Understanding some of the factors involved in assessing and managing the mental health care of the elder is vital in caring for the elderly patient.

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14. Beers, M. & Berkow, R. (eds.) The Merck Manual of Geriatrics, Internet Edition (2000). *Somatoform Disorders,* section 4, chapter 35.
15. Beers, M. & Berkow, R. (eds.) The Merck Manual of Geriatrics, Internet Edition (2000). *Psychiatric Disorders,* section 4, chapter 36.
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Recommended Reading

1. American Nurses Association. *Scope and Standards of Gerontological Nursing Practice*, 2nd ed. Washington, DC: ANA, 2001.
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4. Fulmer T, Foreman MD, Walker M, eds. *Critical Care Nursing of the Elderly,* 2nd ed. New York: Springer Publishing Co.; 2001.
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7. Maas ML, Buckwalter KC, Hardy MA et al. (eds.). *Nursing Care of Older Adults: Diagnosis, Outcomes, and Interventions.* St. Louis: Mosby, 2001.
8. U.S. Dept of Health & Human Services. *Substance Abuse Among Older Adults.* Rockville MD: DHHS, 1998.

Directions for Submitting Your Post Test for Contact Hours

To obtain a certificate of completion for this home study program, please complete the post-test and evaluation on the next few pages. The date on your certificate of completion will be the date that your home study is received. **Any materials received with a postmark after the expiration will be discarded.**

HealthEast, HCMC, & MVAMC Employees

If you are an employee of HealthEast, HCMC, or MVAMC, you may send the post-test and evaluation to TCHP for processing. Your post-test will be returned to you through your hospital. It cannot be mailed to your home.

Paid Participants

If you are not an employee of one of the TCHP hospitals, please send the post-test and evaluation to TCHP with a check for $12.00. Please make check payable to **TCHP Education Consortium** and mail to:

TCHP Education Consortium
Capitol Office Building
525 Park Street, Suite 120
St. Paul, MN 55103

Your post-test will be returned to you with the certificate of completion.

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Post-Test: Mental Health Issues in ElderCare

Please print all information clearly and sign the verification statement:

Name____
(please print legal name above)

Birth date (required)
Format: 01/03/1999

M	M	D	D	Y	Y	Y	Y

For HealthEast, HCMC, or MVAMC, employees only:

Hospital ______________________Unit___________

Personal verification of successful completion of this educational activity (required):

I verify that I have read this home study and have completed the post-test and evaluation.

____
Signature

1) Delirium may be caused by:
   a) Medications
   b) Metabolic disorders
   c) Alcohol overuse
   d) All of the above

2) What percentage of elders with dementia have Alzheimer's disease?
   a) 25%
   b) 50%
   c) 75%
   d) 100%

3) A patient with Alzheimer's disease who presents to your hospital with psychotic symptoms and need for assistance in all ADL's is in what stage?
   a) Forgetfulness
   b) Early confusional
   c) Middle dementia
   d) Late dementia

4) Essential components of the management of dementia should include all EXCEPT:
   a) A safe, structured environment
   b) Frequent checks of skin condition
   c) Increased auditory and visual stimulation
   d) Monitoring non-verbal cues

5) Signs of depression in the elderly could include:
   a) Fatigue
   b) Weight loss
   c) Decreased interest in socializing
   d) All of the above

6) The prevalence of heavy drinking and alcoholism tends to decline after age 65.
   a) True
   b) False

7) Symptoms to consider in an elder who is potentially abusing alcohol or drugs include:
   a) Drinking/taking a drug to calm nerves
   b) Injuries and falls
   c) Social isolation
   d) All of the above

8) Issues to consider in the elder who is paranoid include all of the following except:
   a) Sensory losses or misperceptions
   b) Nutritional status
   c) Sleep deprivation
   d) Intellect

9) Is it mandatory to report suspected elder abuse in Minnesota when the patient lives in an institution?
   a) Yes
   b) No

Expiration date: The last day that post tests will be accepted for this edition is **December 31, 2017**—your envelope must be postmarked on or before that day.

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Evaluation: Mental Health Issues in ElderCare

Please complete the evaluation form below by placing an "X" in the box that best fits your evaluation of this educational activity. Completion of this form is required to successfully complete the activity and be awarded contact hours.

At the end of this home study program, I am able to:	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
1. Review normal changes of aging related to cognitive, mental, and behavioral health.					
2. Discuss the causes, symptoms, diagnosis, and management of mental illness in the elderly patient.					
3. The teaching / learning resources were effective. *If not, please comment:*					

The following were disclosed in writing prior to, or at the start of, this educational activity (please refer to the first 2 pages of the booklet).		
	Yes	**No**
6. Notice of requirements for successful completion, including purpose and objectives		
7. Conflict of interest		
8. Disclosure of relevant financial relationships and mechanism to identify and resolve conflicts of interest		
9. Sponsorship or commercial support		
10. Non-endorsement of products		
11. Off-label use		
12. Expiration Date for Awarding Contact Hours		
13. Did you, as a participant, notice any bias in this educational activity that was not previously disclosed? *If yes, please describe the nature of the bias:*		

14. How long did it take you to read this home study and complete the post test and evaluation:

    ______hours and ______minutes.

15. Did you feel that the number of contact hours offered for this educational activity was appropriate for the amount of time you spent on it?

    ____Yes

    ____No, more contact hours should have been offered

    ____No, fewer contact hours should have been offered.

Expiration date: December 31, 2017

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