

Mental Health Issues in Aging

Lois K. Evans, PhD, RN, FAAN
van Amerigen Professor in Nursing Excellence:
Chair, Family and Community Health Division
University of Pennsylvania
School of Nursing
418 Curie Blvd.
Room 407 Claire M. Fagin Hall
Philadelphia, PA 19104
Email: evans@nursing.upenn.edu
Telephone: (215) 898-2140

This module is:



Endorsed by The American Psychiatric Nurses Association
<http://www.apna.org>



Reviewed and endorsed by
The National Gerontological Nursing Association (NGNA),
May 2007. <http://www.ngna.org>

Introduction

Like each phase of human development, late life poses both opportunities and threats to adaptation and mental well-being. Common late life transitions include retirement, relocation, death of spouse and friends, serious illness, assumption of caregiver roles and transfer of care responsibilities for mentally disabled or ill adult children. While older adults manage these transitions with resilience, hardiness and resourcefulness (Kolanowski & Piven, 2006 [Level VI]), those with specific vulnerabilities—genetic, environmental, recurrent/multiple stressors—may develop maladaptive responses and mental illness. Persons living with a serious mental illness also grow old, and the changes associated with aging may further compromise a lifetime of challenged coping, thus exacerbating symptomatology and well-being. Including elders with dementia, about 20 percent of older adults are estimated to have a mental illness. With the rapid aging of the population, the actual numbers of older persons with mental illness will soon overwhelm the mental health system (US DHHS, 1999). Responding to the many opportunities for mental health promotion and also recognizing the special needs, unique presentations and interventions for mental illness in older adults are imperative as nurses learn to practice in the general area of psychiatric-mental health nursing.

This module is intended to extend general upper division coursework in psychiatric-mental health nursing by providing specific, selected applications to older adults. At the conclusion of this module, the learner will be able to:

1. Identify the myths and realities of mental illness among older adults in America
2. Discuss consequences of late-life depression and mental illness in older adults
3. Appreciate modification in history taking and the approach to the physical examination of older adults with stable mental illness and/or developmental disability
4. Recognize adverse side effects of medications used for the management of mental illness in older adults
5. Identify levels of care in the healthcare setting that are appropriate transitions for older adults with mental illness, for instance transitioning from an inpatient level of care to a partial day care program in the community
6. Assess by interview an older adult with stabilized mental illness to detect comorbidities and associated geriatric syndromes such as dementia, depression and substance abuse
7. Recognize older adults who self-impose threats to safety in daily living (suicide, dementia, psychosis) and help develop appropriate plans of care that ensure safety for all concerned

Mental Health in Late Life

Contrary to many “old wives tales,” older adults do continue to learn, change, grow and develop, and most enjoy good quality of life even when they experience multiple chronic illnesses (Cohen, 2005 [Level VI]). Neither is mental illness in any of its forms—e.g., depression, dementia, substance abuse—a normal consequence of aging.

Older adults do, however, encounter many life transitions that are often stressful

and present challenges to their adaptation. These include retirement, role changes, caring for aging parents/spouses, relocations, loss of health, institutionalization, or death of loved ones. Buffers that aid in coping with the stress associated with these changes include spirituality (Farran, Paun, & Elliott, 2003 [Level IV]; Katsuno, 2003 [Level VI]), social support and friends (Lilly, Richards, & Buckwalter, 2003 [Level VI]), a sense of personal control and prior experience. Risk for developing mental illness in late life is increased when older adults lack adequate social support, have accumulated stressors, unresolved grief, preexisting psychiatric illness, cognitive impairment or inadequate coping resources (Cole & Dendukuri, 2003 [Level I]; Kraaij, Arensman, & Spinhoven, 2002 [Level I]). Social support is a most important resource for coping with and adapting to life stressors, especially in late life (Ryff & Singer, 2005 [Level V]). Thus, the loss of social support through death, disability, and relocation—common experiences in late life—poses a threat to mental well-being. Nurses encountering older adults with dual risk factors of life transition and loss of social support should be alert to the potential mental thus presented.

Given the importance of achieving balance in love, work and play for mental health at any age, nurses in the community can support the efforts of senior centers, places of worship and other organizations to provide recreational and social outlets where older people can meet needs for camaraderie, meaningful roles and work, and recreation. Rowe & Kahn (1998 [Level VI]) found that successful aging is associated with an elder's engagement with life, avoidance of disease and maintenance of high cognitive and physical function. Further, as multiple research findings have made clear, older people who exercise, both physically as well as mentally, do better overall [Brummel-Smith, 2007]. Physical exercise, including walking, aerobics, ballroom dancing, tai chi and yoga, is very important in preventing or improving symptoms of anxiety and depression (Netz, Wu, Becker, & Tenenbaum, 2005 [Level I]; Pennix et al., 2002 [Level II]) and preserving and improving cognitive function (Cohen, 2005 [Level VI]; for more information visit www.ConsultGeriRN.org and select Geriatric Topics: Depression). Mental exercise has been shown to be protective of decline in cognitive function in persons with dementia; especially cogent are activities that tax the brain, such as crossword puzzles and board games, playing a musical instrument, taking courses, doing art and reading (Verghese et al., 2003 [Level II]). Elders' confidence in their ability to manage self care can be enhanced through self-efficacy training in skill mastery, verbal persuasion, role modeling and reinterpretation of physiological cues (Robb, Chen, & Haley, 2004 [Level V]; Rochat, Martin, Piot-Ziegler, Najafi, Aminian, & Bula, 2008 [Level II]). Likewise, learned resourcefulness is a protective attribute that can be enhanced by nurses, using cognitive behavioral skill training (Zauszniewski, 1997 [Level IV]; Zauszniewski, Lai, & Tichiphontumrong, 2006 [Level IV])

Comorbidities

Mental disorders like depression, anxiety or cognitive loss exacerbate the symptoms and functional disabilities associated with medical illnesses and increase the use of healthcare resources (including medications), length of hospital stay and overall cost of care (Unutzer, Patrick, & Simon, 1997 [Level IV]). Likewise, quality of life is further reduced (Butcher & McGonigal-Kenney, 2005 [Level V]). Because older people

are more likely to suffer multiple chronic medical disorders, the nurse must be on constant alert to detect comorbid mental illness that may produce excess disability. Several physical illnesses that are common in old age and also commonly associated with depression include congestive heart failure, diabetes and arthritis (Arthur, 2006; Krishnan et al., 2002 [Level I]; Lin et al., 2003 [Level V]). Since depression and anxiety can be treated, thus, lessening the overall burden of the chronic medical illness, it is important to recognize these comorbidities and assist the older person to access care in a timely manner.

Mental Health System and Older Adults

While changes are expected as “Baby Boomers” age, today’s older adult population has been less likely to acknowledge mental illness or access mental health services. Many stigmas exist regarding the meaning of mental illness, often residual from a time prior to availability of pharmacologic treatments for serious mental illnesses. Still other elders view mental illness as a sign of weakness and are unlikely to admit to problems, especially when they fear loss of independence. Many believe that symptoms of dementia and depression are a normal part of aging. Others, especially rural elders, lack availability of and access to services. For older people who have access and are willing to seek and accept treatment, payment systems that only reimburse for 50% of allowable charges for mental healthcare have reduced severely the numbers of providers willing to accept older clients and the proportion of elders who can afford to pay out of pocket for this care remains low (American Geriatrics Society & American Association of Geriatric Psychiatry, 2003b [Level VI]). Most mental healthcare is delivered by generalists in primary care offices, mainly in the form of psychoactive medications. Finally, few mental health providers have had specialized training in providing care for older adults, and many come with a set of societal-transmitted biases themselves. Beliefs that older people cannot change, that depression or cognitive impairment is normal in aging or that it is “too late for psychiatric care” get in the way of developing the therapeutic alliance needed to help a client get better (Bandua, 1997 [Level VI]; Lagana & Shanks, 2002 [Level VI]). While efforts are afoot to improve the availability and delivery in primary care settings of mental health services with proven benefits to older adults (US DHHS, 1999), the nurse may need to assist elders to locate and access services in the interim.

Settings of Care

Nurses will encounter older people in need of, or receiving, psychiatric services in a wide range of settings today. Whereas a few years ago, most were cared for in state mental hospitals or nursing homes, more effort to provide service integration is now occurring, in part, in an attempt to make care more acceptable and accessible (US DHHS, 1999).

Acute Psychiatric Services

Older people are admitted to acute inpatient psychiatric units. Some hospitals still have special psychiatric units for older adults in which the treatment team is trained in the nuances of caring for this population (Smith, Specht, & Buckwalter, 2005 [Level VI]); more often, the older adult is “mainstreamed” into general inpatient units, often posing challenges for safety and well-being when younger patients lack sensitivity, the staff lack specialized geriatric training and the environment is ill suited to support function and self

care in a physically compromised person. Assessment and evidence-based intervention protocols, individualized to the older adult, must be developed and used in the inpatient setting.

Acute General Hospital Services and Emergency Departments

Increasingly, older adults with mental disorders will be found in the emergency department or in general medical or surgical units, having been admitted with a primary medical problem which is exacerbated or compromised by depression, anxiety, cognitive impairment, substance use or a longstanding serious mental illness. Since, as mentioned previously, comorbidities add to length of stay and increased complications, the astute nurse who can identify the underlying comorbidity early and seek consultation and treatment will best help the older person with timely recovery. The advanced practice psychiatric consultation-liaison nurse can be an important resource (Kurlowicz, 2001 [Level IV]; Slaets, Kauffman, Duivenvoorden, Pelemans, & Schudel, 1997 [Level II]).

Primary Care, Community and Institutional Settings

As mentioned previously, mental health services are more often provided to older adults by their primary care provider (PCP). Increased efforts in recent years to prepare PCPs to recognize and feel competent to treat, at least pharmacologically, as well as refer patients to specialist care are beginning to have an effect. In some cases, mental health providers have been incorporated into primary care settings and in others a referral source has been identified (Bartels, 2003 [Level V]; US DHHS, 1999). Since older adults frequently have longstanding, trusting relationships with their primary care provider, this is an important gate keeping and early treatment setting. In home care, depression prevalence is at least twice as high among home care clients as in those receiving primary care, and most are untreated (Bruce et al., 2002 [Level IV]); nurses have a major role in identifying and facilitating treatment among these patients. Ambulatory psychiatric care, partial psychiatric hospital care, group homes and adult day care are three other settings where psychiatric services may be provided to older adults. More recently, there has been recognition of needs for mental health service for older adults in such settings as the criminal justice system and homeless shelters (Kaas & Beattie, 2006 [Level VI]). In nursing homes and assisted living facilities, a substantial number of residents have a mental disorder. These include dementia, depression and chronic mental illness. Both under- and over-treatment has been documented in these settings, and there is a dearth of specialists available for nursing home mental health services (American Geriatrics Society & American Association for Geriatric Psychiatry, 2003b [Level VI]). In all of these settings, initiation of routine screening for depression and other mental illness is important to understand baseline and recognize changes over time.

Major Mental Disorders: Their Recognition, and Treatment in Aging

Because of their prevalence and their impact on function and quality of life in the older adult population, three disorders will be given focus in this module. They are depression, substance use/abuse and serious mental illness. The cognitive problems of dementia and delirium have been addressed in Module II.

Screening and Assessment Issues

Symptoms of mental illness may not be clearly distinguishable from symptoms of medical illness in older adults; thus, special screening instruments should be incorporated into admission and ongoing assessment procedures. Especially important are tools that have been tested and utilized with older adult populations. Specific tools for each of the three disorders are discussed below. Recalling that diagnosis of a psychiatric disorder is dependent on whether or not or to what extent the symptoms interfere with normal functioning, using a functional assessment instrument may be appropriate as well. For older adults, a screen for Advanced Activities of Daily Living including voluntary social activities, occupational activities and/or recreational activities can be conducted (for more information on Advanced Activities of Daily Living [ADL] visit www.healthcare.uiowa.edu/igec/sptraining/section02/page01.asp, www.ConsultGeriRN.org and select Try This: Katz Index of Independence in Activities of Daily Living (ADL)), and/or The Lawton Instrumental Activities of Daily Living (IADL) Scale (Lawton & Brody, 1969 [Level III]) may each be appropriate. To obtain the best results when using screening instruments, attention must be paid to time of day (for frail older adults, late morning may be the best), use of attending behavior and establishment of rapport, use of appropriate lighting and sensory aids, securing a quiet environment and accessing an informant for corroborating and supplemental information.

Depression

Background, prevalence, and diagnosis Depression is a major problem in late life. While the prevalence for major depression is somewhat lower than that in the general population, there is evidence that minor depression and significant depressive symptoms are experienced by a larger cohort (Koenig & Blazer, 2004 [Level V]). Depression is best viewed as a spectrum that ranges from major to milder syndromes; all have clinically significant symptoms but not all meet DSM-IV-TR criteria for major depression (Butcher & McGonigal-Kenney, 2005 [Level V]). A diagnosis of major depression requires a sad depressed mood or a loss of interest or pleasure in usual activities over at least a two-week period, along with a minimum of five other symptoms that may include weight loss or a change in appetite; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or excessive guilt; diminished ability to think, concentrate or make decisions; or recurrent thoughts of death or plans re: suicide (American Psychiatric Association, 2000 [Level VI]). Even more common among older adults is dysthymia (mild depression) or subsyndromal depression with symptoms that do not meet diagnostic criteria for major depression, yet nonetheless take a toll on function and quality of life. In older adults, signs and symptoms of depression may be clouded by symptoms of coexisting physical illness. Thus, it is important to use a screening instrument that has been normed on older adults and that is not overly weighted by physical symptoms [e.g., gastrointestinal distress, pain]. Most often used are the Geriatric Depression Scale, a thirty item yes/no tool developed for and normed on older adults; a score of ten or above signifies significant depressive symptoms (Scheikh & Yesavage, 1986 [Level V]). A fifteen item GDS-Short Form is also available; with this tool, a score greater than five is cause for further work up (for more information visit www.ConsultGeriRN.org and select Try This: The Geriatric Depression Scale (GDS)). The Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977 [Level IV]) is also used in primary care settings, while in the nursing home there has been reliance on the affective items in the

Minimum Data Set (MDS), an assessment instrument used on admission and periodically throughout each resident's stay; however, recent evidence suggests that the MDS alone is not very useful in detecting depression in this setting (Kerber, Dyck, Culp, & Buckwalter, 2005 [Level IV]). In addition to medical comorbidities, depression is also associated with dementia, anxiety and other mental disorders. Given the sometimes vague symptoms, the history is very important in differentiating depression from other disorders in late life. In particular, a history of previous depressive episodes or a family history of depression is associated with late life depression, as is a plethora of medical disorders including cancer, heart disease and stroke. Further, since many medications have depressive side effects, a medication review is also important.

Treatment Once detected, major depression is best treated with medication, often in combination with psychotherapy (Roose & Schatzberg, 2005 [Level I]; Wilson, Mottram, Sivanranthan, & Nightingale, 2006 [Level I]). The class of medications, Selective Serotonin Re-uptake Inhibitors or SSRIs are recommended as first-line treatment (American Geriatrics Society and American Association for Geriatric Psychiatry, 2003a [Level VI]). Response is very individual-dependent, and indeed, prescribers select a particular drug based on its desired side effect profile. Reaching therapeutic levels of medications and giving a six-week trial are important in overall treatment (Wilson et al., 2006 [Level I]). There is still question regarding long-term maintenance of antidepressant therapy; for those with recurrent episodes, it is currently the preferred regimen. For mild depression, the treatment of choice, at least initially, is usually non-pharmacologic; interpersonal, cognitive and reminiscence therapies (Hill & Brittle, 2005 [Level I]; Puentes, 2004 [Level V]; Woods, 2004 [Level V]), as well as exercise (Fitzsimmons, 2001 [Level IV]) and bright light (Sumaya, Rienzi, Deegan, & Moss, 2001 [Level II]) have all been shown to be effective. For refractive cases, or when psychopharmacologic agents are contraindicated, electroconvulsive therapy (ECT) is efficacious and safe (Salzman, Wong, & Wright, 2002 [Level V]; van der Wurff, Stek, Hoogendijk, & Beekman, 2006 [Level I]). Models for delivering depression care and suicide prevention services in primary care are now well-documented, e.g., IMPACT (Arean, Hegel, Cannoy, Fan, Unutzer, 2008, [Level IV]); Callahan et al., 2005 [Level II]) and PROSPECT (Bruce & Pearson, 1999 [Level II]).

Special nursing issues

The high risk of exacerbation of other disorders (excess disability) and poor quality of life are major concerns for the nurse when older patients are depressed. Equally concerning is patient safety. Suicide in older adults, and especially among those over age seventy-five, is the highest for any age group in the United States, and depression is the most frequently associated mental disorder. Older adult men are more likely to use firearms or other lethal means and are more often successful in suicide attempts than are younger persons. Finally, older adults are far more likely to have seen their healthcare provider within a short period of time just prior to the attempt (Coswell, 1994 [Level V]). Thus, screening for depression and asking specifically about suicidal ideation and plans is an essential component to assessment in any setting (Mitty & Flores, 2008 [Level VI]). Falls are common in older patients taking tricyclic antidepressants, primarily because of the side effect of postural hypotension (Mulsant & Pollock, 2004 [Level VI]). Fall risk assessment in inpatient settings will be important as medications are initiated; patients

and families must also be made aware of particular fall risk side effects and measures that can be taken to reduce risk of injury while maintaining mobility (for more information visit www.ConsultGeriRN.org and select Try This: Fall Risk Assessment for Older Adults: The Hendrich II Fall Risk Model).

Substance Use/Abuse

Background, prevalence, and diagnosis

Older adults do suffer substance abuse problems, notably alcohol, tobacco and prescription drugs. Illicit drugs, such as cocaine and heroine, are also increasingly problematic, as more heroin users live to old age and as the baby boomer cohort-- with its greater lifetime history of substance use-- reaches older adulthood. The DSM-IV criteria for substance abuse and dependence are likely not adequate to diagnose older adults with alcohol problems, and these patients are at excess risk for physical health problems and premature death (Stevenson, 2005 [Level I]). Benzodiazepine use for longer than four months is not recommended for geriatric patients; special care when longer acting drugs are used must be taken, and sedatives/hypnotics should only be used for short-term symptomatic relief. Medications are not well metabolized as people age, and what might have been an acceptable level for social use at an earlier stage of life now becomes problematic (for more information visit www.ConsultGeriRN.org and select Try This: Beer's Criteria for Potentially Inappropriate Medication Use in Older Adults [Molony, Rev 2008]). Safe alcohol use in late life is recommended at no more than one standard drink per day for older men, and somewhat less for older women, due to the changes in metabolism experienced as people age.

Screening for alcohol and prescription drug use should be part of health visits for all over age sixty. For screening of alcohol use in older adults, the most common tool in use clinically is the CAGE (Cut down, Annoyed by others, feel Guilty, need Eye opener) Questionnaire and the SMAST-G (Short Michigan Alcoholism Screening Instrument – Geriatric Version; for more information visit www.ConsultGeriRN.org and select Try This: Issue 17, Alcohol Use Screening and Assessment for Older Adults, 2007; Beullens & Aertgeerts, 2004 [Level VI]). Whenever there is a concern about substance use, the patient should be asked directly using an approach that links worsening medical illness with alcohol or other prescription medication use in a non-accusatory way.

Treatment

The National Consensus Panel at the Center for Substance Abuse Treatment (US DHHS - SAMSHA, 1998) recommends the incorporation of several features into treatment for older alcohol abusers. These include a supportive, non- confrontational style that builds self esteem; a focus on coping with depression, loneliness and loss and rebuilding a social support network; maintaining a pace and content appropriate for the older person; treatment by staff who are experienced in working with elders; and linkages with medical and social services for older adults as well as case management and institutional care. Age specific settings for treatment; development of a culture of respect; a broad holistic approach; flexibility; and gender adaptation is also recommended for older adult treatment. For substance abuse, least intensive options should be explored first; these include brief intervention, motivational counseling and stepped interventions (Coulton et al., 2008 [Level VI])

Special nursing issues

Of importance is the recognition that older people, not just adolescents and adults, may be admitted to emergency departments and medical/surgical/psychiatric settings while using substances. Screening for history of use and being alert to withdrawal symptoms is very important, both for the comfort of the patient and also to prevent adverse events. Even in the case of nicotine, patients who are addicted will better manage their hospital experience and medical/surgical treatment if they can be withdrawn gradually through use of a nicotine patch. Teaching older adults about safe levels of alcohol use and sleep hygiene measures in order to avoid untoward repercussions is an important nursing role.

Serious Mental Illness

Background, prevalence, and diagnosis

Serious mental illness persists over time with remissions and recurrence of severe and disabling symptoms (American Psychiatric Association, 2000 [Level VI]). Persons with long term, even lifelong mental illness have special needs as they age, including coping with a myriad of new chronic physical health problems and associated functional decline. Yet, because of their likely isolation from mainstream healthcare, persons with schizophrenia, bipolar disorder and severe depression are at greater risk of receiving no care or poorer care, despite their greater likelihood of having long-term psychiatric illness and many medical comorbidities (Bartels, Miles, Dums, & Pratt, 2003 [Level IV]). Among older adults with serious mental illness, the common diagnoses are schizophrenia, mood disorders, delusional disorders, dementia, amnesia and other cognitive psychotic disorders (American Psychiatric Association, 2000 [Level VI]). Those with schizophrenia have higher rates of mental health service utilization (Bartels et al., 2003 [Level IV]). In addition to persons with schizophrenia, older adults with dementing illness may also develop psychotic features including delusions, hallucinations and paranoid ideation (Mentes & Bail, 2005 [Level VI]).

Treatment

Maintenance of psychopharmacologic agents will be important, while observing for extrapyramidal side effects (EPS) and tardive dyskinesia. Observation and use of screening instruments may be helpful here, including the Simpson-Angus Scale (Guy, 1976 [Level V]; Simpson & Angus, 1970 [Level III]) for EPS and the Abnormal Involuntary Movement Scale (AIMS) for tardive dyskinesia. Helping the older adult initiate and stay on a regimen that is most acceptable, e.g., long term injectable forms of medication, while developing and maintaining social supports and adjusting to community or nursing home living are aimed at remission of symptoms and better functioning (Mentes & Bail, 2005 [Level VI]).

Special nursing issues

Patients with serious mental illness pose particular challenges on admission to general medical/surgical units or to nursing facilities because of their often paranoid behavior and difficulty clearly communicating their needs. If information can be obtained on transfer regarding the patient's normal functioning and communication patterns, the nurse can more easily recreate a safe environment in which the patient can be treated and heal from the precipitating problem. On admission to an acute medical facility, the nurse should be aware that older adult patients may not have been adherent while living in the community and daily dosing in the hospital may result in an "overdose" of psychoactive drugs.

Patients may not be trusting of strangers; consistency, calmness and respect will be important to communicate as the nurse develops a helping relationship with the patient.

Decisional Capacity/Ethical Issues in Mental Healthcare

While the concept of advance directives for medical care is not new, its application to psychiatric care should the person become unable to make such decisions when s/he has a psychotic episode is a fairly recent application (Vuckovich, 2003 [Level VI]). Further, except for persons with dementia, the concept of palliative care for this population is a novel application (Baker, 2005 [Level VI]). The nurse must be aware of preferences and legal documents when providing care for persons with mental illness, regardless of age (for more information visit www.ConsultGerRN.org and select Try This: Decision Making and Dementia).

Community Resources

Many resources exist to provide information, help, support and services for older adults with mental illness and their families. The Alzheimer's Association is especially important for families with an older adult suffering a dementing illness (see Module II). The National Mental Health Association, National Alliance for the Mentally Ill (NAMI), Area Administration on Aging, community mental health centers and a range of associations provide information, training for caregivers and referral services. Also important for older adults and their families is access to respite services that range from adult or specialized day care to in-home or nursing home respite care options.

Summary/Conclusion

Promotion of healthy aging in all its aspects is an important role for nurses. Early recognition, diagnosis and treatment of mental disorders that are common in late life are important to prevent disability and untoward sequelae. Care for older adults with mental illness requires sensitivity and observational and relational skills in order to help the older person achieve and maintain the highest possible level of function and well being. Providing for a peaceful death in this population is also important. Geropsychiatric nursing is both a challenging and rewarding area of nursing practice.

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Appendix B Web-based resources

Visit www.ConsultGerRN.org and select Try This Series:

Katz Index of Independence in ADL
The Geriatric Depression Scale
Assessing Nutrition in Older Adults
Assessing Dysphagia in older adults with dementia
Decision-Making in older adults with dementia
Brief evaluation of executive dysfunction

Visit www.ConsultGerRN.org and select Geriatric Topics:

Depression
Dementia

Visit www.healthcare.uiowa.edu/igec/sptraining/section02/page01.asp for information on:

Advanced Activities of Daily Living

Additional resources:

American Psychiatric Nurses Association (APNA), available on the Internet at: www.apna.org

International Society of Psychiatric mental Health Nursing (SERPN), available on the Internet at: [www.ispn-
psych.org/html/serpn.html](http://www.ispn-
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American Association of Geriatric Psychiatry (AAGP) available on the Internet at: www.aagp.org

Substance Abuse and Mental Health Services (SAMHSA), available on the Internet at: www.samhsa.gov

Appendix C Examples of Teaching Pedagogies for Care of Older Adults with Dementia

Content Area: Topic

Recommended Pedagogies

Appreciate modification in history taking and the approach to the physical examination of older adults with stable mental illness

1. Prior to performing a history of an older adult with stable MI consider these questions for group discussion with students:
 - a. What are the sources of information that should be accessed to validate/verify the current history/present illness of the older adult?
 - b. For what comorbidities are older adults with depression at risk of developing? How would you screen for these?
 - c. In terms of gathering a social history, what questions are important to ask related to safety and daily living?
2. Prior to examining a patient with mental illness, what do you need to know about with regard to consent to the physical examination?
3. What aspects of the physical examination might give you clues as to the older adult's level of understanding? How would you screen for potential problems?
4. What aspects of the physical examination reveal evidence of signs associated with tardive dyskinesia? What are the ocular manifestations? What are the facial manifestations? What are the extremity and truncal manifestations? How might you validate your observations? How would you monitor the stability of the tardive dyskinesia signs?
5. In an older adult with long-standing tardive dyskinesia, what are your main safety concerns with eating and drinking ? How might meal choices be adapted?

Recognize adverse side effects of medications used for the management of mental illness