National I&R Support Center
Webinar: Building Capacity to Serve Older Adults with Mental Health Conditions
January 19, 2018

"Please stand by for real-time captions." >> I want to welcome all of our participants today. We will begin at 3 PM Eastern time, in about five minutes. Thank you for holding. >>

Hello. I want to welcome all of our listeners to our webinar today. Again, my name is Nanette Relave and I am with the national information and referral support center at NASUAD . Again, welcome to our webinar on serving older adults with mental health conditions. This is a topic that we have been asked to provide training on. In fact I think we had maybe over 500 individuals register for today's webinar. That definitely suggest that this is one of those topics where people are eager for more information, more sharing. We have also heard from the field that many of you are receiving more calls from people with mental health conditions, who are not necessarily receiving adequate care.

So I was really happy to be connected with our speaker today, who is truly able to speak directly to the I&R/A experience in this area . Before we get started, let me cover a few housekeeping items.

The slides, audio recording and transcript from today's webinar will be posted to the NASUAD website within the next week. You can visit the portion of the website that is dedicated to the national I&R/A support center. You will see we have a webpage . Additionally the web link to this piece is also in the chat box. If you look in the chat box the link should be there for your reference.

All of our listeners are mute during today's webinar to help reduce background noise. We do welcome your questions and comments through the Q&A function that is available to your screen. I toolbar on the right-hand side. Please feel free to submit your questions or comments at any time during today's presentation. And we will address your questions after our presenter has gone through her slides.

We also have real-time captioning for today's webinar. On your screen you should see a viewer panel on the bottom right where the captioning will appear. You can have this panel open if you like, if you like to see captioning, or you can minimize it . either way it will not interrupt the slide presentation that you need to enter your name and organization and click submit in order to view the captioning.

Additionally if you are having any difficulty with the media viewer panel, there was also a link in the chat pod that can be put into a separate web browser window. That will also bring up the captioning as well.

I am really delighted to welcome our presenter today, Jocelyn Chen Wise . Jocelyn serves as project director at the Fuqua Center for Late-Life Depression . Which is an initiative of the division of geriatric

psychiatry at Emory University. As project director Jocelyn provides support for community projects, and she also serves as a clinical social worker in the outpatient geriatric psychiatry clinic, to help individuals and families be able to navigate mental health and community resources. She really brings the clinical experience, community experience, to this work. Jocelyn received her Masters in Public health and Masters in social work, from the University of California at Los Angeles. She is also going to tell us a little bit more about whether -- the center where she works. With that Jocelyn I will turn it to you to get us started.

Thank you Nanette. Thank you for inviting me to do this presentation today. I am so pleased to be talking about this issue with this group on a national level. As Nanette was saying, you are already doing this work. Fielding calls from families and individuals all over the country, and as the gateway to aging services I know you are seeing folks who have mental health and issues, and you are already trying to address their needs. But many times people feel like they, this is an important thing to address but they are not sure they are addressing it properly. I think today's topic will hopefully make you feel better about the work you are already doing, make you feel more knowledgeable and prepared, to answer calls that might involve the crisis, might involve different mental health or substance use issues. And we can also continue the conversation further. Nanette and I spoke earlier today and I would really love to hear feedback from this group. About what resonates with you, what are the things you are seeing, and what kind of training or information you want to see more of in the future.

So briefly, the Fuqua Center for Late-Life Depression is part of Emory University school of medicine. We were founded in 1999 with a generous endowment. Mr. Fuqua was prominent in Atlanta business, a political leader and a philanthropist, but he was also a person who suffered with severe depression for most of his adult life. He founded the Fuqua Center with the hope that it would help bring attention to issues faced by older adults who experience mental health issues, because it can be so very isolating. He in particular wanted us to work with the community and folks who might have fewer resources than the Fuqua family, in seeking treatment . One of the wonderful things I have been able to do in my seven years with the Fuqua Center is collaborate with our Area Agency on Aging. The Atlanta Regional Commission has been very innovative in addressing mental health issues. They have actually developed a program with our help, call the behavioral health coach program. It is embedded within the [indiscernible]. Particularly to bring attention to the issues that tend to come across I&R specialist. And come up in the process of helping some aging. That is a little bit of background. What we will do is jump into the presentation. Today's presentation is really meant to be as useful as possible to you. We will start off with kind of going over some general signs and symptoms of behavioral health disorders. We will focus on the things most common for older adults. And then we will talk about some really practical strategies around had we have discussions with people who might be experiencing a mental health issue. Substance abuse issue. Questions we can ask in ways we can get people help. You will see here that there is nowhere here we are trying to get you to be a therapist to somebody, or

to become their doctor or nurse. Because we realize that in the world of I&R , you are there to connect people to resources and help them understand and navigate. But not in a position to become the mental health provider. Which is perfectly appropriate.

The next few slides are just some terms we will use. I want to make sure we have some definitions out there so everyone is thinking the same way as we go further into the presentation. Mental health, you can think of it as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. I really like this definition because it comes from [indiscernible] perspective and it sounds very much like healthy aging. Pretty much what we would all hope for as we get older. Mental health is very much a part of healthy aging.

A mental disorder is defined by the American psychiatric Association this way. A major disturbance in an individual's thinking, feelings or behavior, that reflects a problem in mental function. Mental disorders can cause distress or disability in social, work, or family activities. That is pretty straightforward.

Mental illness, you can think of it as all diagnosable mental disorders, or any health conditions that are characterized by changes in thinking, mood or behavior, or some combination of those things. And associated with distress and/or impaired functioning. What you will notice in all of these definitions is it is about an impairment in functioning. If somebody is anxious or depressed, but it's not really impacting their quality of life, their ability to function, that is much less likely to be considered a disorder or mental illness, then somebody who is unable to get out of bed, unable to make meals for themselves. There is a spectrum in terms of severity we are thinking about, before we characterize something as a [indiscernible] or illness.

Substance use disorders, for current use recurrent use of alcohol or drugs, which causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at home, work or school. More and more these days we are talking about drug use among older adults. Both in terms of recreational drug use like marijuana, but also in terms of opioids. On a national level we are all aware there is a great deal of discussion around the opioid crisis. It really is a crisis. Older adults as we know are among the highest consumers of prescription medication. And are more likely to experience chronic pain from various health conditions and we really need to be very careful to ask people about their use of painkillers. Because most painkillers are prescribed by physicians. It can cause incredible impairment. I can't tell you how often we see folks in our clinic now who are coming in looking like they have early Alzheimer's, or they have you know severe cognitive complaints. And painkillers are playing a part in how people are functioning. So it's an important part of the process of helping somebody seek help and understand their whole, all of the factors contributing to their function. So substance use disorders, alcohol is

still the main substance being abused by adults of all ages. But opioids are really changing the picture as well.

And when we say behavioral health, I want to make sure everyone knows what we mean. It is a newer term that has been used in the last decade or so. When it is referred, it is a umbrella term for mental health and/or substance use. I have this umbrella here, since I had a student years ago that said it was helpful to think of certain terms as umbrellas. She could remember better that way, exactly what things meant behavioral health is sort of what I say behavioral health, what I mean is mental health and/or substance use.

One last term I want to define is psychosis . Psychosis is a severe mental disorder in which thoughts and emotions are so impaired that contact is lost with external reality. So we generally think of someone having psychosis when they are hallucinating, either visually or in terms of hearing things. Or if they are having delusions which is a fixed belief that is not based in reality. When somebody has lost touch with reality in some way, that is what we consider psychosis or you might hear them described as psychotic. Psychosis most commonly in older adults are caused by these things listed here. Usually a dementia related syndrome. You might be familiar with people that have dementia, [indiscernible] dementia. Or people with more severe and progressed Alzheimer's, or parking signs may have Parkinson's may have hallucination or delusions that come with their disease.

Delirium, is most often caused by an infection. UTI is incredibly common in older adults and could cause someone to become delirious. I won't go into a lot of delirium right now, but basically you will be thinking about somebody who one day was functioning okay or functioning at baseline, then you see a precipitous change in the way they are chained functioning. Not like Alzheimer's where you see changes slowly over months or years. This will be within hours or days that you see somebody become delirious. With delirium can come things like psychosis. You can become very disorganized, agitated. Or almost the opposite, kind of catatonic. But also someone can become paranoid, you can have delusions [indiscernible] drug induced psychosis is also a common cause in older adults. Especially when the older average adult is taking a dozen medications. Interactions or changes in medications cause psychosis. And also keep in mind with depression can come psychosis. It is something less commonly thought of or talked about with depression, but when people are severely depressed they can actually start to hear things or see things, or become delusional. It is not uncommon for somebody to have a psychotic depression.

We will go through the next few slides really briefly because this is just giving you an overview of what are the most common disorders out there. What are the things you are most likely to come across in your work with I&R . Anxiety is by far the most common mental disorder. At 19 percent, almost one in five people that are adults in any one year will have anxiety symptoms that are severe enough to be considered a disorder. Substance use disorder. It's the next most common major depressive disorder is fairly common, but keep in mind we are talking about severity that there are a lot of folks that have depressive

symptoms that don't meet full criteria for a major depressive disorder. MDD is when somebody is really quite impaired by their depression, unable to get out of bed, unable to function in life. For energy, poor appetite, things like that. Bipolar disorder, eating disorders, schizophrenia, are all actually less common. But you in I&R might come across some of these conditions more than the regular person in the world. Because folks are reaching out to you for help. And people who have more impairments are probably coming across your desk.

Among older adults specifically you will see anxiety, cognitive impairment, that might be from dementia or other brain injuries or stroke. And then mood disorders. Mood disorders usually we are talking about depression and bipolar disorder. Those are the must most common among older adults. We are seeing more older adults with psychotic disorders these days. That is because people who have severe mental illness used to die so many years sooner. There is actually research showing people with schizophrenia, would live, rarely live beyond the age of 50 in the past. Because they did not get good treatment, they had co-occurring issues. A lot of barriers working against them that shorten lifespan. But people are living longer with severe and persistent illness. For the first time in the aging world we have to become more and more trained in addressing issues that come with older adults who have lived for a long time with severe persistent mental illness. >> So originally this presentation was done by my colleague Dr. Eve H. Byrd , for the eldercare locator folks. There are some statistics we included in the presentation that I kept in because I suspect it is similar to what you see. Only a very small percentage, 2 to 3 percent of people, would call the eldercare locator specifically saying I need help with finding mental health or substance abuse services. But we know, people call for other things and as you talk to them you realize there is more going on. There are layers to their needs. That is the power of the service you provide through I&R . It is also peeling the onion and realizing that the needs are beyond necessarily the things that you have at your fingertips. The meals, transportation, information that can help them with end-of-life planning. So you know there is some digging that happens when somebody calls. Why don't people report having mental health issues or substance abuse issues off the bat? A lot of different reasons, there is a lot of stigma around talking about mental health issues. People are scared of being perceived as weak or crazy. That is changing little by little, but specifically during, in certain cultures also, those are not topics that are okay to talk about it there is a great deal of stigma. There is a lack of language out there. Sometimes people might feel pretty down. But they don't know how to describe it. So for someone to say I'm anxious or depressed, or I'm worried about my memory, a lot of times there is just not the words that people know how to use to articulate it. There is also different presenting symptoms of some of these conditions for older adults. For example with depression, we know older adults actually have symptoms they feel in their body. It is not unusual for an older adult to say I don't think I'm down or blue, but I just feel jumpy, jittery, or my stomach is in knots all the time. Or I just don't feel right, I have pain. Some of it of course could be physical health conditions. But some of it might be sort of body manifestations of the emotional state. That is common in older adults.

All of that to say the assessment and discussion of a person need can reveal their need for behavioral health services.

What we know is that about one third of the crisis calls to eldercare locator are related to elder abuse. The most common type of elder abuse is financial exploitation and scams. So older adults are definitely targets for financial exploitation. And people who have behavioral health issues are for more likely to be targets of abuse . I think the statistic is if you have severe and persistent mental illness you're more likely to be a victim of abuse than to perpetrate violence.

So this page is just saying crisis calls, a lot of times will involve emotional abuse or neglect. Issues that probably tie into somebody's mental health.

A lot of times folks will just call and they will feel better just talking to someone caring on the phone. By being a I&R specialist you are already doing something helpful , by being an active listener and to ask questions. To show that you care, even if in a very professional way, that can be a real comfort to somebody. There has been great work done on the national level around decreasing isolation in older adults. With folks that have been paying attention to social isolation and loneliness. That is a huge factor contributing to depression, anxiety, even psychosis. There are people that can become psychotic because they have no stimulation. So there is a condition called Hospital psychosis. That is common when somebody is in like a beige room with no windows. And they don't know what time it is, what day it is, they don't even know the time of the day it is. You can become psychotic from just the confusion that happens with that type of isolation. Some of the things I&R specialist probably are already doing is identifying these folks are dealing with these circumstances, and asking questions around brief problem-solving questions. So asking questions like who do you turn to when you feel this way and is there anybody you trust in your life to help with the situation. And then helping them think about things that can help them feel better in the short run. Is there anything you enjoyed doing today, or what is the best thing that happened to you usually. Even small things, really helping someone come from a perspective when they're feeling down can help a huge difference make a huge difference.

We will shift gears a little bit to talk about some screening tools that I think can be helpful. One of the things that we have done in Georgia is really encourage the division of aging services to use evidence-based screening tools on all of the phone calls that come in. So they can have a sense of the issues people are dealing with, and that they are not screening inconsistently. One of the things we push for is to just ask these questions in a natural way. Two of the tools we really like for screening are the GAD-2 . In the two means it's only two questions. And the PHQ-2 , patient health questionnaire. Only two questions.

I will go over these tools in the next couple of slides, they are very easy to use.

So the GAD-2 is based on the criteria, clinical criteria from the diagnostic and statistical manual five. For generalizing anxiety disorder. When I'm asking a patient or client about this I usually say you mind if I ask you a couple of questions about your mood. And I want you to think about the last two weeks of your life, not your whole life, just the last couple of weeks and say if these things are bothering you. Have you been feeling nervous, anxious or on edge. If they say yes then I say how often have you been feeling that way? Several days, more than half the days, or nearly every day? Then I mark off what they say. And then I say how about, had you been feeling like you're not able to stop or control your worrying? I prompt them and I say is it bothering you not at all, several days, more than half the days, or nearly every day? Those are the two questions. And you circle whatever answer they give you and you tally up the score quickly. And this tool when it was being tested, it was tested in a primary care setting, but with thousands if not tens of thousands of patients. What they recommend is that if someone has a score of three or higher, that you further evaluate. The screening is not saying this person has generalized anxiety, is just saying they have symptoms that are worth further investigation.

We can talk about what that might mean in terms of follow-up.

Let me go through the PHQ-2 . This is developed by the same people as the GAD-2 . Very similar set up. The way I usually ask is say in the last two weeks again, not your whole life but just the last two weeks of your life, have you been feeling like you have little interest or pleasure in doing things? And I prompt them with how often they feel that way. Several days, more than half of the days, or nearly every day. And have you been feeling down, depressed or hopeless? And again I prompt them. You tally it up and it's the same interpretation. A score of three or higher warrants further evaluation.

And usually when I say to people, let's say somebody scores a three, or a six, said you have symptoms of depression or anxiety, I could be a little concerned for you. Is that something you have been told before? That can open up a conversation.

Both of these tools were developed by Pfizer. They are free and open to the public. They have been used in 1 million different settings and lots of primary care. Different healthcare settings. And then I really think they are helpful in they are very brief.

Now what happens when you get that person that you have opened up this conversation and they said yes I do have a history of feeling anxious or depressed, or I feel overwhelmed right now. My daughter was diagnosed with cancer or my husband died last year and I'm not myself. Now what do you do? -- As we started this presentation we are not putting you in a position where you start to become their therapist. Not you know what I'll be a counselor now. You're an encourager. You probably do this all the time already. For folks that it would be appropriate to refer somebody to, primary care providers, geriatric specialist, but I know they are few and far between. Any healthcare

provider that might see a lot of older adults. Or just any kind of trusted healthcare provider. You can have that discussion with your client about who do you look to when you have problems with your health? Do you like the doctor you have been seeing? Is there a nurse practitioner or a nurse you really like who has helped you before? You can kind of coach them along to helping them have that conversation with their healthcare provider. There have been healthcare settings where they do the screenings and they actually send a copy to the healthcare provider on behalf of the patient and the patient agrees. Or the patient can take a copy of the screening tools and say to the physician, somebody screened me for depression and said I scored high. It could be kind of a communication tool.

We will shift gears a little bit again. We will talk about certain crisis calls you might receive. I will start with suicide. The reason I'm talking about suicide with older adults is because there are certain groups that are at higher risk than others. I often times show this graph because I think it hammers home things to be concerned about. Then we will talk a little bit further about some myths and truths around suicide. Hopefully this will not be too intimidating for you. I think it's just an important thing to have two open discussion around suicide. Some of the statistics based on national data I pulled from the CDC database. When I did this the most recent was in the past, from 1999 to 2010. This is looking at completed suicides, suicide deaths. They are broken down by age and by gender. And also by race. The purple line up here is white males. You can see white males are at the highest risk of dying by suicide. What happens at age 65 to 74, is incredible. There is a steep incline. Why do you think that is? What happens at age 65 to 74? What could change that project three of these people the trajectory of these people? I will just tell you the answer, since we are on a webinar, that is often times retirement age. Around 65 age 74 is when people lose a spouse, or start to have loved ones die. But also remember, this graph is for suicide deaths. White men and men in general, tend to pick very lethal means for killing themselves. They tend to use guns, or hanging. Where women tend to use pills for overdose, or possible cutting. Those types of means are less lethal. So women actually make more attempts but men are more successful at killing themselves. That's because of how they choose to do it but also in terms of coping, men tend to cope differently than women. Women tend to reach out to their community, to family and friends. They try to seek help from other people much more than men. That's the way we are socialized. Men tend to look to substances, maybe abuse alcohol, or they might hold everything in and feel very isolated. This chart is just showing that white men are at highest risk of feeling isolated, feeling a great deal of loss potentially. And choosing to end their lives with suicide. The red line below is black men. You can see it has as much, a much lower rate of suicide deaths. The green line is white females. Even lower. And then the demographic category that is the lowest is black females. So this is actually just something to keep in mind when you are working with folks. It's not meant to scare you. But just to know there are some differences in the way that people approach grief and loss. Challenging situations as they get older. It is just very important to be able to screen and have this discussion.

The next slide kind of reiterates the things I have touched on already. If you look at suicide deaths by firearms it's about 50 percent across people of all ages. But 70 percent in people age 60 to 74 years old. And 80 percent for those over the age of 75. Three quarters of older adults that value

that die by suicide have seen a physician within the last month. So that tells us we don't ask this question enough. Even in the healthcare setting people are not feeling comfortable revealing how they are feeling. That they might be having some suicidal thoughts, and we are also not asking.

So if we were a live audience with you here in front of me, I would ask you to shout the answer to these next few slides. But we will have to imagine. I will put up a few statements and I want you to think to yourself is this true or false, is it myth or a fact? Asking about suicide may give someone the idea to kill themselves? Is that true or false?

That is actually a myth. Asking someone about suicide does not generally give them the idea to kill themselves. In fact the opposite is true. This is based on research done with people who have survived suicide attempts. Asking someone directly about their suicidal feelings will usually make them feel less anxious. It's actually a deterrent to suicide. Often, I've already been talking about people who are suicidal often feel very alone, like they have no options, no one cares or notices. So when someone asked them the question, it is sort of a relief to know somebody has noticed that they don't feel good. That they are very down. They are feeling desperate. When you asked that question, actually acknowledging someone, it acts as a deterrent to the suicide [indiscernible]

Here is another question. Talking about suicide is usually a cry for help? Myth or fact?

That is also a myth. Most people who kill themselves give warning signs of their suicidal intentions. Eight out of 10 people actually. Which means that if someone is talking about killing themselves we need to take them very seriously. I think there is a little bit of a myth that if someone is talking about suicide that they are being dramatic, or looking for attention. But actually eight out of 10 people who make an attempt at suicide have made some sort of statement about it.

One last slide. Once a person is seriously considering suicide, there is nothing you can do. True or false?

That is also a myth. Most suicidal people are suicidal on a time-limited basis . It is when they are really feeling awful, not thinking clearly, and they see no options for the future. So to know that suicidal feelings could be fleeting, means that as an opportunity to engage somebody in a discussion about other options, other ways of addressing the problem. So again, I hope these myths, I put these up here to help you think about being more open in discussing these

things. There is no research showing discussing suicide makes things worse, it actually very much makes things better.

And I think we need to broaden the way that we think about who can touch an older adult and help them feel safer, in a suicidal, when they are in a suicidal state. That includes a lot of collaboration around different agencies. In the past we used to look to mental health providers, behavioral health providers as the sole group that would touch on someone feeling suicidal. It I think there's a huge network out there that can help somebody seek help.

Now let's talk about what exactly do you say to somebody who is feeling suicidal? The best way to go about having this conversation is to be very clear, very straightforward. And you know, even working in geriatric psychology

psychiatry, I actually have a little bit of hesitation when I asked these questions. I hear it in my voice, but I do ask these questions very straightforward. I don't want anybody to misinterpret what I say. Sometimes when we talk about suicide, people say things like are you thinking about hurting yourself? About doing something? That can be vague to the person you're talking to. Hurting myself might be different than taking a bunch of pills. Which would hurt right. I would just go to sleep. And if I say are you thinking about committing suicide or killing yourself, that is not open to interpretation. I personally usually say are you thinking about killing yourself. Most of the time, let me put your mind at ease, people say no I am not thinking about killing myself. If you asked this question, I don't think most of the time people will say yes. But asked these questions. Ask these questions. Do you have a plan to kill yourself? Most of the time even if people say I think about dying, or I think about killing myself, they say no I don't really have a plan. There is also a type of suicidal thinking we call passive suicide ideation. Meaning I would never take action to kill myself, but if I could go to bed and not wake up in the morning, that would be fine with me. That is what we think of as [indiscernible]. Older adults might say that to you. Just validate that and say that is an important sign of how bad you are feeling. So the fact that you would be okay with going to bed and not working up in the morning, waking up in the morning, that is a sign you are feeling really bad. And then continue to talk about what we can do about that.

You want to ask direct questions about the means, their access to means such as guns, pills, etc., if they say they do have a plan. And you can ask if they have anybody around them. These are some ways of doing a suicide assessment, having an open conversation with somebody you worry about it

I think within your agency it is important to talk about how you handle suicidal clients. When you put someone on hold, who you talk to, what is the protocol around this. Our general recommendation, when in doubt connects somebody to the national suicide prevention lifeline. The ideal situation is to have a warm handoff. You have someone on the phone and you say I'm really concerned about you. You have told me about your suicidal thoughts. I would really like to connect you with

the national suicide prevention lifeline and we can call together. You can conference in the suicide prevention lifeline, and give them a little background . Say I have this gentleman on the lifeline with me and has been telling me how bad she's been feeling since her husband died two years ago. She's gotten to the point where she really can't function, she is not eating, and she's telling me she thinks and may consider killing herself, having thoughts of wanting to die. To me that's a fair amount of information to help go from there.

That's what we mean when we say a warm handoff. Also do some crisis planning with that person to say are there people you can reach out to. Help someone that is feeling desperate and alone to do a little bit of problem solving, that can make a huge difference it

Substance use disorders may also come across your desk. And this is just a brief comment to say there is a lot of stigma around substance use and addiction. But these two are brain disorders and we need to treat them as brain disorders. Helping again someone seek professional help, treatment. Also encouraging harm reduction models versus complete abstinence . There has traditionally been judgment against people that use drugs or alcohol, in saying basically you need to stop and absolutely use nothing. And over the last few decades there has been a shift towards more of a harm reduction model. How can we support somebody as they cut back, as they make progress to recovery, and gain momentum that way versus saying abstinence is the only way that you can succeed in your drug recovery.

You may also get calls from people who are talking about a family member with disruptive behaviors. It can be tough to tell what is causing those disruptive behaviors. It could be some manifestation of their dementia. It could be depression. It could be psychosis, uncontrolled pain. It is really hard to know. In those cases, an evaluation is really necessary. If you can get somebody to a geriatric specialist, great. If not, no problem. Just get them to somebody who can potentially help address these issues. Again a warm handoff is usually ideal if you can give some sort of background, to help that family member put words to what they are seeing at home. And if they are seeking admission to a hospital, to help with prescribing exactly describing exactly what kind of behaviors are happening at home. There are certain things that families are sometimes too embarrassed, or don't know are important, when they are seeking hospitalization. For example sexual aggression from a partner, is a sign that somebody is appropriate for hospitalization. But that might not be something that the wife of the patient thinks to talk about with the hospital. So helping families kind of get through the description of what is being happening with the disruptive behaviors.

And in addition to medications or obviously getting treatment for an underlying infection, there are behavioral interventions such as psychotherapy, intensive outpatient therapy are hospitalization programs that can help with things like depression, anxiety, grief and loss. >> When you're working with somebody who has a mental health issue or substance abuse issue, and they are calling you. I know you're already doing this but you are generating a trusting interaction by being an

active listener. That is a huge part of engaging with somebody. Most people, even if they are hallucinating or if they have delusions, they want to be heard. So a tip is that if somebody is saying something you know to be not true, or to be unlikely to be true, like somebody is trying to gas me that I'm seeing aliens coming at night to try to take me away. Or my wife took $2 million out of my wallet yesterday. And she is out to destroy me. You can still validate something about what they are saying. Still validate the emotions behind their experience. That must be scary, or how awful, do you feel safe in your home. Not engaging with the person in their delusion, but to say something about their situation that is true. Their emotions are always valid and that's a way to open a dialogue with somebody who might be psychotic or not based in reality at the time.

Recovery language is very important when someone is experiencing a substance abuse issue. Talking about their strengths, giving them hope for a change in the future. To try not to use [indiscernible]. Keep judgment out of your voice and to feel like the person who is talking to you can be free to tell you what they need to tell you.

There's a couple of evidence-based trainings that I would like to recommend. Mental health first-aid is a type of training that was first developed in Australia did it has now taken hold in the US. A one-day training, a full day eight hour training. It can be done with laypeople or health professionals. But basically what it is doing is giving some basis of knowledge around mental health issues . Helping people understand what the signs and symptoms of different disorders are. A little bit like what we did today. But very interactive, there are videos and exercises you do as a group. And then they teach different skills for empathic listening, encouraging people to seek professional help in getting somebody to a health professional. So again, the way they call it is a little bit like CPR for mental health issues. It's not asking you to become a clinician, if asking you to help somebody seek help. QPR is very similar in that it's helping people find the language around suicide prevention. Helping people ask the question, then encourage the seeking of professional help. Very tied into some of the things we talked about today.

And that is actually the end of my slides. So it looks like we have maybe 10 minutes or so to maybe answer some questions. I will turn to Nanette to help with that. Thank you so much for being engaged in this training, which at the end of the day on a Friday, it is a lot to ask. Thank you very much for participating.

Jocelyn thank you so much for joining us. This has been a great presentation. We do have a number of questions. We will go ahead and see when we are able to get through. The first question ask, towards the front end of the presentation, can an older adult become delirious with bedsores?

Severe bedsores can lead to infection, so yes I think that's very much, it might be the chicken or the egg with someone with severe bedsores. Someone that is bedbound and at risk of beds bedsores, is likely to be understimulated possibly. That might be something that causes delirium.

They might also have an infection. It is hard to treat severe bedsores, so the infection might be there and be causing deliver him delirium.

Thank you. The next question ask, are eating disorders an issue for older adults? If so, how might this show up? How might you become aware of it as a social service provider? Particularly given that we might see a variety of different reasons for malnutrition among older adults, underlying health conditions, and other things that may show the same way.

That is a really interesting question. What a great question. I have to say I have not come across a lot of older adults with eating disorders. Maybe a handful in the last decade or so. But I suspect it is actually going to be a growing trend. Eating disorders you might remember from the early slides, is fairly rare. Is more common among younger people. But it is a serious condition and that it can be very lethal. People who have severe eating disorders can die, simply from the issues that arise with malnutrition. It is something to be cognizant of. I really haven't seen a lot of eating disorders with older adults though. And like you were saying that, a lot of contributing issues. Eating disorders tend to have more to do with body image, versus maybe food insecurity. I could imagine somebody who grew up in the depression, or had a lot of food insecurity throughout their life, having issues with eating. But in terms of anorexia or bulimia, I don't really know. I really interesting question. I am not sure how to answer it entirely.

It sounds like it's probably one of those areas where we need more research. Because something is coming to us that perhaps we have an experienced before. So we have one question that refers back to the graph that we were looking at about rates of suicide by gender and race. One of our listeners asked, is it true even specifically for the older adult population, that women make more suicide attempts but with less lethal means. I heard this for younger populations, but is this true for older adults as well?

I have heard that for kind of like adults in general. I don't know the answer whether that's true for older women are not. You know just anecdotally, from my work in the clinic, I would say that there is certainly older women who have made suicide attempts, mostly again through pill overdoses and things like that, rather than more violent means like guns or hanging. But I don't know specifically the research on older adult women and suicide attempts. I would suspect it is consistent.

So along the same theme, we have one of our listeners who asked, maybe an opportunity for you to perhaps model some ways to address this. What is the best way to support a caller that they are stopping heart medication as a means to end it all.

That is an interesting situation. You also hear that with dialysis patients sometimes. Dialysis is hard on your system, it is very time-consuming, and it basically can consume your whole life. I have certainly met patients that said I just don't want to do it anymore but it is awful, I feel so exhausted. And I have some good times but then I

have to go back. Dialysis is taking over my life. It might be similar with somebody with a heart condition where they just say I feel awful all the time. And I just want to be done with it. Because this is not the quality of life I want. It is a little bit different than actively seeking out means for suicide, sort of stopping your medical care and letting your heart fail, or your kidneys fail. That is a pretty delicate conversation to have someone with someone. I think again to start from a place where you are willing to hear what they have to say. We might be a little freaked out but cannot show it too much with the person. I do think people sometimes say this stuff, and then their family members say oh don't say that. Or their neighbor, or a friend might say you don't mean that. It's obviously too scary for them to talk about it with them. To show that you are an open ear and able to hear what they have to say, is a place to start. And to kind of get at what are the things, you have told me a lot about how hard it is. Are there things that you enjoy in life and are worth living for. Have you been able to talk about this with any of your loved ones? Are there folks you trust that we could reach out to, to help you discuss some of this? And you know, especially with the kidney failure client, we do talk about hospice and palliative care. Hospice is a highly underutilized service that can help people at the end of life, and they are certainly familiar with people who have chronic conditions that are very difficult to manage. So having some discussions around other treatment options that might not be as invasive as what they are going through at the time. That is generally how I have talked with folks who are saying I just don't want to do the treatment anymore. Now choosing not to do the treatment, because you are of sound mind, you have capacity, you have thought about this within your values, to just stop the treatment. That is different than being so depressed that you can't think straight or you're so depressed you can't see any other option. There is a bit of digging. But that might be best left to a medical professional. I think that would be a lot to ask of an I&R specialist . To really parse out what are somebody's motivations and medical condition, and all things contributing to the situation. I think being an active, listening ear, providing validation, helping people think of their strengths. Instilling hope and encouraging them to get help. To say these are such important issues, and what I really want for you is to be able to talk about it with somebody. And can I help you get connected to somebody like that. Is there a doctor, therapist, family member, pastor, spiritual leader, somebody you trust you think you could talk to about this? Can I help you with that.

Great, thank you. Jocelyn are you able to stay on for another minute or two? Okay. For any listeners asking about the slide deck, it isn't automatically sent to webinar participants. It will be available on the website. We have the link in the chat pod.

ASIST training they have taken to help them work on asking some of those, what might feel like more difficult questions about suicide. This person is wondering, have you worked with anyone who is also taking this particular module quick

I am not familiar ASIST for suicide prevention?

I don't know this quite as well. A lot of the suicide assessment trainings are fairly similar, in that they talk about asking somebody who is at risk of suicide questions clearly. I think that is excellent. There are several really good trainings out there that do that. I cannot speak to assist specifically though.

Great, thank you. We have a question that says I have had many calls from older persons who suffer from alcoholism or drug use. In this person state it's difficult to find referrals for mental health. These people are low income and not yet on Medicare. Do you know of any national groups that offer free therapy surfaces?

Services quick

I wish I did. Within the Atlanta area I have some of my go to resources. That is something that I do encourage every agency out there, is to put some time and effort into researching some go to mental health providers for folks who are lower income. For folks that have insurance or don't have insurance. A lot of times for somebody abusing substances, the only thing covered by Medicare and other insurance is detox. A medical detox done in a hospital. It can take over a few days. It doesn't necessarily cover any kind of psychotherapy or long-term treatment. Here in the Atlanta area there is a few residential treatments for substance abuse that are focused on low income populations. Either Medicaid or people who are uninsured. But they are pretty limited. So you know, just knowing that, I wish I could say yes there is a group that does this throughout the country. It is very necessary. But usually, what is covered is just the detox portion. It can be very frustrating for someone to detox, and then be thrust back into their situation with no other supports. It would obviously be easy to start using again. Usually it is a patchwork. What we do here in Atlanta, we kind of patched together as much as we can, to get people to some of the nonprofits that do this work. To really help them navigate that system. The few groups that do it, I have talked to them and asked, tell me exactly when somebody has to show up to the walk-in service to be assessed. 7 AM, I will tell them it has to be 7 AM. Tell me exactly how it is set up, do they see a doctor the first day? Probably not. What information do they need to bring, to show that they are low income or like, really find out in detail the intake process, and help your person have reasonable expectations. Because nothing is more frustrating than being ready to stop using drugs or alcohol, and then to be caught off guard by seeking help and being turned away because you didn't bring the proper identification or you didn't realize you had to get there at 7 AM. That you would wait in line or that you didn't realize you would have to see the doctor on a different day. The best advice I can give is figure out what is out there in your region, and then make some relationships. Really get them to know you as an aging service provider. Help them realize what a huge service it is to have a Medicaid waiver program or to have a case manager. And really help your client understand the expectation. Set expectations for seeking care. Try to be there cheerleader along the way. I know it's annoying, is there anyway you can get there at 7 AM. We can help you arrange for Medicaid transportation, or something. It

will be a long wait but this is a good program that I have heard good things about it from other people. That is the best I usually do.

Thank you. We have actually had a couple of listenership in the Q&A, something I was thinking about as well. Sometimes there are peer support groups we can find in communities across the country. Whether through the national alliance for mental illness, or other organizations that offer peer support. There is always something to think about there as well. A little bit of a different model but effective. In many cases.

[indiscernible] is fabulous. Alcoholics anonymous. Those exist throughout the country. They are very much save space and involve family members. Certainly think about those as starting points for people. You can attend those groups without being off of drugs and alcohol. And talk to other people who have lived it. They are amazingly resourceful.

All right. We are a little bit over time. I want to thank you so much for staying on. We were not able to get to all of the questions and comments. We will copy everything down and share all of your feedback with Jocelyn. I know a particular comment that might be something to think about. Jocelyn's contact information is here. She would love to hear from participants. If there are areas you would like to drill down more or learn more, if we do future trainings it can help inform those efforts as well. Jocelyn I want to thank you so much for providing this wonderful training for us. I thank all of the participants for their engagement. And thank you to the captioner as well. And wishing everyone a good weekend. Thank you.

Thank you very much.

[Event concluded]