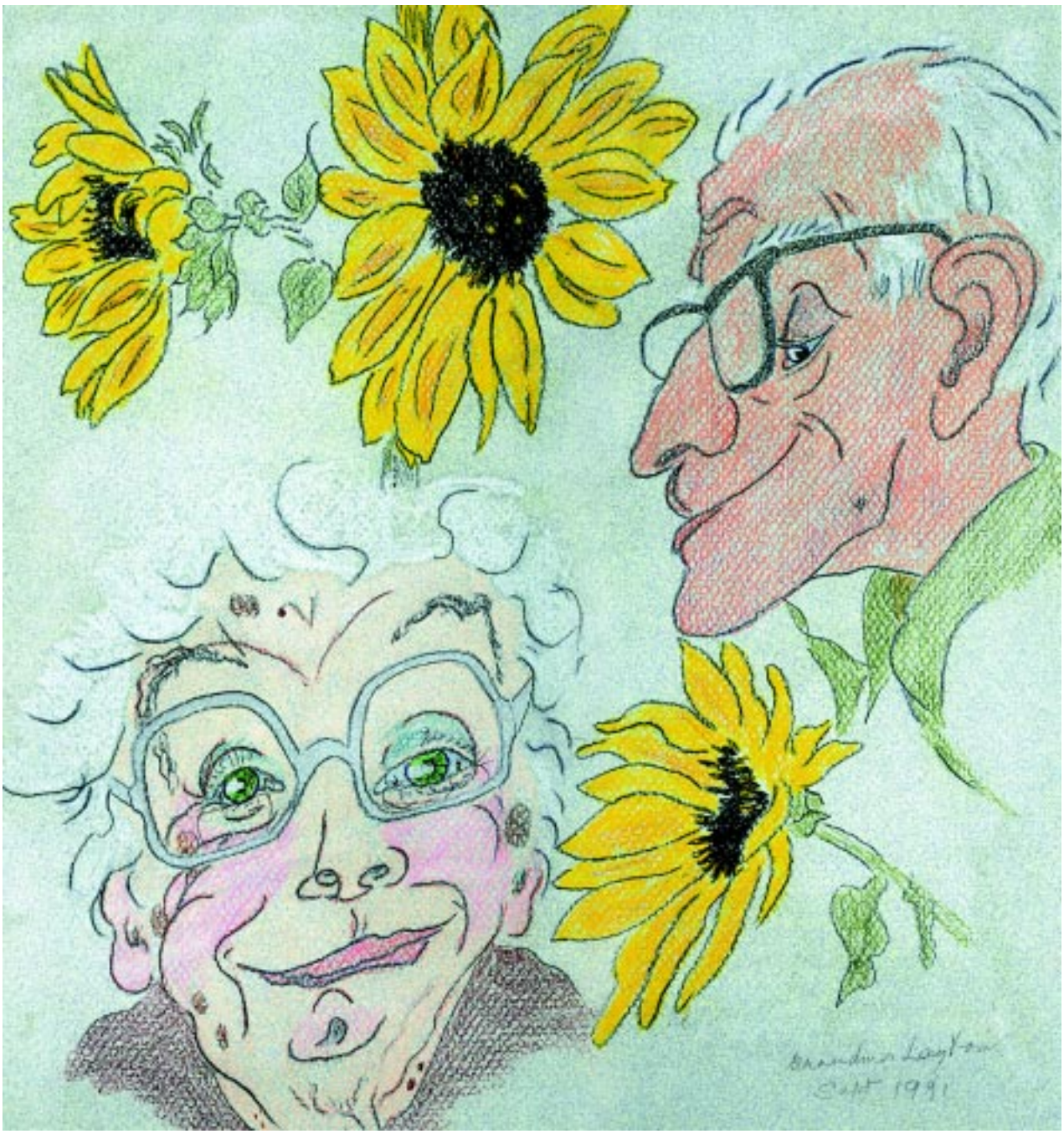

A Mental Health Guide For Older Kansans And Their Families

Mental Health, Substance Abuse, Treatment and Recovery
Kansas Department of Social and Rehabilitation Services
Galichia Center on Aging, Kansas State University
Kansas State University Agricultural Experiment Station and Cooperative Extension Service
Kansas Mental Health and Aging Coalition

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Mental Health, Substance Abuse, Treatment and Recovery (MHSATR), Kansas Department of Social and Rehabilitation Services, administers an array of services for Kansas citizens with mental illness or substance abuse. Direct services range from services provided in three state institutions to direct subsidies to individuals to remain in their homes. MHSATR also conducts major purchase-of-services through contracts with private agencies across Kansas. These services include residential support, supported employment, case management, attendant care and other community supports which enable individuals to live in the least restrictive, appropriate setting. All correspondence and inquiries should be sent to: Mental Health, Substance Abuse, Treatment and Recovery, Kansas Department of Social and Rehabilitation Services, Docking State Office Building - Fifth Floor, 915 S. Harrison, Topeka, KS 66612-1500. Telephone: (785) 296-3773 or toll free (888)582-3759.

Kansas State University's Galichia Center on Aging was formed to establish a focus on aging, to facilitate the coordination of the faculty talents and to orient resources of the university toward identifying and meeting the needs of older citizens. It functions in three major areas: teaching, research, and service. The Galichia Center on Aging coordinates and develops educational and training programs in aging, stimulates and conducts aging research, coordinates outreach activities, and serves as a referral center for information on aging resources in Kansas. Faculty and staff are committed to programs of education, training, outreach and research that address general issues of aging and seek solutions to the challenges of aging in Kansas.

Kansas State University Research and Extension is dedicated to a safe, sustainable, competitive food and fiber system and to strong, healthy communities, families and youth through integrated research, analysis and education. "Knowledge for Life."

The Kansas Mental Health and Aging Coalition was created to educate consumers, family members, professionals, and the general public concerning the nature of mental illness, and to improve the availability and utilization of mental health treatment services to older Kansans and their families. The Coalition works to accomplish these goals through education, reduction of stigma, increased public awareness, and interagency collaboration at state and local levels.

Kansas State University Agricultural Experiment Station and Cooperative Extension Service

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The Kansas Mental Health and Aging Coalition would like to express their appreciation to the family of the late Fran Walden, CARE (Client Assessment, Referral and Evaluation) Level II Manager, Kansas Department on Aging, who self-lessly contributed her expertise and energy to our many projects, one of which is the writing of this book. Her support will be warmly remembered.

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Mom's Story

Mother was born in 1914, the youngest of four surviving siblings living in a small Missouri town on the Mississippi River. Mom was petite, weighing only 98 pounds when she married. When my father met her, Mom was getting on a streetcar in Kansas City and was a "knockout" (his words). He called her his Trolley Dolly. I recall Mom, when I was young, as "five-foot two, eyes of blue" (even though her eyes were not blue).

Mom always considered herself to be a teacher, first teaching piano as a young woman. She earned a degree from Kansas City Teachers College and taught elementary school in the Kansas City School District a total of 16 years. She loved animals (cats and dogs), car rides, ice cream, and her family. And she stressed honesty, hard work, love, and education to her sons. Oh, yes, sons were always better than daughters. Two sons have graduate degrees and one son is a successful writer. (At her funeral, his eulogy alternately had the mourners laughing and crying.)

But there is another side to Mom's story.

When Mom was 6, her mother died during an appendectomy. Her alcoholic father was not able to care for her or her sister. A Presbyterian minister (a wonderful man) and his wife (not a nurturing type) moved her across the state to raise her, away from all of her family.

A male neighbor abused her without her foster parents' knowledge. (She kept this hidden until she was an old woman.)

Her third son, who was born with a heart defect (he was referred to as a "blue baby"), died at age 6 during open heart surgery. Mom cared for her invalid foster mother for several years, including the last four months of her foster mother's life, when she was confined to bed in Mom's home. At the same time she was raising a preschooler and two older sons.

At age 57, Mom had a heart attack while teaching at school. Although she had planned to return to work, her doctor said she had massive heart damage and would never be active again. He was right: She wasn't active. She became more dependent than ever and lived with congestive heart failure for 27 more years.

At age 60, Mom was diagnosed with clinical depression and was hospitalized several times. She was treated with electroshock therapy, which caused some memory loss. The depression was with her for the rest of her life.

When Mom was 64, she and my father came to live with me and my family. My father died 10 years later. At that time Mom's physician predicted that she wouldn't live another six months. That was when, with our encouragement, she sought help from Johnson County Mental Health Center.

Bolstered by the group therapy, family therapy, and other services provided by Johnson County Mental Health, Mom lived another seven years. Six of those years she continued to live independently in an apartment in my home; the last year she was at Johnson County Nursing Center. As a result of the help she received, Mom became more independent in those last years than she had been since her heart attack. She began to take care of her own meals, write her own checks, and make and go to her own doctor and group therapy appointments.

This is the story of my Mom. It could have been the story of yours.

—By Kevin A. Gratton, Ph.D.

Facts And Myths About Mental Health And Aging

Introduction

If you feel stressed, do you know some easy things you can try to reduce those feelings? If you forget someone's name, do you worry that you are developing Alzheimer's disease? If you received treatment for depression when you were young, are you worried that it will recur late in life? Are you concerned about a friend who can't seem to stop grieving the death of her husband and who talks of dying?

If you are worried that you, an older relative, or someone you know might be experiencing a mental health problem, do you know how or where to find help? Do you know what Medicare, Medicaid, or private insurance coverage offer to help with the costs of obtaining mental health services?

This guide provides a practical, easy-to-use resource about mental health problems and mental health services for use by older Kansans, their families, and non-mental health service providers. It describes why people might have mental health problems, the symptoms and treatments for common mental health disorders experienced by older adults, when someone should seek treatment, the kinds of mental health services available in Kansas and how to gain access to them, how to help someone who is experiencing a mental health problem, and information about medications often used to treat mental disorders.

What do you know about Aging and Mental Health?

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

T F 1. All old people are crabby.

False: If you are crabby when you are 25 and 35 years old, chances are that you will be crabby at 55, 75, and 95. Our basic personalities do not change much.

T F 2. The majority of older adults live in nursing homes.

False: At any one time, only about 5 percent of people 65+ are living in nursing homes, and the percentage in decreasing. However, a far greater percentage of people can expect a limited nursing home stay at some point in their lives. Older adults can help themselves stay healthy by living a heathy lifestyle and continuing the activities that they enjoy.

T F 3. Isolation and hearing loss can cause paranoid thinking.

True: Paranoid thinking can develop under these difficult circumstances, when words and sounds may be misinterpreted.

T F 4. Growing old does not really change a person's ability to learn.

True. People maintain the ability to learn throughout life unless a disease interferes. However, learning for some older adults may be slower, and there are some small changes in memory. Older adults' intellectual abilities remain much the same as when they were younger.

T F 5. Serious mental health problems are most common in older people.

False: Only one in eight older adults has been diagnosed with a mental disorder, the lowest rate among all age groups.

T F 6. Older adults can benefit from counseling or psychotherapy.

True: These "talking therapies" often can help older adults, and are used alone or in combination with medication.

T F 7. Poor nutrition can produce mental health problems.

True: Poor nutrition can lead to apathy, confusion, and depression, which then can cause even worse nutrition. Some medications, dental problems, and diseases that make it difficult to cook or eat may increase the risk of poor nutrition.

T F 8. Most older adults would prefer to be young if given the choice.

False. Most older people are satisfied with their lives. They are not eager to turn back the hands of time.

[1] Questions adapted from *The Facts on Aging and Mental Health Quiz* and *The Facts on Aging Quiz* (Palmore, E.B.

Successful Aging

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

There is good news for people approaching or already in their older adult years. They are likely to live longer and be healthier and more independent than people in earlier generations. We have learned that many of the challenges older people face are not necessarily part of normal or usual aging, as was often assumed, and aren't inevitable. Research now tells us disabilities we may experience as older adults come from three things:

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

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

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

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

Reduce risks of disease and disability

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

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

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

Did You Know?

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

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

Maintain mental and physical function

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

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

Stay engaged with life

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

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

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

Tips for Good Mental Health

DO be flexible and learn to adapt to changing circumstances.

DO use your mind and stay active.

DON'T abuse prescription or over-the-counter medications (such as tranquilizers, sleeping pills or alcohol).

DO get regular physical checkups.

DO set goals for yourself and work toward them.

DO check your general attitude: positive or negative? Have you laughed recently?

DO exercise regularly, eat nutritiously, get adequate sleep.

DO learn and know signs of depression; it is treatable.

DO avoid isolating yourself; isolation is a breeding ground for depression.

DO develop and maintain good relationships with others for support.

What Is Mental Health?

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

Common Stressors

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

These are some of the challenges that can lead to serious physical and mental health problems. We are especially at risk if we experience a great deal of stress, have difficulty adapting to change in circumstances and routines, do not have supportive relationships, have difficulty relying on others to help cope with losses, or tend to have a negative outlook on life.

Did You Know?

Mental health problems are common. One in four people experience a mental health problem sometime during their lifetimes.

Checklist of Major Stressors

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

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

Dealing with Everyday Stresses

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

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

Checklist of Stress Symptoms

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

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

Relaxation and Breathing Techniques

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

Easy Meditation Techniques

By allowing yourself to mentally focus on a single, peaceful word, you can create a feeling of relaxation. Reduce distractions in the room: Turn off the television and/or radio and close the door to help keep the room quiet. Sit comfortably, and loosen any tight or restrictive clothing. Close your eyes, and begin to breath slowly and deeply. Picture in your mind a peaceful word. If your mind wanders, turn your attention back to your breathing, and keep repeating your chosen word. For example, if you start thinking about the shopping list, refocus onto your word. Do not worry whether you are relaxing deeply enough or getting the "right" response. If you keep doing it, stress will be reduced.

Visualization

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

Try Humor

Life is like a hot bath. It feels good while you're in it, but the longer you stay, the more wrinkled you get.

-Garfield

Exercise Can Help Mental Health

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

Tips for exercise success:

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

Start out slowly with proper training and supervision. Be realistic about what you can do: Remember the tortoise and the hare!

Stretch before and after exercise to improve movement and flexibility and reduce the risk of injury.

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

Choose enjoyable activities. If you don't like the activity you do, you'll quickly find excuses not to do it very often.

Make small changes so that exercise is part of your daily activity. If you drive the car to do errands, park a few spaces farther away and walk a little farther.

Exercise with a friend or a group. Set goals together and make it fun.

A Little Stress Ditty

For every problem under the sun
There is a remedy or there is none,
If there is one, then go and find it

Dorothy's Story

If there is none, then never mind it.

—Maria Arapakis, *1998*

Dorothy is an intelligent 80-year-old with a master's degree in English. Her husband of 56 years died a year ago after a prolonged illness. They had been very close over the years, and his death was a major loss to her. The costs of his illness used up their retirement savings, so Dorothy is learning how to live on just her Social Security income.

Dorothy "did all right" until two months ago. She believed she did the necessary grieving for such a critical loss in her life. She cried frequently, slept poorly, and lost weight that first month or two, but then tried to resume some kind of normal life. Until two months ago, she thought she was doing "OK." However, she developed some blood pressure problems and had a couple of black-out spells. She couldn't drive until her doctor could find and control the cause of her blood pressure problems.

The loss of her independence and control over her ability to come and go as she pleased made Dorothy feel even lower in her attempt to cope with the profound loneliness and emptiness in her life. She began going out with friends less often and stopped going to church. She found herself crying for hours at a time "for no reason." She stayed in bed until midmorning, even though she seldom slept more than 30 minutes at a time during the night.

Dorothy's physician recognized the signs of depression and started her on an antidepressant medication. Dorothy had never been one to take medications, and she felt that this one upset her stomach. It was stopped and another one was started, with the same results.

A friend who frequently stopped by to visit noticed Dorothy's deep sadness, the fact that she seldom went out and that she hadn't gone to her club meetings or church in several months. The friend suggested that Dorothy "get some counseling" and suggested contacting the Community Mental Health Center (CMHC). She told Dorothy the fees were figured on a sliding scale, based on income and medical expenses, and that people covered by medical assistance pay very low or no fees.

Dorothy took her friend's advice. After three sessions, she began to feel better. With her therapist's encouragement, she began making herself go out with friends, go to church and resume her involvement with her book study club. After eight sessions, her depression had lifted. She was sleeping normally and reengaged in life.

While not everyone improves this quickly, many people do. Often a combination of medication and therapy are needed to relieve depression, but in Dorothy's case, therapy alone was sufficient.

While grief usually does not turn into a clinical depression, it can. This is especially more likely when more than one loss occurs over the course of several months.

When Mental Health Problems Occur

Mental disorders are not part of normal aging, but circumstances that can contribute to the development of mental health disorders in older adults include social isolation, stressful living conditions, bereavement, acute and chronic health conditions and the burden of having to take care of a seriously impaired family member. Many older people develop mental health problems for the first time when they are in their later years. It is important to remember that these problems are treatable. A smaller number of older adults have a history of serious and persistent mental health problems that began in younger years and continue to require treatment as they become older.

How Many Older Adults Are At Risk?

Approximately 33 million people in the United States are 65 and older: nearly 13 percent of the population, or about one in every eight Americans. In Kansas, the number is slightly higher — almost 14 percent. The numbers are growing. From 1900 to 2000, the percentage of Americans 65+ has more than tripled. In the new millennium, these changes will accelerate. The number of older Americans is increasing not only because more people reach age 65, but also because older adults are living longer. More and more people are living well past the age of 85.

- Ten to 28 percent (3.3 million to 9.2 million) have mental health problems serious enough to need professional care.
- Twenty percent (6.6 million) are estimated to experience problems serious enough to put them at risk of psychiatric hospitalization or premature nursing home placement. For this group, the ability to maintain themselves in the community can become compromised as they experience serious mental, physical, social and environmental problems.
- Those who are isolated, who live alone — whether in a rural or urban location — and who have mental health problems such as Alzheimer's disease or severe depression, are especially at risk for hospitalization and nursing home placement.
- Older adults (age 60+) account for about one-fourth of all suicides in the United States and are more likely than younger persons to die from their suicide attempts.

When we read that one in three people have a mental disorder during their lifetimes, or that 14 to 17 percent of people age 60 and older have problems with alcohol, we often don't connect these numbers to real people — ourselves, our families, and our friends. Even applying these numbers to what we know about the population of Kansans age 65 and older can make the problems seem distant. For example, of those 351,595 Kansans in 1997 (Profile of Older Americans, 1998), approximately 117,200 will have suffered a mental disorder during their lifetimes, and 70,300 are at risk for a serious mental health problem. We need to bring these numbers home: Who are these individuals in our families and our

Who is at Risk

communities? The story on the next page illustrates what statistical information about older adults and mental health might mean for real people.

Imagine a Memorial Day or Fourth of July community picnic at the park in a small town here in Kansas. Your plate is loaded with great food, and you sit down at the last place at a large picnic table. The other nine places are already occupied by the kinds of older people you might find in any town like this ...

There's **Dorothy**, who lost her husband just over a year ago after a long illness. She has been looking forward to visiting with her friends, especially the ones who have moved away and returned for this special annual celebration. She is busy chatting with **Mary**, who has come back to visit for the holiday weekend. She had lived here for more than 50 years, but moved to Texas last winter to live with her daughter. Dorothy and Mary lost their husbands about the same time, and they shared a lot of their grief with each other. Mary tells her how much she misses her old hometown and all her friends. She enjoys being able to be closer to her family, seeing her grandchildren every day, and having her own apartment in the remodeled house, but making new friends her own age has been difficult. She is finally getting to know women through the exercise program she joined at the senior center, but still wishes she could visit her lifelong friend more often.

Mary is sitting across from **Clara and George**, who just moved back to town this spring. George grew up in the town, but left when he joined the army after high school. He and Clara came back each summer, though, to visit his parents, both of whom are 90. In fact, they picked up **Emma and Albert**, and brought them to the picnic today. Emma made her famous strawberry pie, just as she has every year, and she grins with delight as friends stop to compliment her. She doesn't get out much now, and spends most of her time caring for and worrying about Albert, who has been diagnosed with Alzheimer's disease. His diagnosis and her chronic heart disease and diabetes were the main reasons their son and Clara decided to move back from Kansas City when George retired this year. Luckily, they can afford a nice home, and the river is nearby, so George can fish. They also plan to take some month-long trips in their motor home as soon as they arrange some help for Emma in caring for Albert.

George is the one who convinced Emma to see the doctor when she just couldn't seem to stop worrying about Albert. She was surprised when the doctor told her it might be partly due to the combination of medications she was taking. She feels a little less anxious now, after a change in her heart medications, but Emma thinks that the biggest difference is having George and Clara nearby to help when she needs it.

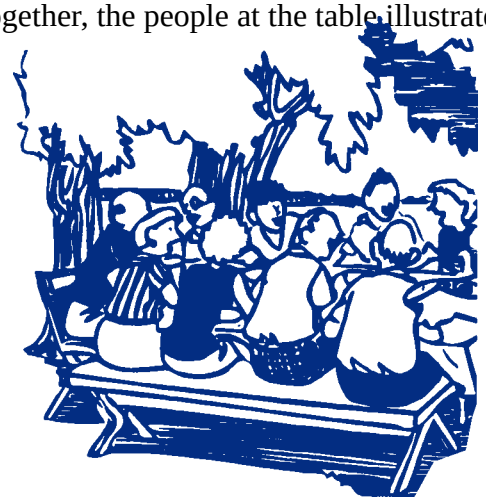
Louise and her 8-year-old granddaughter, Melissa, are sitting next to Albert and Emma and are enjoying the last two slices of Emma's pie. As a schoolteacher, Louise taught the children of almost everyone at the table. She raised her own eight children alone after her husband died in a farm accident when their youngest child, Jennifer, was 6 years old. Louise loves teaching, and had planned to teach at the town's elementary school for many more years. But her family's needs have always come first, and she took early retirement when Jennifer could no longer take care of Melissa.

Unfortunately, Jennifer, who is a single parent, is part of the 1 percent of the population diagnosed with schizophrenia. Although she is receiving treatment and her prognosis is positive, she is not able to provide the parenting that Melissa needs, and Louise has become a parent again at age 60. Fortunately, she has a lot of energy and has been able to stay involved as a classroom volunteer, but she worries about whether her retirement savings can be stretched to cover these unexpected years. Luckily, she has always had a positive outlook, and as long as she has her health, she believes that everything will work out.

Finally, at the end of the table, there are **Gertrude**, age 74, who still helps run the cafe, and her older brother **Ed**. Gertrude has been divorced for many years, and has no children. She likes the chance to work at the cafe for a few hours each day and to be one of the first to hear all the town news. She can't imagine ever stopping what she is doing, and couldn't wait to get back to her job after being treated for cancer 10 years ago. She is sure the support she received from so many friends made the difference in being able to cope with her feelings at that time, and she tries to give that support to others whenever she can. People in town know that if there is a crisis, or a community event, Gertrude is the one to ask for help.

Some people in town joke that they can't understand how Gertrude and Ed can be related because Gertrude loves to be with people all the time, and Ed is the opposite. Ed, a bachelor all his life, says he can't imagine having to live with anyone. He refuses to move into town from the family farm, even though his health is starting to fail, and he really can't take care of the household chores. Rumor has it that he drinks a lot, but he keeps to himself. Gertrude can convince him to come into town sometimes for dinner and a couple of beers at the cafe or for something like this picnic, but otherwise people don't see much of him. He tells everyone that he can take care of himself, and he doesn't want any nosy do-gooders telling him what to do. He plans to live at the home place until they "have to carry me out feet first," and he'll shoot anyone who tries to make him do otherwise.

And of course, you have taken the last place at the picnic table. Perhaps you see some characteristics of someone you know or once knew in one or more of these older people. What is important to realize is that together, the people at the table illustrate



how often older adults experience different daily stresses, mental health risks, and mental disorders, and how they can deal with those stresses.

Treatment Facts

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

In Kansas, about 13.5 percent of all residents are 65 or older. Based on the number of clients age 65+ who received inpatient or outpatient mental health services in 1994, older Kansans are underserved. A report on services provided through the 30 Community Mental Health Centers across Kansas shows that only 4,648 older adults, or 6.6 percent of the total number of adult clients, received services in 1997.

Why? Here are some possible reasons

- Many older persons at risk for serious mental disorders, including those with dementia, do not refer themselves for help or assistance.
- An increasing number of at-risk older adults have no family members available to assist them in seeking services.
- There is an overwhelming lack of information on the mental health needs of older minorities and foreign-born populations in the United States.
- The stigma of mental health problems can prevent older adults from seeking treatment.

Did You Know?

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

Some Common Disorders And Their Treatments

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

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

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

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

- Present distress (such as a painful symptom).
- Disability (impairment in one or more areas of functioning).
- A significantly increased risk of suffering, death, disability.
- An important loss of freedom.

They are not the same as:

- Expected responses to events, such as death of a loved one.

This section describes the most common kinds of mental disorders experienced by older people, including symptoms and effective treatment options. Types of disorders described include depression, dementias, common anxiety disorders, personality disorders, substance abuse disorders, and schizophrenia.

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

Did You Know?

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

Depression In Later Life

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

Depression can be a common and significant problem in elderly individuals and long-term care patients. Depressive symptoms occur in more than five million (16 percent) of the estimated 33 million Americans over age 65. Among older Kansans, this represents well over 50,000 individuals. The rate of depression in nursing homes is greater. Reports indicate that almost one in four nursing home residents may suffer from depression. In addition, approximately one-fourth (20 to 35 percent) of older adults with a significant medical illness may also be depressed. With effective therapy, however, almost 90 percent respond to treatment.

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

What Causes Depression?

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

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

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

Did You Know?

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

What is Depression?

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

Symptoms of Depression

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

In older adults, these additional symptoms often are present:

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

Bipolar Disorder

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

Symptoms of Mania

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

Treatment For Depression

Medication Therapy

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

Many new antidepressants (and some trusted older ones) may benefit the older person. A psychiatrist, especially one who has experience working with older individuals, is the best choice of medical doctor for prescribing antidepressants. In Kansas, Advanced Registered Nurse Practitioners (ARNPs) with speciality in psychiatric mental health may also prescribe medication. It is important that the health-care provider understand the unique health problems of the older person and the combination of other medications the person takes. The older person often requires a smaller dose of medication because of the way his/her body processes the drug. Also, the older person's response to the medication may be slower than that of younger adults. A separate section in this booklet describes medications used to treat mental disorders, including depression.

The person being treated must be patient and give the medication time to work. When first prescribing an antidepressant, the doctor will usually want to "start low and go slow" on the dosage to see how well the drug works. Medication for depression requires a few weeks or longer to build up to a therapeutic level in the body and to start improving symptoms. The medication must be taken regularly, exactly as prescribed, and not just when a person is feeling bad.

Because some antidepressants can cause tiredness, confusion, headache, nausea, or dizziness, they may be prescribed to be taken at bedtime. Some of the newer medications (SSRIs — see section on medications for more information) tend to have fewer side-effects and seem to be tolerated more easily by many older persons. Medication adjustments will be needed to find out what works most effectively for each individual. Over time, the doctor may change dosages, time of day taken, or may change medications altogether until the most effective one is determined. Once an appropriate medication and dosage are found, the older person needs to understand that he/she may continue to take it for a number of months to prevent a recurrence of the depression. If a person has a history of severe or recurring depression, lifelong medication may be needed. It is important not to stop taking a medication without first checking with the health-care provider.

Psychotherapy

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

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

Both Medication and Psychotherapy

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

Other Treatments For Depression

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

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

Suicide: The Risk Of Unrecognized Depression

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

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

Some older persons may not take an active step toward suicide but may quit taking important medications or may not eat properly because of a desire to fade away. It is important to seek help immediately if a person has thoughts of suicide or seems to have lost interest in taking care of her/himself. (See "Helping Someone..." page 58)

Did You Know?

Free, confidential professional screening for depression is available in many communities. To locate the screening site nearest to you, or to obtain more information about depression, call the Information Line for the Campaign on Clinical Depression, sponsored by the National Mental Health Association and its affiliates: 800 / 228-1114.

Some Risk Factors for Suicide

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

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

Some Tips for Dealing with Grief

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

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

Grief And Depression

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

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

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

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

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

Differences Between Grief And Depression

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

Daisy's Story

Daisy was 89 when she had to deal with a loss that seemed as difficult as the death of her husband 10 years before — giving up her car keys. Her daughter believed that the macular degeneration in Daisy's eyes and her arthritis meant that she might not be able to react fast enough in an emergency. Daisy knew she couldn't live with herself if she were responsible for hurting someone else. After a visit to the doctor confirmed that her vision was getting worse, she quietly decided to give up the most important symbol of her independence.

A car had always meant that she could go where she wanted, when she wanted, and help others when they needed it. She had learned to drive when she was 10, and she had loved driving ever since. She even drove trucks as a motor pool volunteer during World War II. She had driven on cross-country trips until she was 85, and still drove to her volunteer work at the library and the historical society, as well as to deliver Meals on Wheels. Now, having to give up some of her volunteer activities and ask her daughter or a friend for rides was almost more than she could bear.

Daisy felt some of the same emotions she had when her husband died — the sadness, frustration, anger — but her family didn't realize that she was grieving for the independence she had lost. Luckily, Daisy had learned what helped her to deal with her grief in the past, and she put those lessons to work again without help from a mental health professional.

What Do You Know About Mental Disorders And Aging?[1]

T F 1. Cognitive impairment (memory loss, disorientation, or confusion) is an inevitable part of aging.

False: Only 5 to 15 percent of people over age 65 have any kind of dementia. For people over 85, the chances of developing a dementia increase.

T F 2. Alzheimer's disease is the only reason older people develop cognitive impairments.

False: Although Alzheimer's disease is the most common cause of cognitive impairment for older people, many other types of dementia and health problems — such as strokes and severe depression—also cause memory loss, confusion, and disorientation. If a person develops such symptoms it is important to get professional help, since some forms of cognitive impairment are easily treated and reversible.

T F 3. Most people with dementia act the same way.

False: Although all people with dementia experience confusion and memory loss, the degree to which they suffer from these problems varies over time. Losing things, hiding things, wandering, inappropriate sexual behavior, insulting or aggressive behavior, and repetition may occur or not, depending on the individual and the course of the disease if it is progressive (like Alzheimer's).

T F 4. Major depression is more common among older people than younger ones.

False: Major depression is less than half as common among people over 65 than among people of all ages. However, more than a quarter of older people experience some depressive symptoms.

T F 5. One-fourth of all suicides are committed by older persons.

True: Although the rate of suicide among women does not increase with age, for men the rate doubles between age 40 and 75. Men also tend to be more violent and to die from their attempts.

T F 6. Most older adults who live in nursing homes suffer from mental disorders.

True: Three out of four older adults in nursing homes suffer from one or more mental disorders, including dementia, depression and anxiety.

T F 7. More older people use mental health services than do younger people.

False: Fewer older people use mental health services, not only because this age group experiences fewer severe problems, but also because of the stigma of mental health problems. Many older adults feel strong resistance to admitting such problems and seeking help.

Questions adapted from *The Facts on Aging and Mental Health Quiz* and *The Facts on Aging Quiz* (Palmore, E.B.

Dementias

What is Dementia?

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

There are many causes for dementia, with perhaps the best known being Alzheimer's disease. Although Alzheimer's disease is the most commonly diagnosed, there are many other dementias, including vascular dementia, Huntington's, Pick's, Binswanger's, and Lewy Body diseases. Dementia also can occur with Parkinson's disease. There are some additional conditions that may imitate dementia, including depression, brain tumors, head injuries, infections, drug reactions, thyroid problems, nutritional deficiencies and other neurological disorders. Because many of the causes of memory problems in older adults are treatable, it is imperative that a person have a thorough diagnostic evaluation by health care professionals.

Delirium is Not Dementia

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

Memory Loss Check List

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

- Has the change in memory happened since a new medication was started or since a medication was increased?
- Has a thorough physical been done to be sure there is no underlying medical illness that might be causing the memory problems?
- Has the doctor checked, using specific blood tests, to be sure thyroid levels, B_{12} levels, and others are normal?
- Has there been a recent loss — such as the death of a loved one, the death of a pet, divorce, loss of a job, financial loss, or the loss of an important relationship (due to moving away or an argument)? If so, depression could be causing the memory problem.
- Was there a recent fall, with possible head injury?
- Is nutrition adequate?
- Is the person drinking more alcohol, or taking a medication that increases alcohol's effects?

Differences Between Depression, Dementia, And Delirium

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

Alzheimer's Disease

Alzheimer's is probably the most common of the diseases that cause dementia. It is estimated that Alzheimer's disease affects more than four million Americans. This disease is progressive (the effects become more severe over time). Currently we do not know how to prevent or cure the disease. However, there are medications that can help slow the disease in some people. These medications work best when started early in the disease, so it is important to talk with a health-care professional. In addition, there are medications and behavior changes that can help the older person and family deal with some of the symptoms. (See page 69 for more detail on Medications.)

The early symptoms of Alzheimer's disease include a very gradual change in the person's ability to remember normal things, such as appointments, names or things that happened within the recent past. As the disease progresses, memory of events earlier in the person's life will also be forgotten. There may be personality changes, and at times a person may become quite suspicious, depressed, hostile, or even see or hear things that are not there. The average length of time from diagnosis to death is approximately seven years, although the lifespan range for individuals with Alzheimer's disease varies from three to 20 years. It is often said by clinicians who specialize in treating Alzheimer's patients that 90 percent of people with Alzheimer's belong at home for at least 90 percent of the illness. Some assisted living and nursing home units have environments and programs designed especially to care for individuals with Alzheimer's and other dementias. These special care facilities should have staff who are specifically trained to deal with people who have moderate to severe dementia.

Did You Know?

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

- Giving a noncommittal answer
- Changing the focus of attention to another topic or another activity
- Changing the environment to reduce anything that might increase confusion
- Considering what the person might be trying to communicate. If someone insists it is winter when it is July, is the person feeling cold?

Vascular Dementia

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

Pick's Disease

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

Lewy Body Dementia

Lewy Body dementia is another irreversible brain disease, associated with deposits of a protein substance called Lewy Bodies in the brain. This is a less common form of dementia than Alzheimer's, and it can be misdiagnosed as Alzheimer's, because the symptoms are similar. A person with Lewy Body dementia may have trouble remembering, may have episodes of confusion, and may have difficulty communicating clearly or following a conversation. The person's functioning may fluctuate substantially. For example, the person may function well for several days or weeks, and then have days or weeks where he/she is confused and has trouble remembering. Early in the course of Lewy Body dementia, the person also may see or hear things that aren't there. (Although people with Alzheimer's disease may develop these symptoms, they happen later in the course of their illness.) Regardless of the type of dementia, such experiences are often frightening. People believe that what they see and/or hear is real and that others may be trying to harm them or steal things from them. Medications usually stop or decrease the hallucinations.

Binswanger's

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

Dementia Associated with Parkinson's Disease

Parkinson's disease is a chronic, slowly progressing disease caused by a chemical imbalance of two neurotransmitters (dopomine and acetylcholine) in the brain that destroys certain nerve centers. A person with Parkinson's disease develops tremors (shaking), rigidity and slowness of movement. He or she may have difficulties with movement, balance, walking and dexterity. Some people with Parkinson's disease may experience depression, and 10 to 40 percent experience dementia. Medications are used to control the

symptoms of the disease. Although there currently is no cure for the disease, many people live out their normal lifespans.

Huntington's Disease

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

Caring For Someone with Dementia

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

DO talk with someone who has dementia: Talking and listening are some of the most enjoyable activities we do.

DO look directly at the person, make eye contact, and be sure the person is paying attention to you. Try to be on the same eye level: Don't talk down to someone from a standing position.

DO remember that a person may also have hearing or sight problems that make it harder for the individual to understand you.

DO talk about the past with someone who has dementia. For some people, old photographs, memorabilia, or familiar music can trigger memories and stories about the past.

See page 60 for further suggestions about caring for someone with dementia.

Anxiety Disorders

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

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

Sometimes symptoms of anxiety are related to a physical illness or the medications taken for that illness. This is the case for many chronic physical illnesses older adults have. For example, people with chronic heart disease have a higher than average rate of anxiety, and digoxin, taken for heart disease, can cause anxiety. Confusion and anxiety are common with congestive heart failure. People with pulmonary disease often have feelings of fear, anxiety, and irritability because of an inadequate level of oxygen in their systems. Common medications for pulmonary disease — such as corticosteroids, bronchodilators, and Theophylline — can cause irritability and anxiety.

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

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

Signs Of Anxiety Disorder

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

Some Symptoms of Anxiety Disorder

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

Common Anxiety Disorders

Panic Disorder

Panic disorder is a diagnosable and treatable illness during which people experience sudden and recurrent "panic attacks" usually lasting between five and 30 minutes. These panic attacks can happen several times a week or within the same day. They reach their peak in about 10 minutes, but leave the person emotionally drained and frightened. Panic disorder sufferers often live in fear of having another attack because the attacks can occur without warning. They may avoid

places or situations where the first attack occurred — or they become afraid to go out in public at all. Many individuals who have panic attacks also suffer from depression.

Panic Attack Symptoms

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

Panic Disorder Symptoms

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

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

The most important decision I've made in my life was the conscious effort not to worry about growing older, to celebrate each new birthday with enthusiasm and happiness.
—Jack Lemmon, *New Choices*, March 1989

What Causes Panic Disorders?

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

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

Agoraphobia

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

Phobia

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

Specific Phobia

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

Social Phobia

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

Obsessive-Compulsive Disorder

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

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

Examples of Common Obsessions

- Repeated thoughts about being contaminated with germs (e.g., from shaking hands or touching a doorknob).
- Repeated doubts (e.g., about having left the door unlocked or the stove on).
- Feeling that items, such as one's dishes or books, must be arranged in a particular order.

Examples of Common Compulsions

- Excessively washing one's hands or showering again and again.
- Excessive and repetitive cleaning or dusting.
- Repeatedly checking door locks or light switches.
- Arranging items in a particular, precise order for no useful reason.

Post-traumatic Stress Disorder

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

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

Treatment for Anxiety Disorders

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

Medication Therapy

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

Merle's Story

Merle is a 76-year-old widower who still lives on the family farm in western Kansas. Merle's family had been concerned that he spent too much time alone and had encouraged him to become involved in activities at the local senior center.

Merle had occasionally visited the nutrition site and had observed others involved in playing dominoes or pool, but he stayed mostly to himself. He told his children that he would rather not attend lunch at the nutrition site because he always ended up with an upset stomach and chest pains. His family encouraged Merle to see his doctor and have a thorough check of his heart and digestive system.

After his physical, which proved Merle to be quite healthy for his age, the doctor investigated the possibility that Merle might be suffering from an anxiety disorder that was aggravated by social situations. He discovered that Merle had always been uncomfortable in crowds. Even as a younger man, he suffered from cold sweats, heart palpitations, and queasy stomach when he was in a group of people. The doctor convinced Merle to try an anti-anxiety medication and to continue to attend activities at the senior center. Merle found relief from his physical symptoms and was able to involve himself with others at the center. He felt less lonely and more satisfied with life.

Psychotherapy

Psychotherapy, or talk therapy, is effective in helping the individual suffering from anxiety gain control of her/his feelings, thoughts, and behaviors. The opportunity to identify the feelings of being overwhelmed, angry, sad, or hopeless can help the individual understand the reason for those feelings and gain control over them. Often the person with anxiety thinks there is something very wrong with him/herself resulting in negative self-talk. In psychotherapy, an older person can gain a better understanding of the reasons for self-doubt and gain a more positive attitude. Talking about feelings can help the individual react differently when an anxiety-producing situation presents itself. Relaxation therapy is also helpful. When a person feels anxious, the body tenses, creating even more anxiety. In relaxation therapy, a person learns to breathe more deeply and to relax muscles, decreasing body tension.

Personality Disorders

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

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

There are many types of personality disorders, with degrees of severity and dysfunction in each. The more widely known personality disorders include: obsessive-compulsive, antisocial, narcissistic, depressive, dependent, and borderline. Examples of narcissistic, borderline, and dependent personality disorders are described below.

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

An individual with a borderline personality disorder may be seen as having erratic moods, being impulsive and/or angry, often engaging in self-destructive acts, and having chaotic interpersonal relationships. A primary problem for people with a borderline personality disorder is a vulnerability to intense emotional reactions while being unable to regulate their emotions. They often suffer from depression, self-hatred, and hopelessness. These people are often in crisis, and frequently injure themselves intentionally (for example, overdosing on medications or cutting themselves). Among those who engage in suicidal behavior, 10 to 29 percent die of suicide. People with this disorder may also suffer from other serious disorders, such as major depression, anxiety, and substance abuse.

A dependent personality disorder is exhibited by excessive need to be taken care of by others. This clinging, submissive behavior begins by early adulthood. The person has difficulty making everyday decisions without an excessive amount of advice and reassurance from others. He/she

fears rejection and will go to great lengths to involve others in day-to-day activities and decisions. When a close relationship ends, the person feels alone and helpless without the nurturing, support, and control provided by the relationship, and will do anything necessary to reinstate it. A widowed person who has a dependent personality disorder may have always depended on the spouse and may try to solicit an adult child to be the major decision-maker.

"The man who is too old to learn was probably always too old to learn."
—Henry Haskins

"How old would you be if you didn't know how old you was?"
— Satchel Paige

Schizophrenia

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

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

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

What Is Schizophrenia?

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

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

Positive symptoms are the active symptoms of psychosis, such as delusions (false beliefs or impressions) and hallucinations (perceiving or sensing that something is present when it is not). Other positive symptoms include severe problems in thought processes, with illogical thinking and/or incoherent speech, and behavior problems, including bizarre, repetitive or ritualistic behavior.

Negative symptoms reflect problems in relating to others. They include a lack of emotional expression, a reduced amount of speech or speech that has no obvious content, social withdrawal, lack of interest or slowing down, and difficulty concentrating or performing tasks.

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

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

The Older Person with Schizophrenia

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

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

The symptoms of schizophrenia can become less intense for persons in later life. This could be due to biological changes in the brain, but may also be due to better self-management of the illness. Keeping stress low, seeking good medical care when indicated, avoiding alcohol or other substance use, and taking medications as prescribed improve the long-term functioning of any person with schizophrenia. Older people with schizophrenia who have family or social support to assist them tend to remain independent more successfully. Managing the disorder can be difficult for older

persons who have never married, who do not have supportive family members, and who have not been connected to community-based mental health services.

Older adults who have schizophrenia also develop some of the medical disorders common among older persons. These medical problems can result in serious complications. In general, the physical health of individuals with schizophrenia in late middle age or early old age may be more typical of the health status of much older individuals without mental illness. Factors that can contribute to poor physical health include frequent health-damaging behaviors such as smoking and substance abuse, limited access to good health care because of financial constraints, and delay in seeking medical treatment as a result of the high pain threshold found in many persons with schizophrenia. In addition, older adults are more sensitive to side-effects of antipsychotic medications. One potentially serious side-effect is tardive dyskinesia, a neurological syndrome of abnormal involuntary movements.

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

Treatment of Schizophrenia in Late Life

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

Medication Therapy

Effective management of psychotic symptoms through use of antipsychotic medications is the first and most important aspect of treating persons with schizophrenia. For older adults who have a change in their metabolic system, and for those people who have life-long schizophrenia, development of the newer, atypical antipsychotics has been important. These medications cause fewer, less intense side-effects, a particular benefit to older adults with schizophrenia who also take multiple medications for other medical problems. Biological changes that occur as the body ages can directly affect the way medication is metabolized and can intensify side-effects. Becoming toxic from combined medications, or failure to take medications as indicated, are common problems for the older person. It can be difficult to evaluate the problems of the older person with schizophrenia if he/she is uncooperative because of delusions.

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

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

Community Support Services

Since family members as support persons may be limited or nonexistent, it is important that the older person with schizophrenia be connected to community support programs. Local mental health centers offer programs that can assist with medication management, crisis intervention, psychosocial programming, case management, and psychotherapy, as needed. (See page 53, Types of Treatment.)

Addiction Among Older Adults

Like adults of any age, some older adults experience problems with addiction. These problems may occur for the first time when a person is older, or may have been a concern for many years.

Alcohol Abuse Among Older People

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

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

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

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

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

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

Facts About Alcoholism and Older Adults

Among today's 25 million Americans age 65 and older, an estimated 2.5 to 3.7 million are addicted to alcohol. Early-onset alcoholism describes the addiction of people who have a history of long-term drinking. They are likely to have serious physical problems as well. Late-onset alcoholism occurs when a person begins abusive drinking late in life, often because of a dramatic change, such as retirement or loss of a loved one.

- Older people are hospitalized more frequently for alcohol-related problems than for heart attacks.
- The drug of first choice in the older population is alcohol. The second is tranquilizers, such as Valium, Ativan or Xanax. The mixture is potentially lethal.
- Alcohol abuse creates and exaggerates medical and psychological problems.
- Twenty percent of older adult patients receiving treatment for medical, surgical or psychiatric difficulties are alcoholics or problem drinkers.
- The cost of alcohol-related hospital care for the elderly was estimated to be as high as $60 billion in 1990.
- Older men are about four times as likely to have alcohol problems as older women, but older women are more likely to drink alone.
- Widowers over 75 have the highest rate of alcoholism in the country.
- The older depressed alcoholic is the person at highest risk for committing suicide in the United States.
- The number of older adults who abuse alcohol is predicted to more than double in the next 50 years because of the projected size of the older population and because future generations of older people are predicted to have more liberal attitudes toward alcohol consumption.

The Good News...

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

Signs of Alcohol Misuse and Abuse

Early signs

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

Addictive signs

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

Chronic signs

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

Treatment of Alcoholism in Older Adults

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

Did You Know?

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

Misuse of Medications

Another area of concern is the abuse or misuse of medications by older adults. Because of the number of medications an older person uses and the number of doctors the older person may see, there is a potential for confusion by health-care providers who prescribe the medications or by the patient who receives the medications. An older person may unsuspectingly abuse medication, increasing the risk of a potentially lethal drug-drug or a drug-alcohol interaction. Overuse of some medications, especially pain or sleeping medications, can lead to drug dependency.

Particular Concerns for Older Women

- Midlife and older women in this country use a lot of medications but often don't perceive this as a concern. The problem is expected to increase with the aging of younger women drinkers and illicit drug users.
- Alcohol and/or medication abuse in older women is often a reaction to fear, grief, pain, and/or loneliness. These issues must be addressed in the treatment process, along with the addiction.
- Alcohol and/or medication abuse in midlife and older women is treatable, and adverse drug-drug or drug-alcohol interactions are often reversible.

Compulsive Gambling

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

One in three probable compulsive gamblers is a woman. As a group, women tend to start later in life, often because they seek an escape from problems or stresses. As the gambling problem increases, losses become blows to self-esteem. People may believe they can stop whenever they wish, but they have no desire to do so. They may gamble to win back losses, hide or lie about their losses, borrow money, and allow relationships to suffer. Feelings of desperation and hopelessness often increase as the amount of loss grows. Unfortunately, some problem gamblers attempt suicide before they receive treatment.

Gambling problems are more common among people who abuse alcohol or other substances. People who gamble compulsively may also experience physical symptoms: digestive problems, insomnia, headaches, high blood pressure, asthma,

Where to Look for Information

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

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

backaches or chest pains. They also may experience mental health problems, such as depression and anxiety disorders.

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

Facts about Gambling and Older Adults

- Since 1974, the highest increase in gambling has been among adults age 65 or over.
- Research shows that the third and fourth days of the month (the days that retirement checks arrive) are the busiest at casinos.
- The easy access to lottery tickets as part of everyday shopping may make problem gambling more difficult to detect as it develops.
- Older persons are at risk of losing everything to gambling and have few, if any, resources to start over and rebuild after a bankruptcy.

Treatment of Compulsive Gambling

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

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

"I promise to keep on living as though I expected to live forever. Nobody grows old merely by living a number of years. People grow old by deserting their ideals. Years may wrinkle the skin, but to give up interest wrinkles the soul."

—General Douglas MacArthur

When to Seek Treatment and Where to Find It

How Do I Know if Someone Needs Help?

"Would it help Mom to see a counselor?"

"How bad is bad?"

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

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

Sometimes, a person can experience stress over a long period of time or have changes in physical health and well-being. As a result she/he may begin to show signs of mental distress. Sometimes a person may be vulnerable to depression, suicidal thoughts, severe anxiety, or to use/abuse alcohol. The need for mental diagnosis and treatment can occur at any time, but most family members are not prepared to cope with mental disorders. Unfortunately, many of us ignore warning signs from those close to us (or signs we see in ourselves). The earlier these warning signs are recognized and help sought, the greater the likelihood that an effective treatment will be found and the person's quality of life will improve.

Warning Signs of Mental Disorders

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

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

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

Often, people find themselves:

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

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

Finding Help in Your Community

When you become concerned about the mental health of an older person, it can be helpful to describe the symptoms and/or problems that concern you to a professional whom the older person trusts, such as a clergy person or the primary-care physician. Other local professionals who can be of assistance are home health-care providers, public health nurses and aging-service case managers. They can help assess the need for assistance and inform you of mental health services in your area. The first phone call can lead to several others when searching for a mental health professional who understands the specific needs of the older person.

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

Where Can I Go For Help?

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

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

- The National Mental Health Association has a toll-free number, 800 / 969-NMHA, for information on specific mental health problems and referral information.
- The National Alliance for the Mentally Ill (NAMI) has a toll-free number for information: 800 /950-NAMI
- Community Mental Health Center. (See Resource Section of booklet for local numbers and addresses.)
- Local public agencies, such as the Social and Rehabilitation Services office, the Area Agency on Aging and the Public Health Department have information on local mental health services. (See the Resource Section of this booklet for your local numbers.)
- Mental-health professionals in private practice.
- The phone book has telephone numbers for mental health professionals under such sections as “Mental Health Centers,” “Mental Health Services,” “Psychologists/ Psychotherapists,” and “Social Worker.”
- Many phone books also have a section entitled “Helpful Numbers” that will lead you to information and referral phone numbers, such as the local mental-health association or a mental health hot line.
- Local social services organizations — such as Catholic Social Services, Jewish Family Services or Lutheran Social Services — can either provide counseling services or refer you to local mental health services.
- Local hospitals may have mental health services. If not, the social services department will be able to inform you of local mental health services.
- Psychiatric hospitals accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHCO).
- Veterans Administration hospitals (for those qualified to receive benefits).
- Mental health units of teaching hospitals, such as the University of Kansas School of Medicine at Wichita and Kansas City, Kansas.
- State offices, such as Kansas Social and Rehabilitation Services or Kansas Department on Aging, have information on mental health services throughout the state.

Who are Mental Health Service Providers?

Community Mental Heath Centers

These are public mental health centers that receive state and local funds to provide mental health services to individuals in their provider area. They have sliding-scale fees and accept Medicaid, Medicare, private insurance and private pay. Community Mental Health Centers in Kansas are listed in the Resource section of this booklet.

Mental Health Professionals in Private Practice

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

Not-for-Profit Mental Health or Counseling Services

These include agencies, such as Catholic Social Services, Family and Children Service Agencies, Jewish Family Services, and Lutheran Social Services, with qualified mental health providers who offer counseling services.

Private Psychiatric Hospitals

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

Mental Health Units of Hospitals

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

Veterans Administration Hospitals

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

Remember

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

What Types of Mental Health Professionals are There?

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

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

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

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

Qualifications: state license; may belong to American Psychological Association

Clinical Social Worker: Therapist/counselor with a master's degree in social work from an accredited graduate program. Trained to make diagnoses and provide individual and group counseling.

Qualifications: state license; may be member of the Academy of Certified Social Workers

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

Qualifications: state license

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

Qualifications: state registration

Nurse Psychotherapist: A registered nurse who is trained in the practice of psychiatric and mental health nursing. Trained to diagnose, prescribe medication, and provide individual and group therapy and counseling.

Qualifications: certification, state license, A.R.N.P.-C.N.S.

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

Qualifications: state license

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

Qualifications: Certification from American Association of Pastoral Counselors

When You Decide to Contact a Mental Health Professional

Therapy helps make a difference in the lives of many people, but it is a collaborative effort in which you must be actively involved. The process is personal and intense, and may be painful at times. You should feel that the therapist functions as a useful tool, helping you address concerns. When you call for mental health assistance, decide whether you prefer to contact your local mental health center or another mental health provider. If you have already contacted your primary-care physician or health-insurance provider, you may already have been given a referral to a specific mental health professional or center. Since making the first contact can be a confusing process, it helps to know what to expect when you make the call.

Contacting a Mental Health Center

If you contact your mental health center, your call will be directed to a mental health professional who will gather information about the concerns you have for yourself or your family member. Although most mental health centers prefer that the proposed client make the initial call, that is not always possible. If you are making a call for someone else, explain to the mental health professional why you are handling the task. Doing so will help the mental health professional better understand the proposed client's needs. Be prepared to give information about who made the referral, financial status, insurance coverage, mental health symptoms, and medical concerns. You will then be given an appointment with a mental health clinician.

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

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

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

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

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

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

Contacting a Mental Health Professional in Private Practice

If you contact a mental health provider who is a private practitioner, you will need to determine the nature of his/her practice. Some providers work independently, while others work as part of a group practice that may have a variety of services. If you feel that both medication and counseling will be needed, determine whether both services are provided by the professional you are considering. If not, find out how he/she makes referrals for those services not provided. As described above for mental health centers, it is important to bring all pertinent information to the appointment, to understand the technical details (such as how billing is handled) and to determine the services available through this professional.

Some Questions to Ask a Therapist/Counselor

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

- What is your training? What degrees do you hold?
- What is your specialized training and experience working with older adults? What kind of experience do you have in treating the kind of problem involved?
- What kinds of certifications or licenses do you hold? Are you a member of _____ (the appropriate professional organization for this type of therapist: see pages 50-51.) Check state license, if required.
- What would your treatment involve?

- What length of treatment might you expect? (This will vary with the client, the problem and the approach the therapist uses.)
- How long does each session last? Forty-five to 50 minutes is common, unless it is to monitor medication, when the time may be 15 to 30 minutes. How often will sessions be scheduled? (Often, meetings are weekly at first and become less frequent later on.)
- What is the appointment cancellation policy? (There may be charges for missed sessions.)
- Is the therapist (or an associate) available by phone in a crisis?
- How much will it cost? Will any portion be covered by health insurance? (See Costs of Treatment for more information.) Are different payment options available?

Are You Getting the Care You Need?

As the therapeutic process progresses, the individual in treatment should begin to feel gradual relief from distress, to develop self-assurance, have a greater ability to make decisions and be increasingly comfortable in relationships with others. The person may feel uncomfortable or angry at times, but episodes of discomfort occur during the most successful therapy sessions. Mental health treatment should help in coping with feelings more effectively. Always directly and openly discuss any aspects of the process that concern you.

If you believe the person being treated is not getting adequate results from therapy, or if you do not feel comfortable with the therapist, discuss the concerns openly. A different approach, or even a different therapist, may be needed. Since therapy is a joint process, with therapist and client working together, it is important for the relationship to be a comfortable, trusting one. A competent therapist will be eager to discuss reactions to therapy and will respond to your feelings about the process.

If medication has been prescribed, remember that it will take time for the body to make adequate adjustment. Especially with an older client, the doctor will start with a low dose and increase it very slowly, which means it may take a long time for the drug to have its full effect. Be patient, but express your concerns.

Types of Treatment

Psychotherapy

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

- **Behavior Therapy:** Includes stress management, biofeedback and relaxation training to change thinking patterns and behavior.
- **Psychoanalysis:** Involves long-term therapy meant to “uncover” unconscious motivations and early patterns to resolve issues and to become aware of how those motivations influence present actions and feelings.

- **Cognitive Therapy:** Seeks to identify and change thinking patterns that can lead to troublesome feelings and behavior.
- **Family Therapy:** Includes discussion and problem-solving sessions with family members. May include several generations of the family.
- **Group Therapy:** Includes a small group of people who, with the guidance of a trained therapist, discuss individual issues and help each other with problems.

Adjunct Therapies and Services

- **Movement/Art/Music Therapy:** Includes the use of movement, art or music to express emotions. Effective for persons who cannot otherwise express feelings.
- **Medication Education:** Includes information about what medications are prescribed. Usually provided by the community mental health center nurse.
- **Mental Health Case Management:** Includes assistance with coordination of services provided through the Community Mental Health Center and other community agencies. Provided by a mental health case manager.
- **Crisis Invervention:** Involves evaluating the needs of a person in mental health crisis who may need more intensive assistance than outpatient therapy and/or medication. Intensive case management services may be recommended to prevent a person from acting on impulses to harm self or others.
- **Psychosocial Programming:** Involves activities for recreation and life skills training for persons who have limited social outlets or life skills abilities.

Medication Therapy

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

Electric Convulsive Treatment (ECT)

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

Some Resources for Support

Self-Help/Support Groups

Self-help/support groups bring together people with common experiences. Participants share those experiences, provide understanding and support, and help each other find new ways to cope with problems. There are support groups for almost any concern: grief, alcoholism, overeating, co-dependency, grandparenting, various mental illnesses, cancer, Parkinson's disease, Alzheimer's and many others. Support groups are offered not only for people who are coping with the problem, but in many cases for caregivers and family members as well. The Kansas Self-Help Network

(800 / 445-0116) has information and listings for at least 1,500 community-based self-help organizations in the state, along with meeting times and locations. Other sources of information about support groups in your community may be the local hospital, senior center, retirement facility, public library, and Area Agency on Aging.

Other Community Services

Finding the right treatment for a mental health disorder is important, but if the person also needs assistance with other activities (transportation, chore services or personal care, for example), other support services may be helpful. Following are some services that might be helpful for people with mental health disorders and their caregivers, and the kinds of organizations to contact in your community. Some services are available at no charge, on a sliding scale or for a nominal fee or contribution. Some services have requirements for age and/or income levels. Case management services, which can coordinate use of other services, can be provided by agencies such as Area Agency on Aging, private care management services, employee assistance programs, etc.

Your local Area Agency on Aging (AAA) is a good place to start if you are looking for information about several types of services in your community. The Resource Section in this booklet lists services and contact information for regional AAA offices. Kansans with low incomes may wish to contact the Kansas Department of Social and Rehabilitation Services as well.

Telephone Reassurance: Daily telephone reassurance programs are available for older people who live alone. Contacts: AAA, police department, senior center, local hospital or home health organization, social service and religious organizations.

Friendly Visitors/Companion Services: Many communities have friendly visitor or companion programs, sometimes as part of a reassurance program. Contacts: AAA; local churches and synagogues; schools; neighborhood, social service, civic, social or volunteer organizations; home health; and hospice organizations.

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

Home Maintenance and Repair: Services can include heavy cleaning, yard maintenance, snow removal and repairs. Contact: AAA, social service agencies, local neighborhood improvement or civic organizations, or community volunteer programs.

Homemaker and Chore Services: Services help people with shopping, meal preparation, light housekeeping, laundry. Contact: AAA, social service agencies, home health agencies.

Meals: Communities have options for participating in group meals or receiving home-delivered meals. Contact: AAA.

Home Health and Personal Care: Services provide health and personal care for homebound individuals. Health care includes assistance with medications, skilled nursing care, physical therapy, etc. Personal care involves help with activities such as bathing, grooming or dressing. Some expenses of home health-care may be

covered by insurance, but the person must be homebound and the care approved by her/his physician. Contact: physician (for referral), AAA, home health, social service and hospice organizations, health department or local hospital.

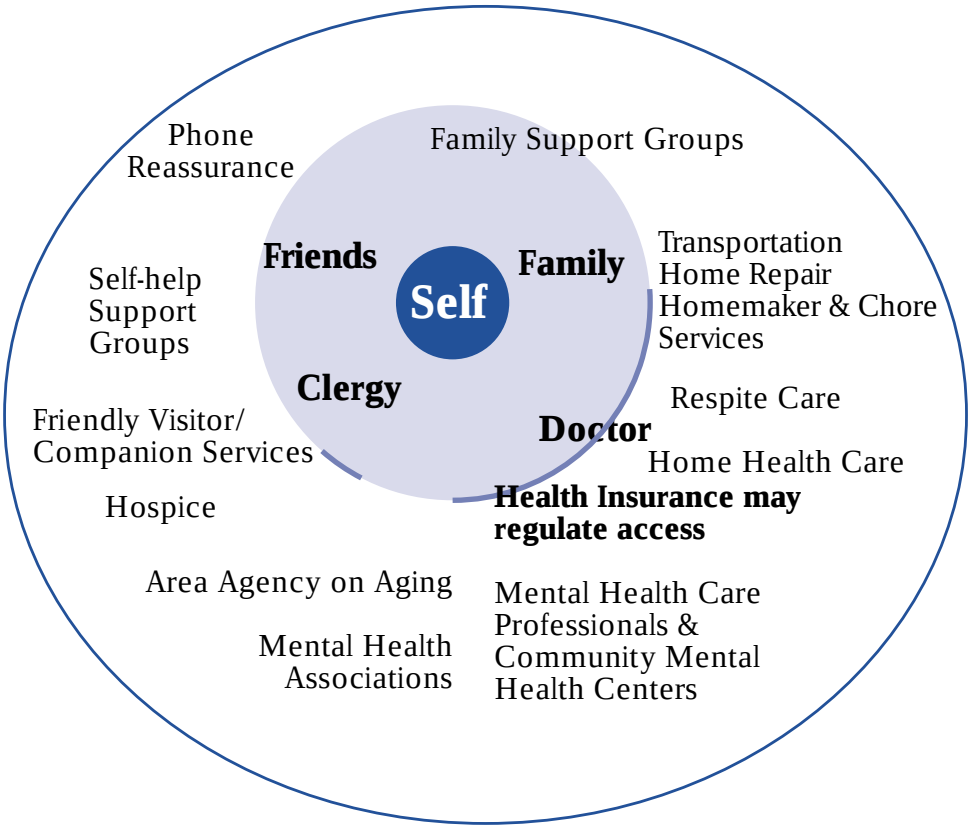
Older Adult Day and Respite Care: Day programs offer a program of health, social and recreational services for adults who need some care and supervision. Programs often are located in long-term care or senior facilities. Some communities also have paid or volunteer respite services that offer caregivers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

Costs of Treatment

This information is accurate as of September 1999. Since government health-care policy, private health-insurance requirements and treatment costs change frequently, get current information about costs from your insurance and/or health-care provider or local Area Agency on Aging.

The cost of treatment for a mental health problem depends on such factors as type of treatment, therapist's training, treatment location and insurance coverage. Older adults are fortunate that Medicare, Medicaid and many supplemental insurance plans (sometimes called Medigap policies) cover a majority of the expense. Most costs of long-term care for older adults who have

COMMUNITY SUPPORT AND SERVICES



Alzheimer's or similar diseases and require nursing facilities are not covered by Medicare. Medicaid pays for treatment of mental health problems and for long-term care, if it is determined to be necessary. People who qualify for Medicaid generally have a very small amount of co-payment or none at all. Definitions for Medicaid, Medicare, and Medigap are provided in the Glossary at the end of the booklet.

The following are descriptions of typical treatment costs with different mental-health care providers:

Community Mental Health Center

Fees at Community Mental Health Centers (CMHCs) are determined on a sliding scale, based on personal income and medical expenses. Families covered by medical assistance pay no fee. The centers can provide a sliding fee scale because of funding they receive from the counties they serve and from the state of Kansas.

Private Clinics

Fees at private clinics are generally higher than those at Community Mental Health Centers. Some nonprofit agencies have a sliding scale system that allows individuals with low incomes to qualify for a lower rate. Fees for group therapy may be lower than for individual therapy.

Private Therapists

Fees generally range in the middle, between those of mental health centers and private clinics. Rates for psychologists and psychiatrists are usually higher than rates for social workers, counselors and psychiatric nurses. Medicare typically reimburses part of allowed charges. If the person in treatment has supplemental insurance (e.g., a Medigap policy with a secondary payer, such as Blue Cross and Blue Shield), that company usually will pay any remaining amount.

Hospitalization

Full hospitalization for mental health treatment is becoming less common. Fees for inpatient care will be higher for the first day than subsequent ones. Charges can range from $650 to $850 or more per day, and may vary, depending on the treatment setting. Physicians' charges are billed in addition to hospital fees. Medicare generally pays for 80 percent of the allowed charges. In some facilities, Medicaid will cover care for individuals screened or assessed as needing hospitalization.

Partial Hospitalization

Typically, day-treatment programs (also called partial hospitalization), are similar to hospital care. Fees currently are about $300 per day. Medicare pays 80 percent of allowed charges. Medicaid coverage is available for those who meet the criteria.

> Not by physical force, not by bodily swiftness and agility are great things accomplished, but by dedication, authority, and judgment, qualities with which old age is abundantly provided.
>
> —Cicero

What Mental Health Services Should My Supplemental Insurance Plan Include?

Many older adults are being offered insurance by managed care organizations (for example HMO, MCO, PPO). While these insurance plans may offer good benefits, the buyer must understand what is and is not covered by each plan. For example, some policies state that an outpatient psychotherapy benefit of 20 sessions is included. However, the buyer may not understand language in the policy that states the sessions must be "medically necessary," a determination made by the insurance company — not the buyer or the physician. Because the insurance company has control, often only a small number of therapy sessions may be authorized, and those may require frequent reviews and authorization for more. Although this does not keep the older adult from receiving services, it does make the coordination of treatment time-consuming.

Having so many health-care insurance options to consider can be somewhat overwhelming. Fortunately, Area Agencies on Aging (AAA) offer a free program, called SCHICK, (Senior Health Insurance Counseling for Kansas) to help older adults choose the best health insurance plans for their needs. Contact the local Area Agency on Aging office to find out more about the program, and make an appointment with a volunteer counselor. You can find how to contact your local AAA office in the Resource Section of this book.

Helping Someone Who Has a Mental Health Problem

Talking to Someone With a Mental Health Problem

Any older person can be vulnerable to developing a mental health problem. If you see it occurring in someone you care about, it is important to address this concern with him or her. Letting the person know that you are concerned and helping to identify and label the problem is the first step.

Labeling the Problem

At a private time, bring up your concern. For example, if talking to your elderly father who seems to have symptoms of depression, you could say something like, “Dad, I’m concerned about you. You seem sad, you’re losing weight, you don’t go out anymore, and I think you may be depressed.” He may deny this, or it may open the door for further conversation about how he’s feeling.

If he is able to talk about being depressed (or “down”or “blue”), it is important at some point in the conversation to ask if he has thought about harming himself or ending his life. Some people are afraid to ask about suicidal thoughts. They mistakenly think the depressed person hasn’t thought about it and they would just be giving them the idea. Nothing could be further from the truth. Asking about suicidal thoughts is critically important.

If the person tells you he or she has been thinking about suicide, it is important to ask if she or he has thought about how to do it. If the person has a plan and the means to carry out the plan, he or she may be at high risk for suicide, and it is imperative to get professional help at once. The next page lists suggestions about what to do if you find yourself talking with someone who is thinking about suicide.

Active Listening

Active listening is an important skill to develop when talking with someone with a mental health problem. This means listening to their feelings as well as their words, and letting them know what you’re hearing. (For example: “It sounds like you’re feeling kind of angry about that.”) Asking questions that will help the person clarify his/her thoughts and feelings is also helpful. Having and expressing empathy for the person is important, but it is not necessary or even helpful to think you must have the answers. It may be helpful to offer an occasional suggestion or ask if the person has thought about a certain solution, but “listening” is even more important.

Showing Concern and Support

Showing concern and offering support by spending time with the person — even 10 or 15 minutes several times a week — is important. Phone calls are also a good way to show support. Some people are afraid they won’t know what to say, but just saying you called because you are concerned and wonder how she/he is doing can be helpful.

When dealing with someone who is depressed or grieving, you and others will have to take the initiative and reach out. The depressed or grieving person often does not have the emotional energy to reach out to others and ask for assistance. Saying “Call me if you need anything” is much less

helpful than trying to put yourself in his or her situation, thinking what would be most helpful, and then offering to do that activity. Often, people forget how long depression or the grieving process may take and don't realize how important the continuing once-a-week phone call or monthly dinner invitation can be.

Talking with Someone Who Might be Thinking About Suicide

Other helpful information about depression and the risk of suicide can be found in "Suicide: The Risk of Untreated Depression" (page 23). The section on "When to Seek Treatment and How to Find It" (page 47) provides information about contacting resources and obtaining referrals.

- DO listen carefully to what the person is saying and the problems the person expresses. In your own words, repeat back what the person is saying to you, so that you are sure you understand what the person means.
- DON'T dismiss the feelings the person describes. If you do, it may make the person less likely to share his/her feelings with you.
- DON'T give advice.
- DO ask the person if she/he is considering suicide. Asking the question will not "plant the idea in their head." Asking the question may allow the person to talk more freely with you because the topic has been opened up.
- DON'T debate the morality of suicide with the person.
- DON'T take anything the individual says personally. Don't allow yourself to become angry or defensive, which is easy to do when you care about the person.
- DO try to find out if the person has a plan for carrying out the suicide. How well thought out is it? How easy would it be to carry out? Are the means already available to the person?
- DON'T promise to keep the person's threat or plan a secret. If the person is set on the intent of committing suicide, then let him/her know you will call the police and get help.
- DO take action. If the situation is life-threatening, call the police. If the person is under the care of a mental health professional, tell him/her that you plan to inform the therapist or counselor about this conversation. Otherwise, offer to make a contact for the person with a health care professional or counselor, and follow up.

"I was surrounded by a wall
of loving silence
that no one dared to break through."
—Margaret Bourke-White

How to Refer a Person for Help With a Problem[2]

- Listen for signs and symptoms that the person or family needs help you can't provide (i.e., legal advice, financial advice, personal counseling). You can link the person or family with resources that can assist.

- Be aware of agencies and resources available in your community. Get to know the professionals and volunteers in your community who can help. Find out what services they offer and what their limitations are. Assess what agency or community resource would be most appropriate to address the person's (or family's) problem. If you have questions about whether a given organization could be of help, call and ask!

- Discuss the referral with the person or family. You might say, "I sense that you need help with _____. I think _____ organization can help you." It's even more useful if you can say "I know of a family that went to ____ organization and they found it to be very helpful." In short, if you know of people who have been helped, share their experiences but keep their names confidential.

- Explore the individual's or family's willingness to make contact with the community resource. You might say "Does it make sense to you to contact _____?" or "How do you feel about seeking help from this agency?" If the person or family feels comfortable making the contact, simply urge them to do so.

- When the person or family is unwilling to make the contact, or where there is some danger if action is not taken, you should take the initiative.
  1. Call the agency and ask to speak with the intake worker (if there is one).
  2. Identify yourself and your relationship with the person or family.
  3. State what you think the person's or family's needs are.
  4. Ask the agency what follow-up action they will take and what (if anything) you can do.

- Try to find out whether the person or family contacted the resource and whether they were helped. Don't be nosy or pry for details—just make sure they know that you care and that you want them to get the help they need.

[2] Adapted from National Mental Health Association, 1999; and *Act by Caring Today*, K-State Research and Extension, 1995.

When There Is Dementia

If Someone Might Have Dementia

If a loved one has symptoms of dementia, one approach would be to say, "_____, I'm concerned about your memory. I think it's harder for you to remember things than is normal for your age, and I know you're frustrated by it too. There are a lot of treatable causes for this, and I want us to talk to_____." Usually a good person to contact first is the older person's physician, who can try to identify treatable causes of the memory loss. If the physician does not find an explanation for the memory problems, you may want to ask for a referral to a specialist who deals with diagnosing dementia. This might be a psychiatrist, a neurologist, or a psychologist who is skilled in this kind of assessment.

When Someone Has Dementia

When dealing with someone who has Alzheimer's disease or another form of dementia, patience and flexibility will help the most. It is important that family members become familiar with the disease and the strategies for dealing with it. Coping with repetitive questions every five minutes or multiple phone calls at work is very trying. It is also stressful when the person becomes angry or accuses you of something. There is excellent information available about coping with dementia and caring for someone with dementia. Using this information can mean the difference between misery and a better quality of life for both you and the person with the disease.

Support groups are available in most communities. Some are run by chapters of the Alzheimer's Association. Others are sponsored by mental health centers, retirement facilities, or hospitals. (See the Resources section of this booklet, page 75.)

In addition, professional help is often necessary. Medications to enhance the person's memory and other medications that can reduce the symptoms (e.g., depression, anxiety, suspiciousness, hallucinations) are available and should be used when needed. The person should be monitored by a health-care provider trained in treating people with dementia. It will be important to develop a partnership with this professional. In the early stages of the illness, counseling with the person as well as the family can be helpful. As the disease progresses, it is the family members who gain the most from supportive counseling and education. This gives them a forum to learn how to interact with their loved one and an opportunity to work on issues of grief with the loss of the person they once knew.

Coping with Challenging Behaviors

Sometimes, especially if a person has dementia, he or she may behave in unusual ways. People may repeat words or activities over and over, be suspicious, have anxious or agitated feelings, be confused and unable to remember or recognize familiar people or places, be verbally or physically aggressive, or even act in sexually inappropriate ways. It is important to realize that it is the disease — and not the person — that creates these problems. It is not done on purpose.

Dealing with these behaviors can be challenging not only for the person, but for any caregivers. The first concern is to determine what problem the behavior is creating, and whether it is harmful to the person or to others. Knowing this will help you find possible ways of responding to the problem. You should also remember that a response that works at one time may not work at another time. Furthermore, what

works for one person or problem may not work for another. You must be a detective who asks "What, where, why, when, and how?" Finding solutions will be a continuing trial-and-error process that changes over the course of an illness.

When a problem behavior occurs, try to find out what contributes to the situation. Taking a "detective's" approach may help to avoid or remedy a problem situation, or help you learn what solutions work best. Often, a person with dementia cannot verbalize the concern or discomfort. The person's behavior, on the other hand, can tell you better than words.

What can cause a problem behavior?

■ **Physical discomfort or pain**

•Has there been a change in the person's health?

•Is the person taking a new medication?

•Is there a physical problem, such as infection or constipation?

•Is the person having pain?

■ **Too much stimulation**

•Is there too much stimulation, such as loud noise from radio and TV?

•Is overstimulation occurring because of active children or too many people?

■ **Unfamiliar people or places**

•Has a routine been changed, or have things in the home been rearranged?

•Has the person had to go to a new place, such as a different doctor's office?

Complicated activities

Sometimes, an everyday activity may be too complicated and frustrate the person. Breaking the chore into simple steps and using reminders may help.

Communication problems

Is the person having trouble expressing wishes or feelings? Is he or she getting the best quality sensory information possible? Do glasses need adjustment, has excess wax accumulated in the person's ears, or does a hearing aid need new batteries?

Something "triggers" it

Does it always occur at the same time of day, in the same location, or with another activity? Who is present? What was going on before the problem behavior occurred? What always happens?

Dealing with a challenging behavior:

■ Be calm and understanding

■ Be patient and flexible

■ Help the person try to name the feeling: "You seem angry."

■ Don't argue, try to convince, or ask for an explanation

■ Is something wanted or needed? If so, acknowledge it and respond

■ Is the person confused about time or afraid of a sight or sound?

■ Will changing the surroundings help? (Too crowded? Noisy? Dark or bright?)

■ Don't take behavior personally: Remember it is part of a disease

■ Afterward, ask yourself:

•How can the problem be prevented?
•Did my response help? How?
•What can I do differently next time?

Tips For Specific Problems

If someone is agitated:

- Be sure there is a quiet place for the person to sit and relax — his or her own room, or somewhere away from the hustle and bustle of everyday activities, TV, children, pets, etc.
- Establish a daily routine. Schedule quiet periods during the day so the person gets enough rest. If a nap is not possible, encourage resting or doing a quiet activity in a recliner.
- Try playing soft music, or sit together and do a quiet activity or talk softly. Try to get the person to tell you a story or memory.
- Always provide a choice. (Do you want to crochet or fold the towels?)
- Try touch, such as a hug, gentle massage on the back or neck, or rubbing lotion on hands, arms, etc.
- Offer a healthy snack. Eliminate or restrict caffeine from the diet.
- Walk slowly with the person.
- Encourage regularly scheduled exercise to reduce any excess energy.

If someone has problems sleeping at night or experiences evening agitation:

- Be sure there are no physical problems, especially with bladder or incontinence, that are the cause.
- Restrict caffeine and sweets to morning, serve the main meal at noon, and offer only a light meal before bedtime.
- Increase activity, such as walks, during the day. Discourage long afternoon naps and resting most of the day.
- Make sure the person is comfortable where she/he is sleeping. Change to a different bedroom, bed, or even a favorite chair. If darkness increases agitation, keep the room partially lit.

If someone is suspicious or accuses the caregiver or others of wrongdoing:

- Acknowledge the person's concern.
- Remain calm and supportive.
- Don't argue or be defensive.
- Don't try to reason with the person.
- Try to distract the person with another activity, familiar object, etc.

If someone has a catastrophic reaction (sudden angry or violent behavior that may be a reaction to the stress of a minor incident or a response to frustration):

- Put your own safety first. Get away from the person's reach. Leave the room, if necessary.
- Don't argue or increase the stress level.
- Quickly distract the person by talking about something else, or offering a different activity, or favorite food. If one doesn't work, try another.
- Remove the source of stress or the person from the situation.
- Report the incident to the health-care provider/therapist.

Inappropriate sexual behavior:

- Try to find if there is another reason for the behavior. If the person is removing clothing, is she/he too warm or ready to go to bed? Does he/she need to use the bathroom?

If Someone is Unable to Make Medical or Financial Decisions

When a mental illness is severe — and especially when it is a long-term mental illness, such as schizophrenia — the person's judgment may be significantly impaired. This situation also may develop if a dementia, such as Alzheimer's, progresses. In this event, it becomes necessary to protect the person and ensure that someone with intact judgment can legally make certain decisions for the impaired person. These may be decisions about where to live, about medical or psychiatric treatment or about finances.

The person's competency or ability to carry out certain functions is ultimately a decision made by the court. Physicians, psychiatrists, psychologists, nurse practitioners or social workers may provide evidence or data to assist the judge in making this decision.

When assessing a person's competence, it is important to ask the question "competency to do what?" A person may be competent to do some things, but not others.

The following are examples of different capacities that may need to be assessed.

Is the person competent to:

- Handle major financial affairs?
- Make decisions about where to live?
- Make decisions about his or her medical care?
- Drive a vehicle?
- Make a will (testamentary capacity)?

The person in question may not be competent in one area (e.g., driving), but may be competent in others, such as making decisions about medical care. Competency may change over time, and decisions that the person could make several months or a year ago may no longer be possible, which is the case as a dementia progresses.

Sometimes the person is so significantly impaired that the decision about competency is a rather easy one. In other cases, he/she may have some impairment, but it may not be clear whether or not it is significant enough for a court to declare the person "incapacitated" or not competent. In cases that are not clear-cut, it may be helpful to have an assessment made by a psychologist, particularly one who has experience in this area.

Psychologists will often give several tests to assess the person's thinking, memory, judgment, planning abilities, etc. The psychologist analyzes the test results, then gives feedback to the individual (and the family) and writes a report that a judge can use in determining competency. Even if legal competency is not an issue, such testing can provide the family information about areas of strength and weakness and suggest coping strategies.

Health Care Directives[3]

Legal tools are available to help anyone plan for a time when he or she might not be able to make medical treatment decisions. This could happen because of an accident, unexpected illness or mental disorders and dementia. All adults should make these plans to ensure that their wishes about medical treatment will be carried out if they become incapacitated.

Hospitals and long-term care facilities will request information about health care directives at the time of admission, and it is best to have resolved these issues earlier, in a less-stressful situation.

Durable Power of Attorney for Health Care Decisions (Medical Durable Power of Attorney)

The Durable Power of Attorney for Health Care Decisions permits one person, "the agent," to make health-care decisions on behalf of another. This permission is to be used when the person granting the power, "the principal," becomes incapacitated.

It is designed to extend the decision-making capacity of the individual into an unknown future, through instructions to some trusted person. The agent has broad authority, so it is important to choose an agent you can trust to do what you want.

To be valid, the Durable Power of Attorney for Health Care Decisions *must be dated and signed in the presence of two witnesses or be signed before a notary public*. The witnesses must be at least 18 years of age, not related to the principal by blood or marriage, and neither financially responsible for the health care nor entitled to any part of the estate.

The statute contains a form to be used as a guide for the document. You may photocopy it and use it as a legal document. You may add to it any further specific instructions you wish. You might, for example, designate an alternate agent to be appointed if, for some reason, your original choice of agent is not able to function in that capacity or if, at some time, it is determined that such is needed for your protection or to protect your estate. A copy should be given to the agent, to the family, and to the doctor to place in your medical record.

The agent may:

- Consent, refuse consent, or withdraw consent for health-care decisions that affect physical or mental well-being.
- Make necessary arrangements for admission to a hospital, nursing home or other medical facility.
- Employ or discharge health-care personnel, including physicians, nurses, and therapists.
- Have full access to the principal's medical records and plan of care.

The agent may not:

- Take any action not provided for in the Durable Powers of Attorney documents.
- Revoke or terminate an existing living will.
- Take any action until the principal is incapacitated, as determined by the attending physician, unless the document has other provisions.
- Take any action contrary to or inconsistent with the expressed wishes of the principal.
- Be the treating health-care provider or be in any way connected with the health-care facility, unless the agent is related to the principal.

[3]Adapted from *A Caregivers Guide to Alzheimer's Disease and Related Disorders,* Kansas Department on Aging and K-State Research and Extension

Living Will

A Living Will allows a person to instruct the physician about his or her wishes regarding extraordinary life-sustaining measures in the event of terminal illness (of any kind). Unlike the Medical Durable Power of Attorney, a Living Will only goes into effect when two physicians certify that the person's condition is terminal. It is not as flexible, because it provides specific instructions that a physician must follow at the end of life. It does not allow for medical decisions that must be made before that point. It also does not allow for an agent to make any decisions in the best interest of the person. A person may have both documents guide his or her care.

To report suspected abuse, neglect or exploitation of an adult, contact the Adult Protective Services Hotline: 800/922-5330. The hotline is staffed 24 hours, and every call is taken seriously.

If You are Concerned for Someone's Safety or Well-being

There are times when some older people need assistance with situations that are abusive, neglectful or exploitative. As family, friends or professional caregivers, we may see situations in which an older person seems to be unduly influenced or harmed by another. We may not have the ability to fully assess the situation and may not be sure about what to do.

The Kansas Department of Social and Rehabilitation Services has an Adult Protective Services program that serves adults 18 and older. Its purpose is prevention: to bring social and medical services to adults, with their consent; to stop abuse, neglect, and exploitation; and to safeguard well-being. The intent is to protect at-risk adults who are unable to protect themselves or who need assistance in dealing with abusive, neglectful or exploitative situations.

An Adult Protective Services program is available through every SRS area office in Kansas. Addresses and phone numbers are located in the Resource Section of this book. All reports to the offices are screened and, when necessary, investigated. Assessments can lead to referral to community services to improve the person's health, safety and welfare. If there is concern for the older person's competency, a referral for guardianship or conservatorship may be made.

Guardianship

If the individual is already incompetent and unable to sign a Durable Power of Attorney for Health Care Decisions, you may need to petition the court to appoint a guardian to handle these matters. The guardian's duties will vary, depending on the limits the court may have defined, but generally they can be designated to assure the physical safety and health and welfare of the impaired individual.

Some duties of the guardian include:

- Assuring that the person receives needed food, clothing, shelter and health care. Payment for these needs usually comes from the incompetent person's funds.
- Assuring that the rights and interests of the incompetent person are preserved.
- Providing timely "informed consent" for needed medical procedures.
- Reporting to the court. A yearly report is required.

Conservatorship

When the individual is no longer able to handle his or her own finances, the family or a caregiver or friend can petition the court to name a conservator to manage the individual's financial assets. Other close family members are notified and have the right to support or object to the petition. The court will require a medical evaluation that states the proposed ward is not capable of making his or her own financial and business decisions. Conservators are monitored by the court.

In Kansas, a "conservator of the estate" and a "guardian of the person" are two separate powers that are normally granted to one person.

Duties of the conservator include:

- Managing the person's money, investments, bills, expenses, property, and other assets.
- Protecting and accounting for all financial transactions.
- Arranging for the person to receive any government benefits or community services.
- Reporting periodically to the court, and provide a financial accounting of the estate.

Where to Get the Kind of Legal Advice You Need

When someone is not able to make decisions, many complicated financial and legal issues may be involved. There are additional tools to manage these issues, as well as the person's estate, if a terminal illness is involved. You may want to start by calling the family lawyer. The Kansas Bar Association operates a lawyer referral service. Contact them at 785 / 233-4322. Or, you may want to contact the nearest Senior Law Project (through the Area Agency on Aging) to get free advice.

Medications for Treating Mental Health Problems

Things to Know About Taking Medications

Some prescription medications (i.e., psychotropic medications) have been used since the 1950s to help treat symptoms of emotional or psychiatric problems. These medications are helpful in illnesses that are due to imbalances in chemicals that the brain uses to communicate with itself and with the rest of the body (neurotransmitters).

Medications can correct the imbalances that disrupt brain communication, reduce symptoms, and sometimes prevent their recurrence. Because these medications help the brain's communication system function, it is important to report problems with side effects to your physician. **Do not stop taking a medication without talking with your health-care provider.** To do so could cause serious complications. Reporting problems with side-effects gives the health-care provider the opportunity to prescribe a different medication that may work better for you.

In prescribing medications to treat mental disorders in older adults, the physician must take into account physical changes that occur when a person becomes older. These changes include a decreased ability to absorb, metabolize, and excrete medications. Older adults are particularly vulnerable to side effects of many medications. In addition, older adults as a group use more prescription drugs and more over-the-counter drugs than younger adults, and drug interactions can have serious side-effects.

When taking any medication, it is important that the person prescribing the medication know about all other medications — prescriptions, over-the-counter medications, and all vitamin and herbal supplements — that you take. Also check with your pharmacist about possible medication interactions. Give your pharmacist a written list of your medications, dosages, times of day taken, and any over-the-counter medications you may take (cold remedies, antacids, aspirin, etc.). Certain medications, such as antacids and some stomach medications like cimetidine, can interfere with the absorption of other medications.

You must be a partner in your health care and take responsibility for knowing your medications.

Did You Know?

When someone asks about the medications you take, they need to know not only about prescriptions, but also about the over-the-counter remedies or nutritional supplements such as vitamins and herbs. It is also important to be open about whether you drink any alcoholic beverages. Many medications do not mix well with alcohol, and in some cases the mixture can be deadly.

Depression and Antidepressants

Antidepressants may improve mood, appetite, sleep, energy and social functioning. Since depression can make it difficult to concentrate and may affect memory, antidepressants may also help the depressed person's memory and concentration. There are many categories of antidepressants, but in general they are divided according to their mechanism of action. Generally, antidepressants must be

given **several weeks** before a response is seen, and must be continued for months or sometimes years to maintain a beneficial effect. It is important to be patient and not expect overnight results. Doctors frequently "start low and go slow" in adjusting the dose upward in older adults to avoid and assess side-effects. Antidepressant medication needs to be taken regularly, as prescribed, in order to be effective. Taking antidepressants only on days when you are "feeling blue" is not effective.

Tricyclic antidepressants are the oldest group of such medications. They are used less commonly now that newer antidepressants, such as the Selective Serotonin Re-uptake Inhibitors — or SSRI's, described below — are available. Tricyclic antidepressants are effective in treating depression but have side effects that may be detrimental or even harmful, especially for a person with dementia. Confusion, dry mouth, urinary retention, weight gain, constipation, dizziness, and irregularity of the heartbeat can result during their use. In general, physicians try to avoid prescribing this group of antidepressants for older adults, although very low doses of amitriptyline, doxepin, nortriptyline, or desipramine are sometimes prescribed.

Trazodone (Deseryl) is an older antidepressant that is safer than many tricyclics and excellent for sleep or agitation. It must be used in low doses to avoid such side-effects as dizziness, low blood pressure and the risk of falls.

Selective Serotonin Reuptake Inhibitors (SSRI's) are a group of newer antidepressants with fewer reported troublesome side-effects. These SSRIs include fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), fluvoxamine

Common Antidepressants

Generic Name	Brand Name
Tricyclic (TCA)	
Amitriptyline	Elavil
Doxepin	Sinequan/Adapin
Nortriptyline	Aventyl/Pamelor
Imipramine	Tofranil
Clomipramine	Anafranil
Desipramine	Norpramin
Dopamine and Norepinephrine Reuptake Inhibitors	
Bupropion	Wellbutrin
Serotonin Selective Reuptake Inhibitors (SSRI)	
Fluoxetine	Prozac
Sertraline	Zoloft
Paroxetine	Paxil
Fluvoxamine	Luvox
Citalopram	Celexa
Serotonin-2A (5HT2A) Receptor Blocker and Weak Serotonin Uptake Inhibitor	
Nefazodone	Serzone
Trazodone	Desyrel
Serotonin and Norepinephrine Reuptake Inhibitor (SNRI)	
Venlafaxine	Effexor
Serotonin (5-HT2A and 2C)and a-$_2$ Norepinephrine Receptor Blocker	
Mirtazapine	Remeron
Monoamine Oxidase Inhibitors (MAOI)	
Phenelzine	Nardil
Tranylcypromine	Parnate

Table on Common Antidepressants taken from "Outpatient Management of Depression: A Guide for the Primary-Care Practitioner." Second Edition. Published by Professional Communications, Inc. Copyright 1999. Author is Sheldon H. Preskorn, M.D., Professor and Chairman, Dept. Of Psychiatry, University of Kansas School of Medicine. He is also president and medical director of the Psychiatric Research Institute and Center for Phase 1 Research, Via Christi Medical Center, Wichita, KS.

(Luvox), and citalopram (Celexa). These medications can affect the levels of other medications an older person takes, however, and their combined effects must be monitored.

Other, newer medications have different mechanisms of action that make them better choices for people with certain symptoms of depression. Mirtazepine (Remeron) frequently helps people with appetite problems, sleep problems, or stomach/bowel irritability. Nefazadone (Serzone) may help people with sleep problems, anxiety, or pain disorders, but cannot be used with Seldane or Hismanal and must be used cautiously with Xanax. Buproprion (Wellbutrin) may help increase a person's energy, but has a slightly higher risk for seizure in some people. Venlafaxine (Effexor) may help with depression and lack of energy. People who have severe problems with fatigue or apathy (indifference, absence of feeling) may benefit from methylphenidate (Ritalin), although blood pressure and pulse should be monitored, and sometimes agitation can result. Alprazolam (Xanax) used to be marketed for depression, but its effect is not long-term and it can be addictive. It is more commonly used now as an anti-anxiety agent.

For a few individuals, physicians may prescribe an antidepressant that inhibits the enzyme monoamine oxidase, called MAO inhibitors. These medications are prescribed with great caution because they require many dietary restrictions to prevent serious or even fatal side effects from food-medication interactions. People eating foods that contain the amino acid tyramine (such as aged cheeses, wines, cured meats and fish) can have a hypertensive reaction or even stroke or cardiac failure. If your physician prescribes this type of medication, ask him/her to discuss carefully all the foods you must avoid, and observe the limitations carefully. MAO Inhibitor antidepressants include Phenelzine Sulfate (Nardil), Tranylcypromine Sulfate (Parnate) and Isocarboxazid (Marplan). Some medications used to treat Parkinson's, such as Eldepryl or Carbex, are MAO inhibitors as well.

St. John's wort is a herbal dietary supplement currently being studied for its effects on depression. Improvement past six weeks of treatment has not yet been proven, and nonstandardization of various formulations make its safety data unclear. It should not be used with other antidepressants. Discuss its use with your doctor before trying it.

SAMe (S-adenosylmethionine) is another dietary supplement prescribed in foreign countries to treat depression, arthritis, and liver disease. It has recently become available in the United States, but it has not been tested or approved by the FDA. It is expensive and varies in formulation.

Anxiety and Agitation Medications

Although minor tranquilizers (benzodiazepines) were used frequently in the past, they are now mostly recommended only for short-term use because of adverse effects on mood, memory and risk for dependence. In general, physicians try to avoid long-acting tranquilizers, such as diazepam (Valium) or flurazepam (Dalmane: a sleeping medication), because they build up in the body of the elderly person. Instead, lorazepam (Ativan) is often used for temporary anxiety or agitation. Oxazepam (Serax) may also be used, and occasionally clonazepam (Klonopin) may be prescribed at low doses, when it does not cause over-sedation.

Buspirone (Buspar) is a newer medication that may help with anxiety or agitation. It must be taken (usually two to three times a day) for two to four weeks before response can be expected. It is safe, nonaddictive, and rarely interacts with other medications (except Haloperidol).

Many antidepressants are also highly beneficial for anxiety and are frequently the physician's first choice in treating an anxiety disorder that includes both agitation and depression. Many antidepressants can be combined with Buspirone for even better effect.

Beta blockers are blood pressure medications that may have beneficial effects on anxiety and agitation when used alone or with an antidepressant. Examples include propranolol (Inderal) and pindolol (Visken). They should not be used if a person has asthma or bronchitis, low blood pressure, or slow pulse, because they may worsen these medical conditions. Beta blockers sometimes also worsen depression.

Common antianxiety agents (minor tranquilizers)

Generic Name	Brand Name
Diazepam	Valium
Clorazepate Dipotassium	Tranxene
Triazolam	Halcion
Clonazepam	Klonopin
Lorazepam	Ativan
Chordiazepoxide HCL	Librium
Alprazolam	Xanax
Oxazepam	Serax
Temazepam	Restoril
Prazepam	Centrax

Agitation, Aggression, and Psychotic Symptoms

Antipsychotic medications are prescribed for people with psychotic symptoms such as hallucinations and delusions (paranoia or suspiciousness) and have a limited role in reducing behavioral agitation, if other behavioral strategies have failed. Many of these medications carry a risk of causing Parkinson's-like symptoms and disorders of movement. A doctor should be notified promptly if movement problems occur in a person taking these medications.

Some of the older antipsychotic medications are helpful in calming agitation and clearing up irrational thinking or hallucinations. However, many (such as Mellaril and Thorazine) have side-effects similar to the tricyclic antidepressants and are too risky for elderly patients. Haloperidol (Haldol) and fluphenazine (Prolixin) may be used in low doses. Many healthcare providers prefer to prescribe one of the newer anti-psychotics. These do not pose as much risk for movement problems as do the older medications. Risperidone (Risperdal), olanzepine (Zyprexa), and quetiapine (Seroquel) are examples of the newer medications.

Anticonvulsant medications such as valproic acid (Depakote), carbamezepine (Tegretol), and gabapentin (Neurontin) can be helpful for people who develop agitation, aggression or severe unstable mood. Blood tests must be done routinely to monitor for effects on blood components and the liver.

Common Anti-psychotics (major tranquilizers)

Side effects are noted in the text

Generic Name	Brand Name
Clozepine	Clozaril
Haloperidol	Haldol
Thiothixene	Navane
Fluphenazine HCL	Prolixin
Perphenazine	Trilafon
Chlorpromazine	Thorazine
Thioridazine	Mellaril
Mesoridazine	Serentil
Newer Anti-psychotics	
Risperidone	Risperdal
Olanzapine	Zyprexa
Quetiapine	Seroquel

[1] Sadavoy, *Comprehensive Review of Geriatric Psychiatry (Second Edition)*, 1996.

Medications Used in Treatment of Memory Symptoms

People with Alzheimer's disease and other dementias may benefit from medication that can be prescribed to help delay memory losses and to treat coexisting problems of behavior, mood, or thinking. Agitation, depression, anxiety, hostility, delusions, and hallucinations are a few of the symptoms that affect the quality of life of both the person with dementia and the person's caregiver. It is often possible to control some of these symptoms through the use of medications.

The need to deal effectively with these symptoms is great. Research indicates that caregivers seeking assistance in caring for dementia patients in the community report that 70 percent have disturbed behavior and 50 percent have hallucinations or delusions. The severity of the dementia correlates with the number and type of behavioral problems. For example, 82 percent of mildly impaired people with Alzheimer's disease have behavioral problems compared to 95 percent with severe impairment; 30 percent of those with severe dementia have hallucinations compared to 10 percent with mild impairment.[1]

We can divide the types of medications used in people with dementia into two main categories: those used for the memory symptoms of dementia and those used for associated symptoms, such as depression, anxiety, psychosis, or agitation. Many of the older medications mentioned previously in this section can be prescribed in generic forms, and are cheaper because of this, but may be less desirable due to the increased risk of side-effects. Dietary supplements have been mentioned in some articles on the treatment of Alzheimer's. These "alternative medications" have not been demonstrated to have the efficacy necessary to substantiate advertising claims, nor is there data indicating they meet elementary requirements on manufacturing and dosage safety. Be aware that the Food and Drug Administration has no real enforcement of these supplements, as they are not considered "drugs" under FDA regulations. Use caution whenever trying these substances or when using them, especially when you are already taking prescription or other medications.

Tacrine (Cognex) was the first medication approved for improving memory, attention, reasoning, language, and the ability to perform simple tasks. The response rate is moderate in some people, and benefits may be greater in the early stages of the disease. Liver problems may limit use of the drug, and routine blood tests are necessary.

Donepezil (Aricept) is a newer drug that may be slightly more successful in treating memory symptoms and presents less risk for stomach upset, bowel problems, or liver toxicity. Recent studies also show that it may help with agitation.

Vitamin E is an antioxidant that may slow the progression of Alzheimer's disease, which then can increase the length of time before the person may need to move to a long-term care facility.

Nonsteroidal anti-inflammatory agents, such as ibuprofen, may be beneficial in delaying symptoms as well. Their use needs to be discussed with the physician, since they present risks for ulcers or bleeding.

Ginkgo biloba is an "herbal" dietary supplement that is not regulated by the FDA, but has been shown in some recent studies to be of benefit in delaying memory loss. Some persons at risk for Alzheimer's have chosen to take this supplement.

For postmenopausal women, hormonal substances such as estrogen may have a beneficial effect on memory and may help delay memory loss. Research data are only available for short-term benefits (two weeks) and unclear for longer term use. These hormones may also help with agitation in older men and women, and are being used for people with dementia who become hyper sexual. For older men who have significant problems with hypersexual behavior, physicians may prescribe Medroxyprogesterone.

Ways of Coping With Behavioral Problems

Medications can be beneficial in treating a variety of symptoms associated with dementia. Before choosing to use medication, it is important to try addressing these symptoms with some behavioral coping strategies. (See the Resources section for sources of information.) Using behavioral strategies is equally important whether the person with dementia lives at home or in a long-term care facility. It is always important to make sure that new medical problems — such as urinary tract infections, heart or lung problems, or even other medications — are not causing a new or sudden change in behavior or thinking.

When Taking Medication

- Be sure you understand the directions for taking the medication. Ask about any special precautions. Check with your doctor or pharmacist.
- Find out about possible side-effects, and report any that occur. Be sure the doctor closely monitors side-effects and interactions of medications.
- To be sure of the best benefit from the medication prescribed:

  Read the label carefully and follow all the directions.

  Establish a routine to avoid forgetting or resisting taking medication.

  Use a pill box.

  Do not stop taking medication without telling the doctor.

  If you are caring for someone with dementia, be sure that the person has swallowed the medication by checking the inside of the cheek and under the tongue.

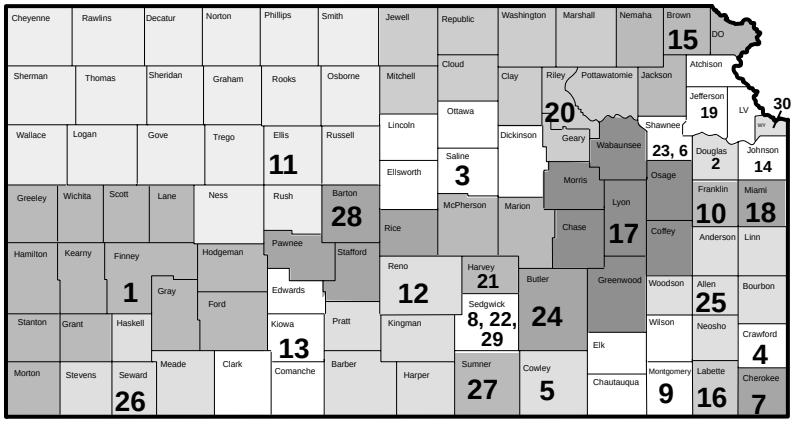
  Using alcoholic beverages should be avoided by anyone taking medications and by people with dementia. Alcohol may increase confusion and cause dangerous interactions with over-the-counter and prescription medications.

Youth is a gift of nature;
age is a work of art.

— Anonymous

Resource Guide

Locations Of Community Mental Health Centers (CMHCs) In Kansas



The map above shows the locations of Community Mental Health Centers in Kansas. Some Centers have offices in several communities within the region they serve.

When you call your local mental health center, the first person you will speak with will usually be the receptionist, who will ask you for some very basic information such as your name, phone number, address, what you think your problem is and insurance information. After you give this information he/she will arrange an appointment for you with an intake worker. When you meet with your intake worker, he/she will then help you get the type of services that you need from the Center. From that point you will probably see another mental health professional, such as a social worker, psychologist, nurse practitioner or psychiatrist.

1. Garden City Area Mental Health Center
156 Gardendale
Garden City, KS 67846
316-276-7689

2. Bert Nash Community Mental Health Center
200 Main Street, #A
Lawrence, KS 66044
785-843-9121

3. Central Kansas Mental Health Center
809 Elmhurst
Salina, KS 67401
913-823-6322

4. Community Mental Health Center
of Crawford County
PO Box 550
Pittsburg, KS 66762
316-231-5130

5. Cowley County Mental Health
and Counseling Center
22 Club House Drive
Augusta, KS 67010
316-775-5866

6. Family Service and Guidance Center
2913 Plass Court, Suite 200
Topeka, KS 66611
785-266-0092 (serves children and families only)

7. Family Life Center
201 West Walnut
Columbus, KS 66725
316-429-1860

8. Family Consultation Service
560 North Exposition
Wichita, KS 67203
316-264-8317

9. Four County Mental Health Center
201 Pennsylvania Ave., Suite 614
Independence, KS 67301
316-331-1748

10. Franklin County Mental Health Center
204 East 15th Street
Ottawa, KS 66067
785-242-3780

11. High Plains Community Mental Health Center
208 East 7th Street
Hays, KS 67601
785-628-2871

12. Horizons Mental Health Center
1715 East 23rd
Hutchinson, KS 67502
316-665-2240

13. Iroquois Center for Human Development
103 South Grove
Greensburg, KS 67054
316-723-2272

14. Johnson County Mental Health Center
6000 Lamar, Suite 130
Mission, KS 66205
913-831-2550

15. Kanza Mental Health and Guidance Center
PO Box 319
Hiawatha, KS 66434
785-742-7113

16. Labette Center for Mental Health Services
3101 Main, PO Box 258
Parsons, KS 67357
316-421-3770

17. Mental Health Center of East Central Kansas
1000 Lincoln
Emporia, KS 66801
316-342-054818.

18. Miami County Mental Health Center
401 North East Street
Paola, KS 66071
785-294-5755

19. Northeast Kansas Mental Health
and Guidance Center
818 North Seventh
Leavenworth, KS 66048
785-682-5118

20. Pawnee Mental Health Services
2001 Claflin
Manhattan, KS 66502
785-587-4300

21. Prairie View, Inc.
Box 467
Newton, KS 67114
316-284-6400

22. COMCARE of Sedgwick County
635 North Main
Wichita, KS 67203
316-383-8251

23. Shawnee Community Mental Health Center
5401 W. 7th
Topeka, KS 66606
785-233-2252

24. South Central Mental Health Counseling Center
2365 West Central
El Dorado, KS 67042
316-321-6036

25. Southeast Kansas Mental Health Center
1106 South 9th
Humboldt, KS 66748
316-473-2241

26. Southwest Guidance Center
Box 2945, 333 West 15th
Liberal, KS 67905
316-624-8171

27. Sumner County Mental Health Center
1601 W. 16th Street
Wellington, KS 67152
316-326-7448

28. The Center for Counseling and Consultation
5815 Broadway
Great Bend, KS 67530
316-792-2544

29. Wichita Guidance Center
415 North Poplar
Wichita, KS 67214
316-686-6671 (serves children and families only)

30. Wyandotte Mental Health Center
PO Box 3228, Eaton at 36th
Kansas City, KS 66103
913-831-9500

Locations of Area Offices for the Department of Social and Rehabilitation Services (SRS) in Kansas

In each Kansas county, a local office of the Department of Social and Rehabilitation Services offers programs and services administered by the agency. The state's 105 counties are organized into 11 administrative areas. Among the programs administered by SRS are: Adult Protective Services, Medicaid, MediKan, Home and Community Based Services (HCBS), and mental health and substance abuse treatment. Locations of the 11 SRS Area Offices (including Adult Protective Services) are listed below.

1.Chanute Area Office
1500 W. 7th.
Chanute, KS 66720
316-431-5000
Counties served: Allen, Anderson, Bourbon, Cherokee, Crawford, Labette, Linn, Montgomery, Neosho, Wilson, Woodson

2. Emporia Area Office
1015 Scott
Emporia, KS 66801
316-342-2505
Counties served: Butler, Chase, Chautauqua, Coffey, Cowley, Elk, Greenwood, Lyon, Marion, Morris, Osage

3. Garden City Area Office
1710 Palace Drive
Garden City, KS 67846
316-272-5800
Counties served: Barber, Clark, Comanche, Edwards, Finney, Ford, Grant, Gray, Greeley, Hamilton, Haskell, Hodgeman, Kearney, Kiowa, Lane, Meade, Morton, Ness, Pratt, Scott, Seward, Stafford, Stanton, Stevens, Wichita

4. Hays Area Office
1105 E. 30th
Hays, KS 67601
785-628-1066
Counties served: Barton, Cheyenne, Decatur, Ellis, Gove, Graham, Logan, Norton, Osborne, Pawnee, Phillips, Rawlins, Rooks, Rush, Russell, Sheridan, Sherman, Smith, Thomas, Trego, Wallace

5. Hutchinson Area Office
501 N. Monroe
Hutchinson, KS 67501
316-663-5731
Counties served: Harper, Harvey, Kingman, McPerson, Reno, Rice, Sumner

6. Kansas City Area Office
400 State Ave.
Kansas City, KS 66101
913-279-70000
County served: Wyandotte

7. Lawrence Area Office
PO Box 590 -1901 Delaware
Lawrence, KS 66046
785-832-3700
Counties served: Atchinson, Brown, Doniphan, Douglas, Franklin, Jackson, Jefferson

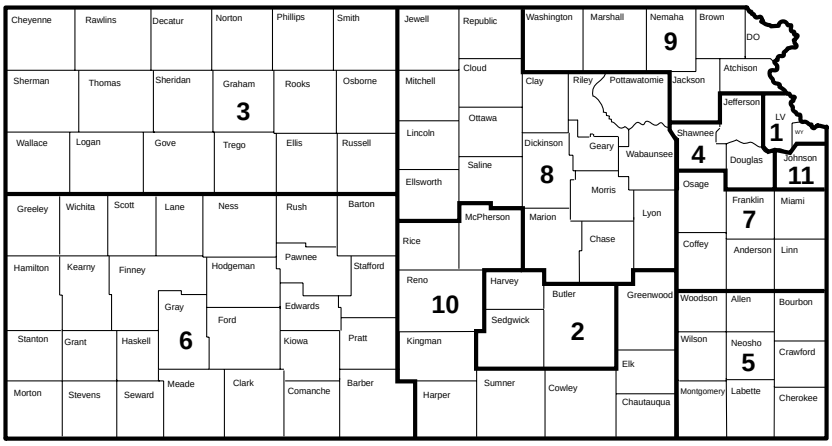
8. Manhattan Area Office
327 Colorado
Manhattan, KS 66502
785-776-4011
Counties served: Clay, Cloud, Dickinson, Ellsworth, Geary, Jewell, Lincoln, Marshall, Mitchell, Nemaha, Ottawa, Pottawatomie, Republic, Riley, Saline, Wabaunsee, Washington

9. Olathe Area Office
401 W. Frontier Lane
Olathe, KS 66001
913-768-3300
Counties served: Johnson, Leavenworth, Miami

10. Topeka Area Office
235 S. Kansas
Topeka, KS 66603
785-296-2500
County served: Shawnee

11. Wichita Area Office
230 E. William
Wichita,KS 67202
316-337-7000
County served: Sedgwick

Locations Of Area Agencies On Aging In Kansas



There are 11 Area Agencies on Aging (AAAs) in Kansas that coordinate programs and services for people age 60 and over. The numbers on the map above correspond to the geographical regions served by each AAA. Some AAAs may have offices in several communities within the region they serve. Since each AAA manages programs and services designed to meet the needs of its particular region of Kansas, services offered may vary. In addition to Older American Act Services, AAAs may offer Senior Care Act Services, Income-Eligible Home Care Program, Home and Community Based Services for Frail Elderly, and the CARE Program. Information and Referral services are available at all AAAs.

Older Americans Act Services, provide services such as information, legal assistance, in-home services, transportation, nutrition sites, etc. to persons 60+ years of age at no cost (donations are encouraged).

Senior Care Act Services provide a variety of services including homemaking, personal care, respite and other services designed to help older adults live as independently as possible at home. Persons who are 60+ years of age with physical or mental limitations which restrict their ability to perform two activities of daily living may be eligible to receive services based on a sliding fee scale according to income.

Income-Eligible Home Care Program serves individuals age 60 + who meet certain income and level of care criteria. The program provides a variety of services including attendant care, case management, and homemaker services, on a sliding fee scale according to income. The program also has the flexibility to meet the unique needs of individuals on a case-by-case basis.

Home and Community Based Services for Frail Elderly (HCBS/FE) provides long-term care services to Kansans who are age 65 or older, in frail health, and qualify for Medicaid benefits. Services include personal care such as feeding, bathing and dressing; household tasks such as shopping, meal preparation, house cleaning, and laundry. Services are provided at no cost, unless the person's countable income exceeds a specified amount.

Client Assessment, Referral and Evaluation (C.A.R.E.) Program provides the assessment required by Kansas law before admission to a nursing home. The assessment is designed to evaluate need and inform people about community based alternatives to institutional care.

Information and Assistance provides confidential information on available services and referrals to agencies. It is available to adults age 60+ and adult children caring for their parents.

Other Programs / Services may include:

Nutrition Programs provide hot meals for older adults in a congregate setting at senior centers/nutrition sites or by delivery to homebound residents. Some may offer nutrition counseling, grocery shopping assistance, and/or commodities.

Senior Centers offer educational activities, social activities, and exercise opportunities at senior centers/nutrition sites.

Elder Employment Programs assist adults 55 years + years of age in securing employment.

Senior Health Insurance Counseling for Kansas (SHICK) offers trained volunteer insurance counselors who provide one-on-one counseling, assistance and advocacy relating to Medicare, Medicaid, private health insurance (Medicare supplements, long-term care insurance, etc.) and related health coverage. Counselors also can assist with completing insurance forms.

Legal Services offer legal advice and assistance from an attorney. Cases that can be handled are income maintenance (Social Security, food stamps, etc.), housing cases, Medicare/Medicaid insurance claims, consumer cases and wills.

Adult Abuse Prevention and Legal Counseling offers services to protect older adults from personal and financial injury.

Medical Services may offer preventive health services, wellness programs, prescription drug programs, and linkage to medical agencies.

Mental Health Services may include public education, support groups, and counseling.

Transportation may be available to provide rides for older adults to insure access to needed medical and community services.

Housing programs offer information on housing alternatives, home sharing, and/or rental assistance (Section 8 housing).

Environmental Modification, **Home Repair, and Home Maintenance** services help older adults remain at home in a safe, secure environment. Programs can include chore service, weatherization, and loans or grants for home modifications.

Case Management or Care Coordination assists older adults and their families by assessing needs, identifying resources, and facilitating the coordination of these services on their behalf. Services may include personal care, home health, adult day care, homemaker services, transportation, home delivered meals, etc. Case managers monitor continued need for the services provided.

In-Home Services programs assist frail older adults who need only intermittent care and assistance to remain at home. **Services may include:**

Home Delivered Meals for homebound older adults.

Personal or Non-Medical Attendant Care services provide help with meals, walking, bathing, personal hygiene, dressing, and self- administered medications.

Homemaker services provide help with tasks required to maintain a home, including cooking, laundry, planning meals, light housekeeping, and essential shopping.

Chore/Home Maintenance services may provide help with heavy housework, yard work, snow removal, etc.

Custom Care services enable case managers to address unmet or unique needs.

Respite provides support and relief to relatives who regularly care for frail older adults.

Area Agencies on Aging also may coordinate **Friendly Visiting** and **Telephone Reassurance** programs, support **Volunteer Services**, the **Silver Haired Legislature**, publish periodic **Newsletters,** engage in **Advocacy,** and offer **Education** and/or **Technical Assistance**.

Area Agency on Aging Offices

Additional information about the services offered at each AAA may be found on the Kansas Association of Area Agencies on Aging web site: http://www.k4s.org/aaa/default.htm

1. **Wyandotte/Leavenworth Area Agency on Aging**
9400 State Avenue
Kansas City, KS 66112
888-661-1444
913-328-4531

2. **Central Plains Area Agency on Aging**
510 North Main, Room 502
Wichita, KS 67203
800-367-7298
In-home Services Intake 316-383-7893

3. **Northwest Kansas Area Agency on Aging**
301 West 13th Street
Hays, KS 67601
800-432-4722
785-628-8204

4. **Jayhawk Area Agency on Aging**
1195 Buchanan, Suite 202
Topeka, KS 66604
800-789-1300
785-235-1367

5. **Southeast Kansas Area Agency on Aging**
PO Box J
1 West Ash
Chanute, KS 66703
800-794-2440
316-431-2980
In Pittsburg 232-5944

6.**Southwest Kansas Area Agency on Aging**
PO Box 1636
Dodge City, KS 67801
316-225-8230

7.**East Central Kansas Area Agency on Aging**
132 North Main
Ottawa, KS 66067
800-633-5621
785-242-7200

8. North Central - Flint Hills Area Agency on Aging
437 Houston
Manhattan, KS 66502
800-432-2703
785-776-9294

9.Northeast Kansas Area Agency on Aging
526 Oregon Street
Hiawatha, KS 66434
800-883-2549
785-742-7152

10. South Central Kansas Area Agency on Aging
114 West 5th Avenue
PO Box 1122
Arkansas City, KS 67005
800-362-0264
316-442-0268

11. Johnson County Area Agency on Aging
11875 S. Sunset Suite 200
Olathe, KS 66061
888-214-4404
913-894-8811

County Health Departments In Kansas

Each of the 105 counties in Kansas has a County Health Department that may be able to help you identify services and resources that are available in your county. Check your telephone directory to find the location and phone number of the Health Department in your county. You should find it listed under your county's listing in the white pages.

Want to Learn More? Some Helpful Books

Burnham, R.W. (1994). *Life's Third Act: Taking Control of Your Mature Years.* New York: MasterMedia.

Carter, R. & Golant, S. *(1998). Helping Someone with Mental Illness: A Compassionate Guide for Family, Friends, and Caregivers*. New York: Times Books.

Carter, R. & Golant, S. (1994). *Helping Yourself Help Others: A Book for Caregivers*. New York: Random House.

Golant, M. & Golant, S. (1996). *What to Do When Someone You Love is Depressed*. New York: Henry Holt.

Gorman, J. M. (1996). *The New Psychiatry: The Essential Guide to State-of-the-Art Therapy, Medication, and Emotional Health*. New York: St. Martin's Press.

Gwyther, L. (1985). *Care of Alzheimer's Patients: A Manual for Nursing Home Staff.* Washington, DC: American Health Care Association and Alzheimer's Disease and Related Disorders Association.

Hatfield, A. *(1991). Coping with Mental Illness in the Family: A Family Guide*. Washington, DC: National Alliance for the Mentally Ill.

Kuber-Ross, Elizabeth. (1969). *On Death and Dying.* New York: MacMillin.

Lefley, Harriet. (1996). *Family Caregiving in Mental Illness.* Thousand Oaks, CA: Sage.

Mace, N. & Rabins, P. (1999). *The 36 Hour Day (third edition).* Baltimore: John Hopkins University Press.

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

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

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

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

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

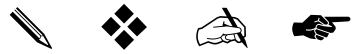
Weiden, P., Scheifler, P., Diamond, R. & Ross, R. (1999). *Breakthroughs in Antipsychotic Medications: A Guide for Consumers, Families, and Clinicians.* New York: W.W. Norton.

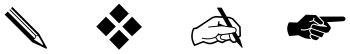
Organizations Offering Information and Self-help Groups

In the rapidly changing world of technology, more and more information is becoming available on the internet. Many public libraries provide computers that allow you to access these internet resources. New web sites are constantly appearing and old ones sometimes change their addresses. Although this information is correct as of September 15, 1999, changes are to be expected. If a site address changes, it usually provides a link from the old address to the new one.

- Telephone Information Center / Help Line
- Fact Sheets / Newsletters (many available on-line)
- Policy / Legislative Updates
- Bibliographies, bookstore, book reviews, and/or audiotapes, videotapes
- Referral options and/or support
- Self-help and/or support groups
- Research Updates

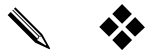
General Health Web Sites	Resources	Web Site
HealthFinder A Service of Health and Human Services		www.healthfinder.gov
AMA Health Insight Consumer Health Information sponsored by the American Medical Association		www.ama-assn.org/ consumer.htm
National Women's Health Information Center (NWHIC) 8550 Arlington Boulevard, Suite 300 Fairfax, VA 22031 Links to Federal health clearinghouses, private sector organization resources	800-994-WOMAN (800-994-9662) 703-560-6598 (Fax) TDD: 888-220-5446	www.4woman.gov
Mayo Clinic Health Oasis Men's, Women's, Alzheimer's Centers		www.mayohealth.org

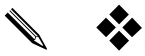
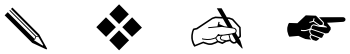
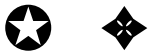
Mental Health Issues	Telephone	Web Site
National Mental Health Association (NMHA) 1021 Prince Street Alexandria, VA 22314-2971 **Mental Health Information Center**  **Kansas / Kansas City Area Affiliates:** MHA in Reno County MHA of Kansas MHA of South Central Kansas MHA of the Heartland (Kansas) MHA of the Heartland (Missouri)	703-684-7722 703-684-5968(Fax) 800-969-NMHA(6642) TTY 800-433-5959	www.nmha.org
National Association for the Mentally Ill (NAMI) 200 N. Glebe Rd. Suite 1015 Arlington, VA 22203  **NAMI-Kansas Affiliate**: 112 SW 6th Street, Suite 505 P.O. Box 675 Topeka, KS 66601	703-524-7600 703-524-9094(Fax) Helpline 800-950-6264 800-539-2660 785 / 233-0755(Fax) 785 / 233-4804	www.nami.org
The Center for Mental Health Services (A Service of the Substance Abuse and Mental Health ServicesAdministration) P.O. Box 42490 Washington, DC 20015  Knowledge Exchange Network (KEN)	KEN: 800-789-CMHS(2647) TDD: 301-443-9006	www.mentalhealth.org
American Psychiatric Association 400 K. St., N.W. Washington, DC 20005  Public / Consumer Information Consumer Drug Information	202-682-6000	www.psych.org
Mental Health Net (Web only) (Sponsored by CMHC Systems) 		http://mentalhelp.net

Mental Health Issues	Telephone	Web Site
American Psychological Association Office of Public Affairs 750 First St., N.E. Washington, DC 20002-4242  Psychology in Daily Life Consumer Information / Fact Sheets Mental Health Patients Bill of Rights Help Center	202-336-5700	Psychology in Daily Life www.apa.org/pubinfo Help Center http://helping.org Adult Development & Aging Division 20 www.iog.wayne.edu/APADIV20
American Geriatrics Society 770 Lexington Ave. Suite 300 New York, NY 10021  Consumer Education Page AGS Foundation for Health in Aging 	212-308-1414 212-832-8646(Fax) 800-247-4779	www.americangeriatrics.org www.healthinaging.org
National Mental Health Consumers' Association (NMHCA) 4401-A Connecticut Ave., NW Suite 308 Washington, DC 20008  Advocacy for patients' rights, consumer-run programs, representation	216-241-3400 216-861-5067(Fax)	
National Association of Protection and Advocacy 900 Second Street, NE, Suite 211 Washington, DC 20002 (Fax)  Protect and advocate for the rights of people with mental illnesses **Kansas Advocacy and Protection Services, Inc.** 3218 Kimball Ave Manhattan, KS 66503	202-408-9514 TDD: 202-408-9521 202-408-9520 In Kansas: 785-776-1541 785-776-5783(Fax)	www.protectionandadvocacy.com/region4.htm
GriefNet (Web only) (Supervised by Cendra Lynn, Ph.D) 		www.rivendell.org

Mental Health Issues	Telephone	Web Site
National Mental Health Consumers' Self-Help Clearinghouse (NMHCSHC) 1211 Chestnut Street, Suite 1000 Philadelphia, PA 19107  Technical assistance for self-help groups	800-553-4539 215-751-1810 215-636-6312 (Fax)	www.mhselfhelp.org
Self-Help Network of Kansas Psychology Department Wichita State University Wichita, KS 67260-0034  ***Connections*** - A Directory of Self-Help Groups in Kansas communities including: Mental Illness/Health Grief and bereavement Physical Illness/Health/Disability Additions	Kansas Toll-Free Information Line: 800-445-0116	wsypsy.psy.twsu.edu/shnok
Health Care Policy Division **Mental Health, Substance Abuse, Treatment and Recovery** Dept. of Social & Rehabilitation Services 915 S. W. Harrison St. Topeka, KS 66612 **Adult Protective Services**	888-582-3759 (toll free) 785-296-3773 785-296-6142 **Adult Protective Services HOTLINE 800-922-5330**	www.ink.org/public/SRS/mentalhealth.html
Menninger Foundation PO Box 829 Topeka, KS 66601-0829  Clinical Services	800-351-9058	www.menninger.edu
Kansas Mental Health and Aging Coalition 1125 West Spruce Olathe, KS 66061  Videotapes: Mental Heath & Aging Local coalitions exist in Sedgwick County & Eastern Kansas	913-782-2100	www.oznet.ksu.edu/mhaging

Specific Disorders	Telephone	Web Site
Alzheimer's Association 919 N. Michigan Ave, Suite 100 Chicago, IL 60611-1676  National and chapter newsletters Information/education on the disease, caregiving, long-term and respite care, etc. **Kansas Area Chapters:**	National Information Help Line 800-272-3900 TDD: 312-335-8882	www.alz.org
Heartland Chapter (Greater KS City) 3846 West 75th Street Prairie Village, Kansas 66208 **Topeka Chapter** P. O. Box 1427 Topeka KS 66601-1427 **Sunflower Chapter** (Wichita region) 347 South Laura Wichita KS 67211	In Kansas: 800-733-1981 913-831-3888 Help Line:785-831-0003 785-234-2523 316-267-7333 or 877-267-7333	www.alz.org/chapters/template/kc/Welcome.html
Alzheimer's Disease Education and Referral (ADEAR) Center (A service of: The National Institute on Aging -NIA) P.O. Box 8250 Silver Spring, MD 20907-8250 	800-438-4380	www.alzheimers.org
Alzheimer's Disease Research Center **Washington University -St. Louis** ***The Alzheimer Page***  Links to many Alzheimer webpages		www.adrc.wustl.edu/ALZHEIMER
Alzheimer's Disease Center- Boston University On-line caregiver resources 		http://206.119.4.214/alzheimer
National Depressive and Manic-Depressive Association 730 North Franklin Street, Suite 501 Chicago, IL 60610 	Information Line 800-826-3632 312-642-0049 312-642-7243 (Fax)	www.ndmda.org

Specific Disorders	Telephone	Web Site
Depression and Related Affective Disorders Association (DRADA) Meyer 3-181, 600 North Wolfe Street Baltimore, MD 21287-7381 	410-955-4647	www.med.jhu.edu/drada
National Foundation For Depressive Illness P.O. Box 2257 New York, NY 10116 	800-239-1265	www.depression.org
National Alliance for Research on Schizophrenia and Depression 60 Cutter Mill Road, Suite 404 Great Neck, NY 11021  Raises/awards funds for scientific research	NARSAD Infoline 800-829-8289 516-829-0091 516-487-6930(Fax)	www.mhsource.com/narsad.html
Pendulum Resources: **Bipolar Disorders Portal** (web only) 		www.pendulum.org
Anxiety Disorders Association of America (ADAA) 11900 Parklawn Drive, Suite 100 Rockville, MD 20852 	301-231-9350	www.adaa.org
National Anxiety Foundation 3135 Custer Drive Lexington, KY 40517-4001 		http://lexington-on-line.com/naf.html
American Association of Suicidology 4201 Connecticut Ave., NW Suite 408 Washington, DC 20008  (Understand/prevent suicide)	202-237-2280 202-237-2282 (Fax)	www.suicidology.org

Specific Disorders	Telephone	Web Site
Suicide Information & Education Centre #201, 1615 - 10th Ave. SW Calgary, Alberta Canada  (library and resource center only)	403-245-3900 403-245-0299 (Fax)	www.siec.ca
National Institute on Drug Abuse 6001 Executive Boulevard Bethesda, Maryland 20892 		www.nida.nih.gov
Substance Abuse and Mental Health Services Administration National Institutes on Drug Abuse 6001 Executive Boulevard, Room 5213 Bethesda, MD 20892-9561 **National Clearinghouse for Alcohol and Drug Information** 	800-729-6686	www.health.org
Alcoholics Anonymous 		www.alcoholicsanonymous.org
Salina, KS -Area Assembly Central Office Shawnee Mission, KS Information & Service Center Topeka Area Answering Service Ulysses, KS -United Service Intergroup Wichita, KS -Central Office	785-823-3058 913-384-2770 785-354-3888 316-356-3003 316-684-3661	
Gamblers Anonymous St. Francis Hospital and Medical Center 1700 SW 7th Street Topeka, KS 66606-1690 	800-432-0976	www.gamblersanonymous.org

Other Helpful Resources	Telephone	Web Site
Access America for Seniors (Web only) Access government services electronically including Medicare, Medicaid, VA, FDA site for older Americans, Social Security		www.seniors.gov

Other Helpful Resources	Telephone	Web Site
Administration on Aging (AoA) 330 Independence Avenue, SW Washington, DC 20201	National Aging Information Center 202-619-7501	www.aoa.dhhs.gov
The Aging Network / Eldercare Locator **ElderAction Booklets** **Resource Directory for Older Persons** Also: Financial, legal issues, web links	800-677-1116 (to find services for an older adult in his or her locality)	
Kansas Department on Aging 503 S. Kansas Ave. Topeka, KS 66603-3404 Web Links to Area Agencies on Aging	800-432-3535 or 785-296-4986 785-296-0256(Fax)	www.k4s.org/kdoa
American Association of Retired Persons (AARP) 601 E Street, NW Washington, DC 20049 **Kansas AARP Office** 3601 S. W. 29th , Suite 125 Topeka, KS 66614	800-424-3410 **Kansas Office:** 785-228-2557 785-228-2531 (fax)	www.aarp.org
KSU Research and Extension Distribution Center, 24 Umberger Hall Manhattan, KS 66506 Publications on mental health, grief, and health and wellness (some on-line)	785-532-5830 785-532-7938 (Fax) Most publications also available from county extension offices	www.oznet.ksu.edu www.learnmore.k-state.edu
National Family Caregiver Association 10605 Concord St. Suite 501 Kensington, MD 20895-2504	800-896-3650 301-949-2302 (fax)	www.nfcacares.org
Family Caregiver Alliance **690 Market Street, Suite 600** San Francisco, CA 94104	415-434 3388 415-434 3508	www.caregiver.org On-line Resource Center

Glossary of Terms

Acute	having a sudden onset or quickly becoming worse; lasting a short time
Agitated	excessive motion when feeling inner tension: restless, inability to sit still, pacing, wringing of hands, pulling at clothes
Antidepressants	medications that help alleviate symptoms of depression
Antipsychotics	medications used to decrease symptoms of psychotic disorders
Anxiety	feeling of fear, unexplained nervousness or dread that something terrible will happen
Atypical	not typical; unusual or irregular
Alzheimer's disease	illness that affects the way the brain works; damage occurs when cells are lost and nerves are damaged; causes general deterioration of mental ability
Biofeedback	training program designed to develop a person's ability to control his/her involuntary nervous system
CARE Program	(Client Assessment, Referral and Evaluation Program) assessment program to help individuals find appropriate long-term care services
Chronic	marked by long duration or frequent reoccurrences (as in arthritis, heart disease, asthma)
Conspicuous	obvious, attracting attention, noticeable
Delusion	false belief
Dementia	a general term for several diseases which cause changes in a person's thinking, ability to remember, reasoning and judgment
ECT	electroconvulsive therapy; use of an electric impulse to the brain to treat some cases of major depression
Hallucination	perception having no relation to reality and not accounted for by any outside factor; most common are hearing or seeing things no one else does
Incoherent	unable to express one's thought in an orderly manner

Mania	characterized by abnormal excitability, exaggerated feelings of well-being; flight of ideas, excessive activity
Medicaid	federal/state cooperatively funded and state-operated program of health benefits available to eligible low-income persons, established under Title 19 of the Social Security Act; states determine program benefits, eligibility requirements and rates of payments for agencies and institutions that provide services, as well as methods of administrating the program under federal guidelines; Medicaid operates in every state except Arizona, which has a comparable program
Medicare	federal health insurance program for persons age 65 and over who are eligible for Social Security or Railroad Retirement benefits and for some people under age 65 who are disabled; established under Title 18 of Social Security Act; program has two parts: hospital insurance (Part A)covering inpatient hospital, skilled nursing care and home health; and supplementary medical insurance (Part B) covering physician and other services; Part B is voluntary and requires payment of monthly premium
Medigap insurance	private health insurance purchased to cover the gaps, and often some additional services, not covered by Medicare
Metabolic system	chemical and physical changes that take place within human cells
Neurotransmitters	chemical substances in the brain (such as dopamine, seratonin) that transmit nerve impulses across a synapse
Psychosis	mental disorder marked by impairment in person's ability to think, remember, interpret reality and behave appropriately
Psychotherapy or Therapy	therapy involving talking with a professional about problems and issues in individual's life
Stigma	mark of disgrace or reproach
Schizophrenia	brain disorder characterized by disordered perceptions, thinking and behavior that has a comprehensive effect on personal, social and work functioning
Testamentary capacity	ability to make a will

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(1989) *"I wonder who else can help."*
(1989) *"If only I knew what to say or do..."*
(1990) *Backgrounder: Stress in Later Life.*
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(1991) *"If only I could get a good night's sleep!"*
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About the drawing on this cover,
"Self-Portrait with Glenn and Sunflowers," by Elizabeth Layton

Elizabeth Layton came to art late in life at the age of 68 in 1977. The lifelong resident of Wellsville, Kansas, took her first and only art course at Ottawa University. There, she learned blind contour drawing, whereby the artist does not look at the paper while drawing.

The result was that Elizabeth Layton ended her 35-year depression and completed nearly 1,000 self-portrait drawings during her 15-year drawing career.

While some of her drawings, such as the one on this cover, show her and her husband happy and at peace, others do not. Some show her feelings about social issues such as women's rights, racial prejudice, the environment, and the right to die. Through the efforts of a young newspaper reporter in Ottawa, Don Lambert (a 1972 graduate in journalism from Kansas State University and now a freelance writer in Topeka), Layton's drawings have been seen in 20 Kansas communities and in more than 200 art museums and art centers across the country. Bookings have included the National Council on Aging and the Smithsonian's National Museum of American Art in Washington, D.C. Layton was featured in People, Life and Parade magazines, among others. She died after having a stroke in 1993.

A true Kansas treasure, Elizabeth Layton became a symbol of hope and triumph to individuals across the country.

"Self-Portrait with Glenn and Sunflowers," reproduced with permission by the owner of the drawing, Cecelia Sexton, Manhattan, Kansas.