

Healthy Aging : Maximizing the Independence, Well-being and Health of Older Adults
The Impact of Mental Health on Healthy Aging; Mental Health, Social Isolation and
Loneliness

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As the body ages, the focus is naturally on physical health, mobility, chronic disease, medications, pain, nutrition and cognitive changes. As we age, we are disproportionately affected by chronic conditions like diabetes, arthritis and heart disease that require prescription medications. Approximately 85 percent of older adults have at least one chronic health condition, and 60 percent have at least two chronic conditions. (CDC)

And these chronic diseases, and the medications to treat them, increase a person's risk of developing mental health disorders. Life changes and experiences like retirement, health challenges, financial challenges, maintaining independence, grief and mourning from the loss of people and opportunities, hearing and/or vision loss, loneliness and trauma increase the risk for developing mental health issues.

One in four older adults experiences a behavioral health problem such as depression, anxiety, or substance use. (*Substance Abuse and Mental Health Services Administration {SAMHSA} and Administration on Aging {AoA}*) Excessive alcohol use accounts for more than 23,000 deaths among older Americans each year. (CDC) These problems can complicate the treatment of other medical conditions, reduce quality of life, increase use of health care services, and lead to premature death. (SAMHSA, AoA)

So the large population of Americans with aging bodies, chronic diseases, medications, life experiences, including loneliness and trauma, have an increased risk of developing a disorder like depression, anxiety, PTSD, and substance use of medications, alcohol and illegal substances. Untreated, these conditions can seriously diminish the quality of life and can be a factor in suicide.

Yet we do not have a system of care that addresses the mental health, or illness, of older adults. A different standard of care exists for people as they age, there are disparities in health equity.

Behavioral health services developed for infants, children, youth, young adults, or adults do not and cannot address the diversity of older adult experiences, the developmental stages of aging or the mind-body connection of an aging body and brain.

While other age groups have specialized services, older Americans, spanning 4 to 5 decades of diversity, are expected to “fit in” to the current service delivery system.

And the “advanced age” older adults, 80, 90 and above, with a culture of bootstrap strength, stoicism and self-reliance, do not use mental health services. Their culture and experiences do not include positive views about treatment and recovery. Primary care is trusted and utilized by this group, which presents an opportunity to provide mental health services through integrative health efforts.

Yet as many as 70% of older adults’ primary care visits were driven by psychological factors such as panic, generalized anxiety, major depression and stress. Older adults in distress utilize health care at a rate 2 to 3 times higher than non-distressed individuals, but they are often not screened for underlying causes of their complaints. (SAMHSA/AoA)

Age appropriate mental health services provided in accessible and age friendly environments by providers who have been trained in geriatric issues is only the first step in supporting wellness as we age. The following issues need to be incorporated:

Challenge Ageism – Ageism is defined as the societal norms that marginalize older adults, treat them with disrespect, make them feel unwelcome, incompetent and invisible. Ageism views aging as a disease itself, with sadness, loneliness, emptiness, thoughts of suicide, emotional and physical pain being symptoms of aging and a normal part of aging. When depression is viewed as a normal part of aging, there is no need for a policy for early identification and screening, much less a referral to supportive or professional services. Ageism contributes to over-treatment - treating expected changes of aging as though they were diseases, and under-treatment - dismissing treatable pathology as a feature of old age. Self-ageism, when an older adult accepts diminishment and insignificance, interferes with the disclosure of physical and mental symptoms to family and professionals who can help alleviate them. Aging adults are not just one big lump of neediness and vulnerability. Challenging ageism includes clarifying the conundrum of acknowledging the strength and resiliency of older adults, but describing them as fragile and vulnerable.

Wellness – The management and maintenance of chronic illnesses is not the definition of wellness. The 8 elements of wellness – social, occupational, financial, environmental, physical, intellectual, spiritual, emotional – comprise a blueprint for supporting people of all ages. However, the propensity for age related diseases, an aging body, retirement and it's resulting impact on social and financial support, life transitions and repeated life experiences, some traumatic, over decades of time, illuminates the need for Wellness to be the core of both physical and mental health treatment – the integration of physical and mental health. This integration

would address the underutilization of mental health services by older adults. Identification of people in distress and a referral to treatment would initiate in the primary care office.



“Older Adults may be at risk for deficits across the elements of wellness”

(National Council for Mental Wellbeing)

Mind/body connection - Older adults with behavioral health disorders have 47% to 200% higher disability rates, poorer health outcomes, hospitalizations and emergency room visits.

(Summit on Older Adults, 2014)

In older adults, physical, behavioral and cognitive conditions often overlap and present differently. A behavioral health condition may present as a physical condition or cognitive impairment; a physical condition may present as cognitive decline or as a behavioral health issue. Depression often occurs with physical health conditions and is often exhibited as aches and pains

and not sadness and crying. Those aches and pains may be attributed to aging itself, and dismissed, or treated with yet another medication. The vast majority of medications are prescribed to older adults, who also have the highest rate of opioid prescriptions. The interaction of multiple medications can lead to adverse events resulting in ER visits and hospitalizations. Symptoms of dementia and delirium can accompany both behavioral health and physical health conditions

An appetite change could indicate depression, or a urinary tract infection. Impaired memory, confusion or cognitive decline could be symptoms of prescription drug misuse, alcohol use, depression, urinary tract infection or thyroid disease. (*integration.samhsa.gov*)

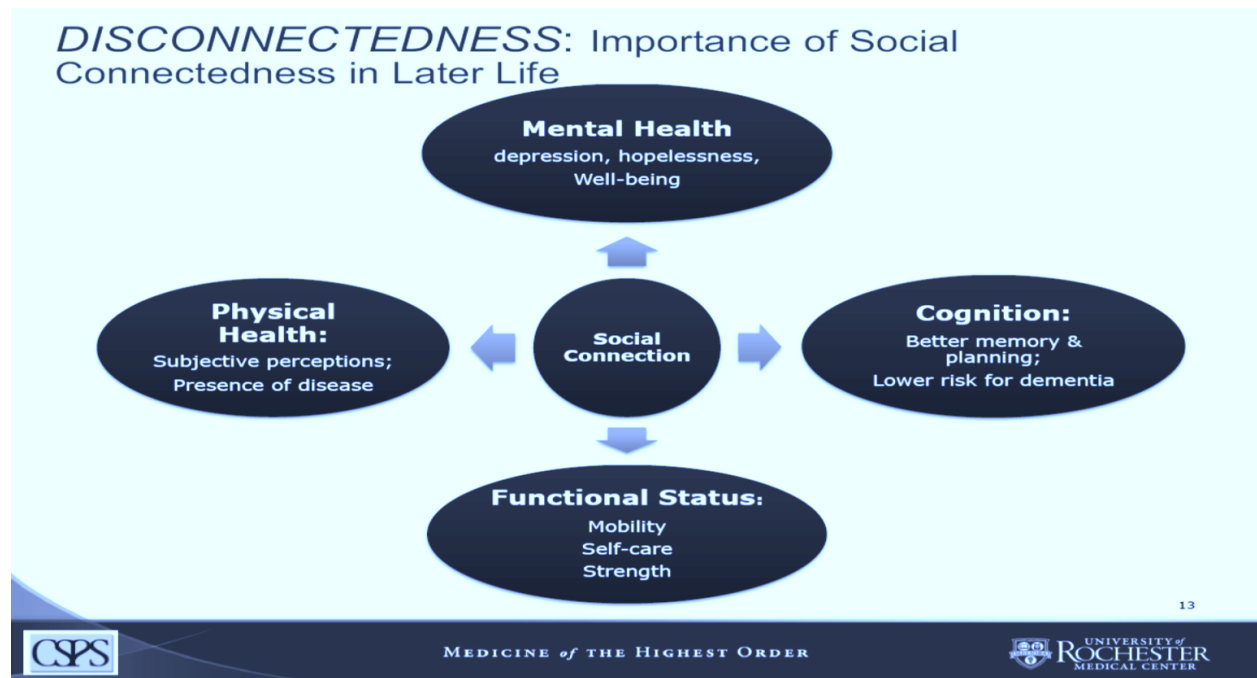
A recent study reported people 65+with Alzheimer's were more than 2 times as likely to die from suicide in first 90 days following their diagnosis. (*Journal of Alzheimer's Association*)

A Spain study found that older adults with type 2 diabetes and depression have greater mortality and poorer survival rate. (*Diabetes Research & Clinical Practice*)

The mind-body connection cannot be denied and the overlapping of symptoms of physical and mental disorders supports the model of integrated care.

Loneliness and Social Isolation - Loneliness is not just a feeling, but a striking example of the mind-body connection. Isolation is defined as being physically alone and is not the equivalent of loneliness. Loneliness is the feeling of being alone regardless of the amount of social contact and can be identified by the level of satisfaction with your connections. Loneliness has both a physical and mental impact. It poses health risks similar to smoking, obesity, physical inactivity and changes in physical functioning and cognitive sharpness. Additionally, it can cause poor sleep quality, depression, poor cardiovascular function, impaired executive function and impaired immunity. Research indicates a 50% increase in developing dementia, a 59% increased

risk of functional decline, 45% increased risk of death, and an increased risk of heart disease and stroke. Loneliness among heart failure patients can quadruple the risk of death and increase the risk of hospitalization by 68%. With the onset of COVID came the recognition that older adults were most often and most severely affected due to age and medical illness. Appropriately, social distancing became the norm. However, the very effort to protect from physical disease led to disconnectedness, which led to loneliness, and which spawned an altered immune function, which could increase the risk of COVID. Healthy Aging can be complex.



Trauma -The Jewish Federations of North America and SAMHSA state the 90% of older adults have experienced at least 1 traumatic event. We have to admit that the longer time we are on this earth, the more opportunities we have to experience trauma. Exposure to trauma leads to stress responses and biological changes that are highly associated with post-traumatic stress, and other mental and substance use disorders. Stress caused by trauma increases a person’s vulnerability

to developing chronic diseases, physical illnesses, mental illnesses, substance related disorders and impairment in other life areas. (CDC) Decreased mobility, hearing or vision loss or the death of a loved one can trigger trauma. Trauma has both a mental and physical impact on health, and can cause the development of depression, anxiety, panic attacks, memory problems, hypertension, coronary disease, sleep disorder gastrointestinal issues, substance use and fibromyalgia. Adults of advanced age, 80's, 90's and 100's, share a culture of shame, secrets and silent stoicism. As such this age range needs special attention because they may have never shared their trauma and pain with another soul. A tenet of trauma informed care is talk, talk, talk about the trauma. So many have never acknowledged nor sought help for their traumatic experiences. Unaddressed trauma can fester like an untreated wound, making recovery difficult or impossible. (SAMHSA)

Suicide – a public health problem.

In 2014, nearly 11,000 people 60+ died by suicide in the U.S. Men aged 85+ have a suicide rate that is about four times higher than the rate for all ages. (CDC)

In Oklahoma, 2019, the suicide rates were higher among adults ages 45 to 54 years (19.60 per 100,000) and 55 to 64 years (19.41 per 100,000). The rate was highest among adults aged 85 years or older (20.12 per 100,000). (CDC)

Suicidal behavior is more lethal in later life than at other points in the life course. Older adults are frailer and more likely to die, more isolated and less likely to be rescued, are more planned and determined, and have access to deadly means. Older adults have higher rates of completion with 1 completed suicide for every 4 attempts, compared to 25 attempts for every death by suicide for all other ages combined. (American Association of Suicidology)

Opportunities for intervention are extremely limited but could be dramatically increased through

a comprehensive system of care that would identify distress, provide screenings and appropriate treatment and support.

Suicide results from a combination of circumstances, but key conditions can be identified. The top three circumstances for older adult suicide in Oklahoma are depressed mood, physical health problems and mental health problems.

Suicide, culture and ageism are intertwined. While suicide is viewed as a tragedy for young people, the suicide of the old and/or sick appears to be understandable and culturally accepted. For ages 65+, white men account for 80% of suicides. Attitudes that may make older white men vulnerable are the belief that aging is undignified, that suicide is a masculine response to aging, so it is a strong, powerful and acceptable act.

Research findings support the importance of screening in primary care or other specialty settings at the time of diagnosis: For Veterans, suicide attempts were 75% higher with a recent diagnosis of mild cognitive impairment and 44% higher with a recent dementia diagnosis; Parkinson's disease is associated with an increased risk of suicide; in both middle aged and older adults, there was an association between hearing loss and suicidal ideation.

IN SUMMARY, depression and other behavioral health problems are not a normal part of aging and can be treated. Despite the availability of effective interventions, 66% of older adults are not receiving the care they need. (*Journal of the American Geriatrics Society 59(1):50-56*) Addressing mental health can result in improved functioning and quality of life, improved health maintenance and decreased physical health expenditures.

Positive Action – A Proposed Blueprint

- Recognize older adults as a priority population with providers who are trained in geriatric issues, can identify overlapping symptoms and issues and are part of an integrated network with shared resources to interface services and address the elements that comprise wellness for an older adult.
- The development of a comprehensive system of care to address the intersecting and overlapping elements of wellness to benefit all people as we age. A model system of care would eliminate the creation/duplication of specialized services in various sectors. Creating a comprehensive system of care for a group spanning over 4-5 decades, can address the disparities existing for Veterans, American Indian, Alaska Native, White, Black, Asian, Hispanic, Latino, Native Hawaiian, Pacific Islander and LGBTQ populations. Additionally, for Republicans, Democrats, Independents, Protestants, Catholics, Jews, and Americans of Irish, German, Polish, Japanese or other descents, together with other numerous segments and identities that comprise this diverse group
- Recognize the signs and symptoms of behavioral health needs and provide screenings to identify symptoms of depression, anxiety, trauma, suicide and substance use at agencies, organizations, community sites and follow up with appropriate resources or referrals.
- Confirm that services are accessible and affordable and address transportation issues.
- Expand the use of older adult peer specialists. Support efforts to revise the Medicare rule requiring Licensed Clinical Social Work level providers which limits both the number of services and providers.

Age should not disqualify an individual from services.

Oklahoma

While progress has been slow, Oklahoma has made remarkable strides towards behavioral health equity for Oklahomans as they age and the Oklahoma Mental Health and Aging Coalition has played the part of advocate, cheerleader educator, and partner. Oklahoma provides Mental Health First Aid for Older Adults and an Older Adult Peer Support Specialty. The Department of Mental Health and Substance Abuse Services is in the planning stage of implementing an Older Adult Behavioral Health State Plan. OMHAC took action to address depression and increase screening by developing the Reducing Depression Initiative, which has been delayed due to COVID.

Oklahoma has created a nationally renowned Systems of Care for children and has the experience and know-how to construct a service system with supports to address the physical, mental and emotional well-being of older Oklahomans.

Another Oklahoma highlight is the Hope Research Center, University of Oklahoma – Tulsa, focusing on both the science and power of hope as a psychological strength among those experiencing trauma and adversity, and creating targeted interventions for better social, psychological and behavioral outcomes. My hope is that the power of hope will be integrated to any strategy or conversation about Healthy Aging.

In Closing, any discussion of Healthy Aging must include the intersecting areas of physical health, mental health, social connections, resiliency, environmental factors, functioning, cognition, nutrition, aging in place, age-friendly systems, caregiving and caregiver services, resources, and ageism. Mental health is an integral factor in each one and can have a positive, or negative, impact on each one.