African American Elder Mental Health and Substance Use

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9:00AM – 1:30PM

Disclosures

- No conflicts of interest to report
- No financial disclosures to report

Measurable Learning Objectives

- List five core concepts of psychopharmacology for elders.
- Learn five signs of cognitive impairment.
- Identify three tools that can help clinicians assess mental health conditions (like depression, cognitive impairment and anxiety)
- Identify four factors that can impact the outcome of depression in Black elders.
- Identify four factors related to substance use and geriatric mental health.

Warning:

This may be disturbing

This is deeply uncomfortable

You may feel sad, angry, guilty, and sad about the trauma of loved ones, over what you've seen and experienced with patients and clients, too

Explore the emotions and reflect on them

Let's use this time as an opportunity to engage ourselves and our elders differently

Epidemiology and Useful Facts

- Geriatrics is one of few medical specialties in the United States that is **contracting even as the need increases**, **ranking at the bottom** of the list of specialties that...[residents pursue].
- Seniors have **special healthcare needs** that can make their **medical care more complicated**.
- Approximately 20,000 geriatricians are needed now to care for over 14 million older Americans. As of 2016, there were **7,293 certified geriatricians nationwide**.

More Useful Facts

- The population of older African Americans is expected to triple by 2050
- African Americans have greater risk factors for psychiatric disorders including higher levels of poverty, poorer health, higher rates of discrimination, and greater likelihood of residing in neighborhoods with higher levels of social stressors (e.g., crime).

Instead of these words and cues:	Try:
"Tidal wave," "tsunami," and similarly catastrophic terms for the growing population of older people	Talking affirmatively about changing demographics: "As Americans live longer and healthier lives . . ."
"Choice," "planning," "control," and other individual determinants of aging outcomes	Emphasizing how to improve social contexts: "Let's find creative solutions to ensure we can all thrive as we age."
"Seniors," "elderly," "aging dependents," and similar "other-ing" terms that stoke stereotypes	Using more neutral ("older people/Americans") and inclusive ("we" and "us") terms
"Struggle," "battle," "fight," and similar conflict-oriented words to describe aging experiences	The Building Momentum metaphor: "Aging is a dynamic process that leads to new abilities and knowledge we can share with our communities."
Using the word "ageism" without explanation	Defining ageism: "Ageism is discrimination against older people due to negative and inaccurate stereotypes."
Making generic appeals to the need to "do something" about aging	Using concrete examples like intergenerational community centers to illustrate inventive solutions

So…how are we doing?

Depression

- Higher depressive symptom severity was associated with greater use of antidepressants in older Caucasians, but not in African Americans.
- Multiple studies have shown the rate of antidepressant use in older Africans Americans was about half that of Caucasians
- African Americans had the lowest expenditures for antidepressant meds compared to other races, and were more likely to use older, generic medications
- Compared to older Caucasian veterans, African Americans with subsyndromal depression were less likely to view antidepressant medication as beneficial.

Pickett, 2014

Anxiety

Older African Americans had lower 12-month prevalence rates of the following:

- General anxiety disorder (GAD),
- Social anxiety (or social phobia),
- Agoraphobia without panic (Himle et al., 2009).
- African Americans were less likely than non-Latino whites to have 12-month or lifetime panic disorder (Levine et al., 2013).

Suicidality Among African American Elders

- The rate of suicide is highest in **middle-aged white men**
- In 2020, **men died by suicide 3.88x more than women**.
- The Rising Tide of Elderly African-American Suicides: A Call for Action
- Two methods were used in at least 70% of them, firearms and poisons (e.g., pills).

https://afsp.org/suicide-statistics/

#BTW

ME:

- Psychiatrist
- Consultant
- Former Medical Director at one of the largest health systems in NY
- Trained in Public Health
- Formerly a middle manager at Verizon

ALSO ME:

- Descendants of enslaved West Africans
- Grandparents = Refugees
- Parents: Harlem in the 60's
- Sister to two Black men

Background

- "…early racial socialization experiences often include listening to their parents' and grandparents' stories of living through different periods of racial tension in the U.S., including the Civil Rights movement, Jim Crow laws, and for some slavery (Shenk, 2000)."

Background

- Conversations about survival and trauma get passed down.
- There is an underlying fear/anxiety of the consequences of discrimination: Death? Physical harm? Job loss? Unemployment? Separation from treatment team?

Racism Refresher

Interpersonal:

- **Occurs between individuals**
- **Public expressions of prejudice, hate, bias, and bigotry**
- **Burning a cross on someone's lawn, lynching, calling them a derogatory name**

Systemic:

- **"…the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice" (Krieger, 2017)**
- **These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources.**

Racism Refresher 2

- Black Codes
- Jim Crow
- Redlining - Discriminatory lending practices
- Loss of generational wealth available to most Americans (see more on the Social Security Act of 1935)
- GI Bill: denied mortgage and educational subsidies, restricted education access to 4 year colleges

Taxonomy of Microaggressions

- Microaggression
  "Brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color."
- Microaggressions are considered small, common, and sometimes ambiguous, yet they are particularly stressful for those on the receiving end, given their ubiquity and deniability.

Glossary

- Microinsults: “I like your hair better when it’s straight”
- Microinvalidations: “I don’t see color,” mistaking people of similar background, or “How could I be racist? My last boyfriend was Kenyan.”
- Macroaggression: severe acts of racism: e.g., lynchings, beatings, cross burnings, attacking someone for their ethnicity or gender expression or sexual identity

Trauma and Microaggressions

- History
- Violence
- Vigilance
- Microaggressions can have a similar effect as being exposed to a hate crime.
- Hate crimes can be vicariously experienced and sensitize community members
- Microaggressions can be felt intensely because they symbolize hate crimes and their historical force.

Everyday Discrimination Scale

- Measure:
  In your day-to-day life, how often do any of the following things happen to you?
  1. You are treated with less courtesy than other people are.
  2. You are treated with less respect than other people are.
  3. You receive poorer service than other people at restaurants or stores.
  4. People act as if they think you are not smart.
  5. People act as if they are afraid of you.
  6. People act as if they think you are dishonest.
  7. People act as if they're better than you are.
  8. You are called names or insulted.
  9. You are threatened or harassed.

  Recommended response categories for all items:
  Almost everyday
  At least once a week
  A few times a month
  A few times a year
  Less than once a year
  Never

- Follow-up Question (Asked only of those answering "A few times a year" or more frequently to at least one question.): What do you think is the main reason for these experiences? (CHECK MORE THAN ONE IF VOLUNTEERED).
  RECOMMENDED OPTIONS
  1. Your Ancestry or National Origins
  2. Your Gender

Everyday Discrimination Scale

- How many have you experienced?
- What do you think African-American elders have experienced?

How Does This Specifically Affect The Black Body?

- Chronic exposure to stress:
  - Hypothalamic-Pituitary Adrenal Axis
  - Weight
  - Hypertension
  - Respiratory health
  - Glucose metabolism
  - Maternal Health

Cardiovascular Health

- Black people have a higher odds of reporting discrimination than White people and report discrimination in nearly all aspects of experiences in public and private institutions, including health care and the police. (Bleich, 2019)
- Participants with a history of mood disorder who reported high levels of racial discrimination had the greatest risk of cardiovascular disease (Chae, 2012)

SHUR Study:

- 2017 Survey of the Health of Urban Residents (SHUR) identified connections between police brutality and **medical mistrust**.
- Measures a range of negative encounters with the police, frequency of these encounters, and respondents' assessments of whether the encounters were necessary.
- SHUR assessed likelihood of calling the police if there is a problem, worries about incarceration, and cause-specific stressors such as race-related impression management.
- Definition of **Brutality**: Not merely use of force; police action that dehumanizes the victim, even without conscious intent

CASE 1

Case 1

- Pt Mr. M is a 78 y/o man, domiciled alone in an apt w/dog
- Contracted HIV through IVDU in 1980s
- Has been sober since late 1990s, first through methadone, no M.A.T. currently
- Has been host to multiple relatives, his children and grandchildren who are trying to find work, earn and save money
- Has chronic pain, depression, chronic insomnia and PTSD from multiple violent encounters when he was incarcerated
- He is on an opioid for pain, a benzodiazepine for anxiety, and smokes cigarettes

Case 1 (continued)

- Seven years into treatment, he reports worsening depressive symptoms
- He discloses that he's been having a romantic relationship with a sex-worker who is using heroin. Mr. M is very concerned for her safety and well-being and wants to help her decrease her opioid use.
- When asked how this is impacting his wellbeing, he explains he doesn't like to feel lonely, identifies strongly with his romantic partner, but is also afraid because the relationship is complicated
- She has been helping him manage his money through online bill pay and he does not understand how it works. She might have his passwords.

Case 1 (continued/2)

- He has noticed significant withdrawals from his bank account, and he wonders if he has done something wrong with his attempts to do online bill pay. Or if he has mistakenly trusted his partner.
- She lives with him
- She is married to a violent man who is going to be released from prison in two months.

What problems need to be addressed?

Trauma history
Depressed mood
Anxiety
Sleep problems
Chronic pain
Cognitive Impairment
Polypharmacy
Social isolation/Sexuality
Housing stressor
Safety

Definition of Elder Abuse

E.A. refers to an intentional act or omission occurring in a relationship of trust that causes harm or serious risk of harm to an older adult or deprives an older adult of basic needs. Elder Abuse encompasses physical, sexual, emotional, and financial abuse or neglect toward an older adult

(National Research Council [NRC], 2003)

Where (health) Inequities Intersect with Abuse

- Racial trauma > Mental Health > Heightened Vulnerability and Increased complexity
- Vulnerability and experience of help (familial vs institutional)
  - Impact on reporting
- Power and privilege in helping professions
  - Can bias be encoded in assessments?
  - Resistance vs Mistrust
  - "Poor decisions"
  - Understanding of what remedies are helpful

Health Equity and Abuse Perspective

- Economic conditions in The South necessitating migration
- Economic conditions in the Bronx upon arrival and for the next 20 years
- What opportunities did he have for education? Economic advancement? Support of his sobriety?
- "Substance use disorders among older populations: What role does race, and ethnicity play in treatment and completion?"

Substance Treatment to Prevent Elder Abuse?

- The proportion of older adults seeking treatment for OUD rose steadily between 2004-2013 (41.2% increase; p-trend=0.046), then rapidly between 2013-2015 (53.5% increase; p-trend=0.009).
- The proportion of older adults with primary heroin use more than doubled between 2012- 2015 ($p<0.001$);
- Individuals were increasingly male ($p<0.001$), African American ($p<0.001$), and using via the intranasal route of administration ($p<0.001$).
- Ortega, et al "SUD in Older Populations"

Demographic Factors

- The baby boomer cohort (those born 1946 - 1964).
- The cohort turned 55 years old between 2001 and 2019, and 65 years old between 2011 and 2029.
- Higher prevalence of lifetime substance use, compared to earlier older cohorts. In addition, a history of alcohol abuse increases the risk of substance use in late life. Thus, some of the observed growth in number of older adult admissions to substance abuse treatment programs may be a reflection of aging of the baby boomer cohort.

Chhatre, S., Cook, R., Mallik, E. et al. Trends in substance use admissions among older adults. BMC Health Serv Res 17, 584 (2017

Invisible Epidemic

- Substance use disorders among older adults have been termed an invisible epidemic (Alpert, 2014).
- Substance use decreases with age (Mattson et al., 2017),
- Factors: pain associated with chronic illnesses, social isolation, depression, and other psychosocial issues that older adults face create a need for coping mechanisms that often involve drugs and alcohol (Heron, 2019; Reid et al., 2015).
- Aging cohort's increasing exposure to and usage of drugs (Mattson et al., 2017), the number of older adults in need of substance use treatment is on the rise.
- 60–64 year olds 5x more likely to receive MAT for opioid use disorder (Neighbors, 2019)

Neighbors CJ, Choi S, Healy S, Yerneni R, Sun T, Shapoval L. Age related medication for addiction treatment (MAT) use for opioid use disorder among Medicaid-insured patients in New York. Subst Abuse Treat Prev Policy. 2019 Jun 25;14(1):28.

Elders and Substance Use

- Nearly 1 million adults aged 65 and older live with a substance use disorder (SUD), as reported in 2018 data.[1]

- SUD admissions to treatment facilities between 2000 and 2012 differed slightly, the proportion of admissions of older adults increased from 3.4% to 7.0% during this time.[2]

Substance Abuse and Mental Health Services Administration. (2019). Results from the 2018 National Survey on Drug Use and Health: Detailed tables. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

Elder Mental Health + Substance Use

- Majority of the admissions were for alcohol as the primary substance 2000-2012
- Proportion of participants using heroin increased
- Proportion of participants using crack increased

Elder Mental Health + Substance Use

- Most admissions from 2000 to 2012 were among non-Hispanic white, male, unmarried, high school graduates, unemployed and those with housing.

- Admissions for older adults increased between 2000 and 2012 for African Americans (21% to 28%) … and those with psychiatric problems (17% to 32%).

CASE 2

Case 2

- Ms. T, never married, retired, mother of 9, has 6 adult children living with her
- Referred to psychiatrist by her PCP for c/o “I have bugs in me”
- Ms. T has brought in jars of what looks like dandruff and there are scabs along her hairline where she has been using a paring knife to excise the bugs
- What considerations should we make?

Case 2, continued

- Social History: Ms. T was born in North Carolina to a very low-income family of tenant farmers, was sexually abused by her stepfather and became pregnant at age 12.
- She was sent to live with a relative who kept her hidden in the back of the home and made her work as a maid until Ms. T and her child were given enough money for them to go to New York during the Great Migration.
- She was sexually assaulted two more times
- Ms. T worked hard to provide for her and her child and had new relationships and 8 more children

Case 2, continued

- Ms. T started drinking at 30, when her sexual trauma symptoms became overwhelming
- She drank heavily for 43 years as she raised her children as a single parent
- Ms. T has been sober about 3 years.
- She no longer craves alcohol and through her faith has come to accept the traumatic events of her life and doesn't feel haunted by them the way she used to.

Case 2, continued

- When asked about her relationship with the mix of six adult children (and grandchildren) currently living in the apartment, she simply states, “I wasn’t the best mother to them. They’re addicted now and I long-term be there for them.”
- Let’s talk about infestation
- Trauma
- Substance Use/Sobriety
- Medical complications of long-term alcohol use

What is your differential for psychiatric diagnoses?

Complex PTSD

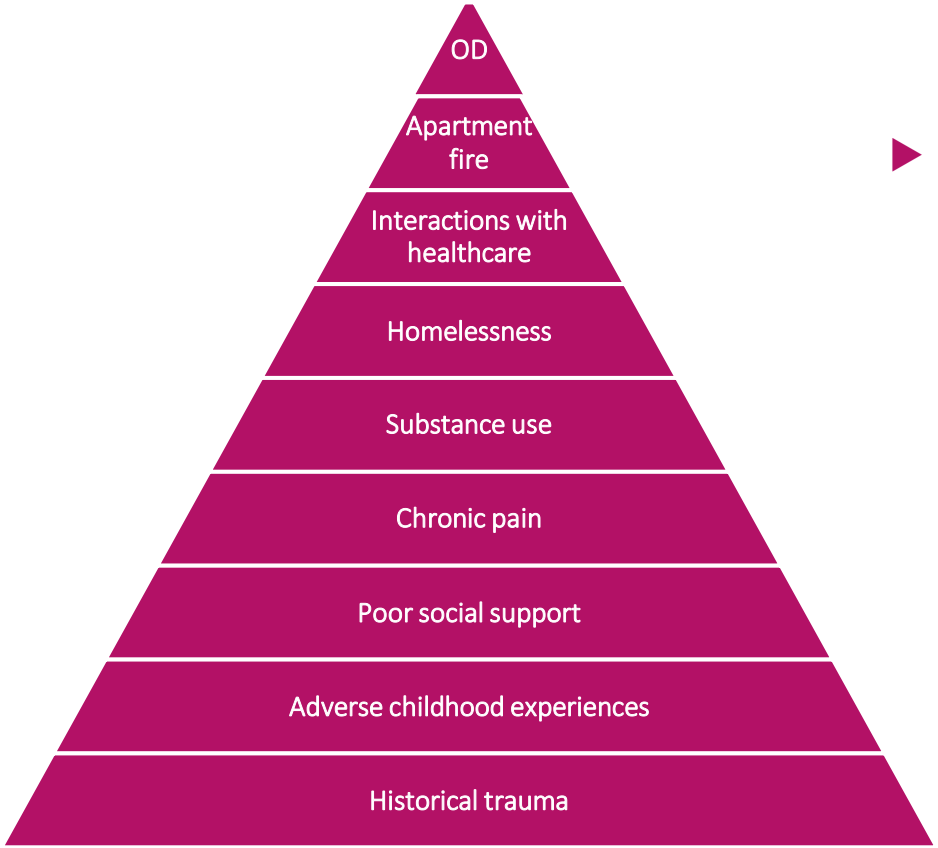
Dementia

Psychotic Disorder

Major depressive disorder

Generalized anxiety disorder

Understanding the Patient's Experience



- "PTSD and addiction are a marriage made in the avoidance of unbearable affect; an avoidance that is costly in the resulting traumatic reenactments experienced by patients whose attempts to escape the past keep them ever more tightly bound to it."
  - - Margaret A Cramer, PhD

(Cramer 2002)

Post-traumatic Stress Disorder Criteria

- Post-traumatic stress disorder (PTSD)
  - Exposure
  - Intrusions
  - Avoidance
  - Negative alterations in mood or cognition
  - (2 or more)
  - Hyperarousal (2 or more)
  - Symptoms last >1 month
  - Functional impairment

- Complex PTSD
  - Occurs when individuals experience:
    - Multiple traumas
    - Prolonged and repeated trauma during childhood
    - Repetitive trauma in the context of significant interpersonal relationships
  - Consists of difficulties in the following areas:
    - Emotional regulation
    - Consciousness
    - Self-perception
    - Distorted perceptions of the perpetrator
    - Relationships with others
    - One's system of meanings

(DSM-5, SAMHSA 2014)

Goals of Intervention

- Repairing and Restoring
  - Radical Health
  - How are we protecting and maintaining family ties?
- Protect the patient
  - Remove patient from dangerous environment : The potential for houselessness and further intergenerational trauma)
  - Increase number of caregivers and amount of oversight
  - Consider guardianship.. B U T we're still applying an equity lens, so what can it look like if we routinely assess for remaining abilities?
- Reduce the risk of future mistreatment
  - Try to improve functional capacity (decrease dependence and caregiver stress)
  - Explore entitlements and resources (ie. Managed Long Term Care Programs)
  - Caregiver education and support when appropriate

What Will We See in an Equitable Elder Protection System?

Summary of Techniques

Take a patient-centered approach

- Generate empathy
- Validate suffering
- Create a space to tolerate and contain affective states

Co-create a treatment plan

- Be clear and honest about goals and expectations

Regularly reflect on the treatment and relationship

- Identify countertransference
- Seek support from peers
- Elicit feedback from patient

(Stubbe 2018)

Elders and Substance Use

- Remember the following:

- For elders of color, substance use and advanced age (which can come with additional discrimination, cognitive impairment, sensory deficits, chronic pain, frailty) adds additional layers of vulnerability

Substance Use Disorder Criteria

1. Taking the substance in larger amounts or for longer than you're meant to.
2. Wanting to cut down or stop using the substance but not managing to.
3. Spending a lot of time getting, using, or recovering from use of the substance.
4. Cravings and urges to use the substance.
5. Not managing to do what you should at work, home, or school because of substance use.
6. Continuing to use, even when it causes problems in relationships.
7. Giving up important social, occupational, or recreational activities because of substance use.
8. Using substances again and again, even when it puts you in danger.
9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance.
10. Needing more of the substance to get the effect you want (tolerance).
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.

Mild = 2-3 | Moderate = 4-5 | Severe = 6+ (DSM-5)

History of Opioids (1800s-1900s)

- Timeline
  - 1800s – Opium predominated
  - Post-Civil War – Rise of morphine
  - Early 1900s – Heroin and cocaine promoted to "cure" morphine addiction
  - 1930s – Methadone developed by German scientists as an effective and less addictive substitute for opioid painkillers
  - WWII – German medics used methadone when morphine stores ran low
  - 1947 – use of methadone reached the US
  - 1955-1975 – Post-Vietnam War rise in heroin use
  - 1971 – FDA approved methadone as a treatment for opioid addiction
  - 1980s – Crack epidemic
  - 1990s – Rise of prescription opioid use
- *Our older adults ≥65 years old were born on or before 1957

(Associated Press 2017)

History of Opioids (2000s)

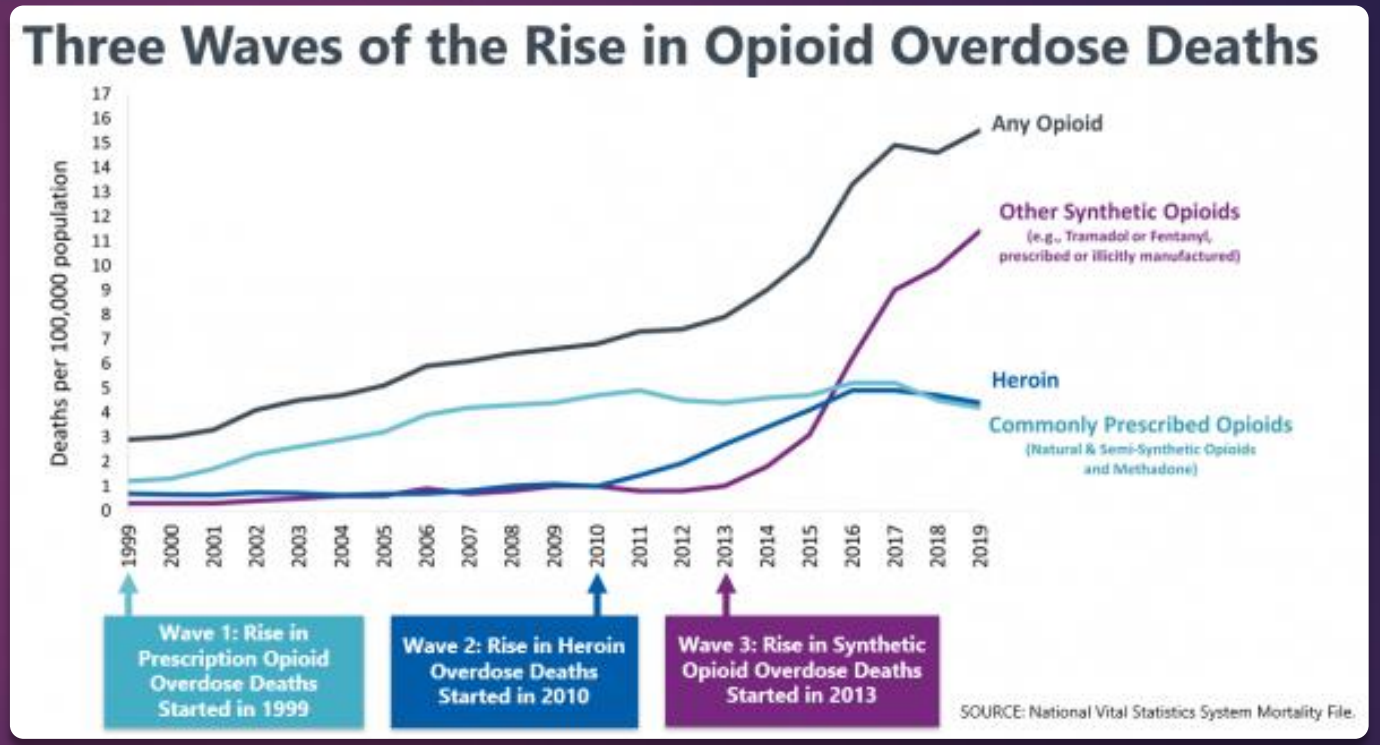


IMAGE CREDIT: CDC

Opioid Use in Older Adults

- The population of adults with opioid use disorder on methadone is aging
- Adults over age 50 admitted for substance treatment tripled from 1994 to 2004
- In 2003, largest cohort in methadone treatment was 40-50 years old (now 60-70)
- Approximately 5% of the 160,000 patients in methadone treatment programs are ≥55 years old

(Kerfoot 2011, Rosen 2008)

Methadone

- Mechanism of action: Slow-acting opioid agonist
- Indication: Opioid use disorder and opioid withdrawal management
  - Suppresses opioid withdrawal
  - Blocks the effects of illicit opioids
  - Reduces opioid craving
  - Facilitates engagement in nonpharmacological interventions
- Side effects
  - Physical: QTc prolongation, syncope, lightheadedness, respiratory depression, sedation, dry mouth, urinary retention, gastrointestinal distress, erectile dysfunction
  - Psychological: depression, anxiety, suicidal ideation, paranoia, hallucinations, delusions
  - Cognitive: impaired processing speed, poor concentration, executive dysfunction, working memory deficits
  - Sleep: decreased REM and slow wave sleep, central sleep apnea

(American Addiction Centers, Li 2016, Wang 2007)

Comorbidities in Older Adults on MMT

- Study of 140 participants >50 years old on methadone maintenance through a Pittsburgh clinic
- There is a high comorbidity with other psychiatric disorders
- 87% reported that they currently smoked cigarettes
- 58% reported fair to poor physical health with high rates of arthritis, hypertension and hepatitis C

12-month prevalence of mental health disorders in older adult methadone patients (N=140)	
Major depressive disorder	32.9%
Generalized anxiety disorder	29.7%
Post-traumatic stress disorder	27.8%
Specific phobia	26.4%
Social phobia	16.9%
Agoraphobia	13.6%
Panic disorder	13.6%

(Rosen 2008)

Prescription Misuse in Older Adults

- High prescription medication utilization
- Prone to medication errors due to complex regimens
- Adults 65 and older are vulnerable to misusing prescription medication to address sleep problems, chronic pain and anxiety
- Rates of death and suicide caused by prescription opioid misuse are increasing
- Benzodiazepines are linked to dependence, falls, cognitive impairment, motor vehicle accidents and overdose death

EXHIBIT 1.6. Substance Misuse Risk Factors in Older Adults[104,105]

- Retirement (when not voluntary)
- Loss of spouse, partner, or family member
- Environment (e.g., relocation to assisted living)
- Physical health (e.g., pain, high blood pressure, sleep and mobility issues)
- Previous traumatic events
- Mental disorders (e.g., disorders related to depression and anxiety)
- Cognitive decline (e.g., Alzheimer's disease)
- Social changes (e.g., less active, socially disconnected from family and friends)
- Economic stressors (rising medication and healthcare costs, living on reduced income)
- Lifetime or family history of SUDs
- High availability of substances
- Social isolation

(SAHMSA 2020, Chen 2011)

Treatment Recommendations

- PTSD
  - Trauma-focused therapy
  - Monotherapy with sertraline, paroxetine, fluoxetine, or venlafaxine
- Opioid use disorder
  - Over-standard doses of methadone (up 120 mg/day) are needed with comorbid affective disorders
  - Sleep evaluation
  - Cognitive testing
- Tobacco use disorder
  - Motivational interviewing
  - Medication-assisted treatment
- Benzodiazepine use disorder and dependence
  - Medically supervised taper
  - Harm reduction – clonazepam is a safer alternative to other benzodiazepines
  - Concomitant therapy

(Maremmani 2019, Rao 2019, VA/DoD 2017)

Substance Use Treatment Completion

- Higher socioeconomic status is a protective factor for treatment completion. For example,
- One study found that African Americans had a 17.5% substance use treatment completion rate while Whites had a 26.7% completion rate, and this disparity was attributed to differences in socioeconomic factors such as homelessness, employment, and health insurance (Jacobson et al., 2007).
- Black/African American adults have also reported delays in substance use treatment entry as compared to Whites in a study assessing racial and socioeconomic disparities in substance use treatment (Lewis et al., 2018).

Black Elders and Substance Use

- From the critical race theory perspective, Black/African American older adults may have less substance use treatment completion for several reasons. Dovidio and colleagues (2008), for example, have found that experiences of racial bias and aversive racism have resulted in a distrust of the health care system among Black older adults.

- On a systemic level, this can be seen in terms of the geographic placement of health care facilities, the cost of services, the availability of insurance coverage, and the quality of the service relative to its location (Dovidio et al., 2008).

Black Elders and Substance Use

- In practice, this calls for a culturally sensitive approach to treatment retention for Black/African American older adults in substance use treatment programs
- With a policy and funding lens, it calls for a total overhaul of systems that have negatively influenced Black/African American perception of the health care system.
- Need to destigmatize substance use in general is critical, and the expectations of older adults to be model citizens without fault must go.

Black Elders and Substance Use

- Older adults, like many younger adults, have risk factors that make them susceptible to substance use dependency including chronic pain, social isolation, depression, suicidal ideation, and despair (Arndt et al., 2011; Assari et al., 2019; Cleary et al., 2017; Thandi & Browne, 2019; Millar et al., 2017), and Black/African American adults in particular have "double jeopardy" as a result of their membership in two vulnerable groups (Ferraro, 1987).

Questions To Consider:

- Many elders who have battled substance use disorders most of their lives have ruptured relationships with children, spouses, ex-spouses, caregivers.
- Their relatives may want nothing to do with them
- What is the incentive to be sober?
- If dealing with chronic pain, what is the incentive for sobriety?
- What is the incentive for recovery?

Cannabis

- **Medical Marijuana May Be Beneficial For Elderly Patients Reducing Pain, Anxiety, And Use Of Opioids, Research Suggests.**
- MedPage Today reported "medical cannabis was well-tolerated among elderly patients and provided significant symptomatic benefits."
- Researchers found that older adults with "an average age of 81 experienced relief in chronic pain, sleep, neuropathy, and anxiety with medical cannabis."
- As reported in HealthDay, reports the researchers found that "a third of" study participants "who took medical marijuana" reduced "their use of opioid painkillers."

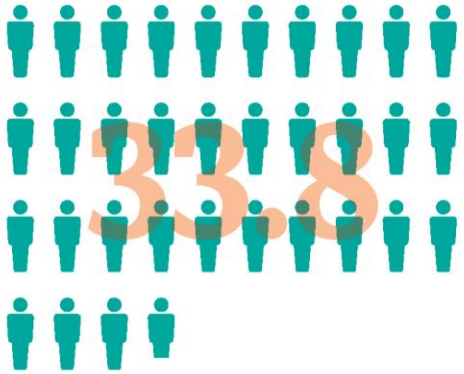
https://www.medpagetoday.com/meetingcoverage/aan/78289

Suicide Risk Factors

SUICIDE RATES (PER 100,000):

MEN OVER 65

MEN OVER 90



(Statistics Canada, 2017).

SUICIDE ATTEMPTS

Older males die by suicide more often than any other group because they use more lethal means when attempting suicide.

(O'Dwyer & De Leo, 2016; CCSMH, 2009; Marcus, 1996).

Image credit: Ardent Solutions, Centre for Suicide Prevention

NEWS

Who Is Amelia Baca? Woman With Dementia Shot to Death by New Mexico Police

Fatal Police Shooting in Bronx Echoes One from 32 Years Ago

Is Help/Intervention Equitable?

- Calling the police on Black elders can be the ultimate abuse
- Resources for mental health crises
- Primary Care
- Leveraging Case Management Services
- Mobile Crisis (do we know about 1M4.org ?)
- Effectively partnering with law enforcement
- Preparing the clients for the presence of law enforcement
- Making use of 988

Social Isolation and Older Adults

- Increased risk for loneliness and social isolation because they are more likely to face factors such as living alone, the loss of family or friends, chronic illness, and hearing loss.
- Loneliness associated with higher rates of depression, anxiety, and **suicide**.
- Social isolation was associated with about a 50% increased risk of dementia

CASE 3

Case 3

- Ms. A is a 74 y/o widowed woman with a history of depression with psychotic features. She has been adherent to her antidepressant and her low dose antipsychotic for several years.
- When she is transferred to you from her male psychiatrist of the past 8 years, she starts the appointment by saying she wants to come off her medications.
- Further dialogue reveals Ms. A misses having an orgasm. She is on a special diet because of her poor dentition and difficulty digesting certain foods leaves her bloated and feeling little enjoyment from eating. She doesn't use any substances and misses the simple pleasures of life, she explains.

You React by Doing What?

1. Blushing you say, “Ma’am you are too old to be doing that kind of thing!”
2. Reminding her she was hospitalized for psychosis, and we can’t stop any medications, so find a new pleasure please.
3. Listen to her concerns and validate.
4. Listen, validate, and problem-solve around her side effects

Older Adult Sexuality

- Side effects of psychotropic meds
- Female sexuality over 65
  - approximately 50% of postmenopausal women experience vaginal dryness, painful penetration
  - Age-related decrease in genital blood flow and diminished genital sensation, along with decreased pelvic floor tone may contribute to a delayed or a less intense orgasm.
  - Decreasing levels of estrogen and androgens may also contribute to low desire, difficulty with arousal, and impaired orgasm.[5]

Older Adult Sexuality

- Normalize talking about sex
- Give the patient permission to discuss
- Counsel the patient based on their health status, NOT their age
- Patients with more complex sexual health issues may need a multidisciplinary approach including psychotherapy or sex therapy.

Older Adult Sexuality

- How are we talking about their use of sex workers?
- Older American male customers of sex workers pay for more sex as they age.
- 208 men across 36 US states participated in a study published in 2016
- The majority were having fellatio without a condom and vaginal intercourse with a condom
- Are we offering older adults PrEP?
- Are we offering them condoms?

Structural Racism and Your Step Count

Structural Racism and Step Counts

- Increased dementia risk and sedentary lifestyle
- Where can aging people walk safely?
- Daily step count
- What's the walking like where you live or work?

https://jamanetwork.com/journals/jamaneurology/fullarticle/2795819

Walking and Dementia Risk

- "Routine annual assessments of gait speed and cognition will need to be established in clinical settings to identify dual decliners."
- Compared with the adults who did not experience any declines, adults who had gait decline along with either memory decline or global cognition decline were more than 20 times likely to develop dementia, Collyer et al found. Those experiencing slowing gait along with processing speed or verbal fluency decline were about 4 to 5 times more likely to develop dementia, although this risk was about the same as for adults experiencing gait decline alone.
- https://jamanetwork.com/journals/jamaneurology/fullarticle/2795819

Sleep and Dementia

- Daytime sleepiness
- Sleep equity
- A study of 3000 older adults showed that excessive daytime sleepiness in cognitively normal elderly leads to a buildup of amyloid
- Amyloid is associated with preclinical stage of Alzheimer's
- Treating clinical sleep disorders must be a current prioroity for mental health in older adults

JAMA Neurology 2022

Dementia vs Cognitive Impairment

- Dementia: typically diagnosed when acquired cognitive impairment has become severe enough to compromise social and/or occupational functioning.

- Mild cognitive impairment (MCI): between normal cognition and dementia, with essentially preserved functional abilities.

Mini-Cog©

Instructions for Administration & Scoring

ID: _____ Date: _____

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.[1-3] For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

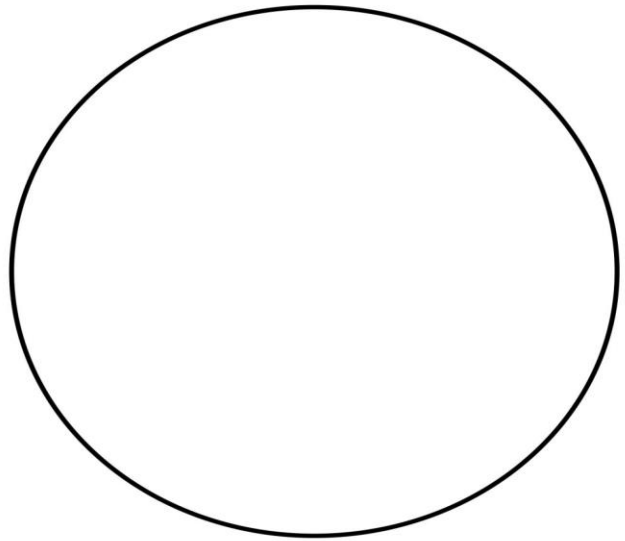
Word List Version: _____ Person's Answers: _____ _____ _____

Scoring

Word Recall: _____ (0-3 points)	1 point for each word spontaneously recalled without cueing.
Clock Draw: _____ (0 or 2 points)	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.
Total Score: _____ (0-5 points)	Total score = Word Recall score + Clock Draw score. A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.

Clock Drawing

ID:_____ Date:_____



References

1. Borson S, Scanlan JM, Chen PJ et al. The Mini-Cog as a screen for dementia: Validation in a population based sample. J Am Geriatr Soc 2003;51:1451–1454.
2. Borson S, Scanlan JM, Watanabe J et al. Improving identification of cognitive impairment in primary care. Int J Geriatr Psychiatry 2006;21: 349–355.
3. Lessig M, Scanlan J et al. Time that tells: Critical clock-drawing errors for dementia screening. Int Psychogeriatr. 2008 June; 20(3): 459–470.
4. Tsoi K, Chan J et al. Cognitive tests to detect dementia: A systematic review and meta-analysis. JAMA Intern Med. 2015; E1-E9.
5. McCarten J, Anderson P et al. Screening for cognitive impairment in an elderly veteran population: Acceptability and results using different versions of the Mini-Cog. J Am Geriatr Soc 2011; 59: 309-213.
6. McCarten J, Anderson P et al. Finding dementia in primary care: The results of a clinical demonstration project. J Am Geriatr Soc 2012; 60: 210-217.
7. Scanlan J & Borson S. The Mini-Cog: Receiver operating characteristics with the expert and naive raters. Int J Geriatr Psychiatry 2001; 16: 216-222.

What Can Help Isolation?

1. AARP—Provides helpful information to seniors and shares Community Connection Tools.
2. Area Agencies on Aging (AAA)—A network of over 620 organizations across America programs including nutrition and meal programs (counseling and home-delivered or group meals), caregiver support, and more.
3. Eldercare Locator—A free national service that helps find local resources for seniors such as financial support, caregiving services, and transportation.
4. National Council on Aging—The place to find senior programs to assist with healthy aging and financial security.
5. National Institute on Aging (NIA)– Provides materials on social isolation and loneliness for older adults, caregivers, and health care providers.

Chronic Pain and Cognitive Decline

- Older adults troubled by persistent pain may be at a greater risk of rapid memory decline, according to a study published in *JAMA Internal Medicine*.
- Participants reporting persistent pain had more depressive symptoms, a greater prevalence of limitations in activities of daily living, and more comorbid medical conditions than those not experiencing pain.

https://jamanetwork.com/journals/jama/fullarticle/2802174

Recommendations for Mental Well-being

- Expand suicide prevention efforts
- Prevent the recurrence of psychiatric disorders such as mood and anxiety disorders, which are common in older populations
- Treat older patients for substance use disorders
- Investigate the impact of mental illness on general medical disorders

Diet and Depression

- **Elderly People Who Follow DASH Diet May Have Lower Rates Of Depression, Researchers Say.**
- Investigators "studying 964 elderly participants over six and a half years found those who followed the DASH diet, which emphasizes whole grains, fruits, and vegetables, had lower rates of depression, while those who ate a traditional Western diet were more prone to depression."
- "…other researchers have found similar antidepression benefits from the DASH diet, which was developed by the US National Heart, Lung, and Blood Institute."

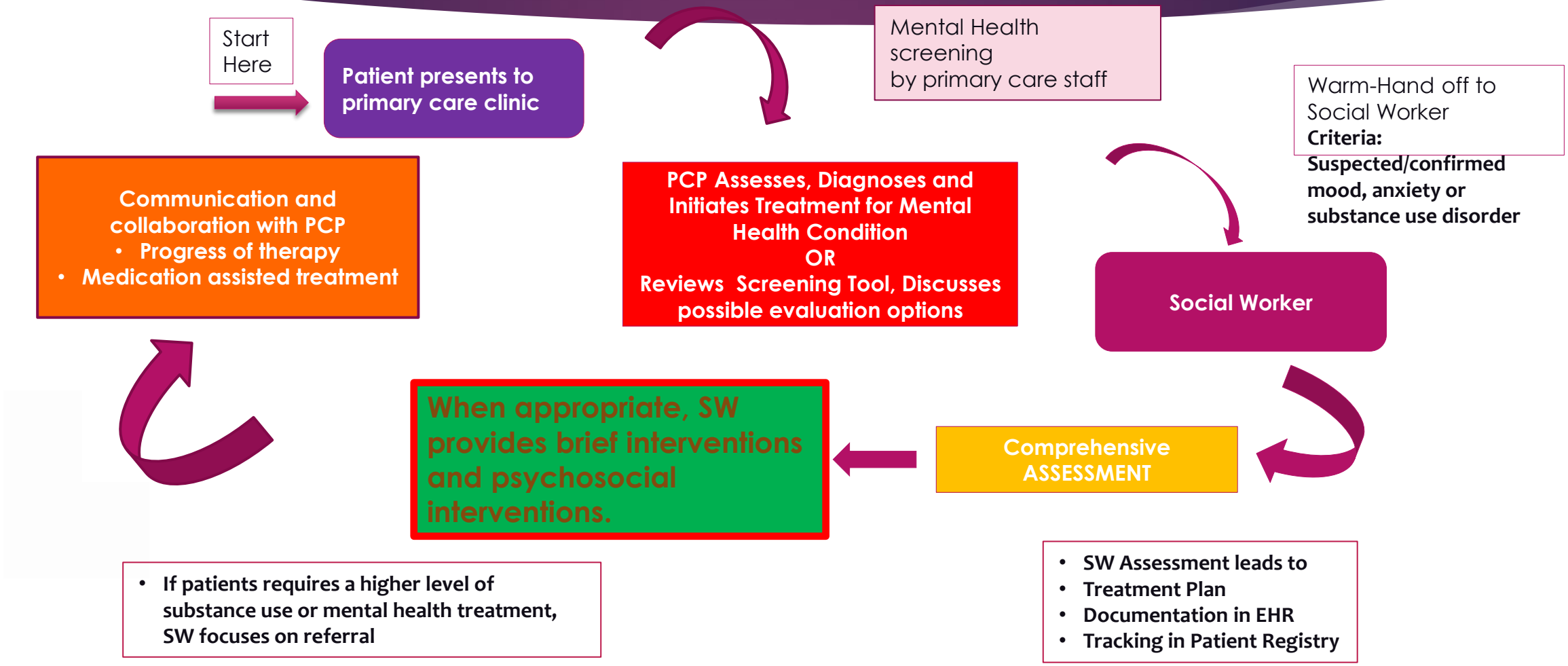
A Note about "Food Deserts"

- A better term might be "food apartheid"
- Affordability and ease of access to the foods recommended in the DASH diet
- How easy is it to bring that food home if the elder has mobility issues?
- How easy is it to prepare?

The Role of Collaborative Care (A Healthcare Model)

- Psychiatrist and social workers embedded in primary care
- Able to identify depression, anxiety, and problem alcohol use through routine screening in primary care
- Tracking symptoms
- Working across systems

Typical COLLABORATIVE CARE WORKFLOW



Collaborative Care can also Create/ Perpetuate Inequity

- PROVIDER
  - How to assess? Bias within assessment tools
  - Where to go for help? What we consider to be helpful?
  - Not enough time
  - Negative effect on relationship with patient
  - Fear of reprisal
  - "Not my job"
  - Avoidance of legal system
  - Not mandated reporters in NYS
- PATIENT (when we discount…)
  - Shame
  - Guilt
  - Embarrassment
  - Desire to keep family intact
  - Fear of retaliation e.g. nursing home placement
  - Patient consent and willingness for particular help

Telemedicine and the Elderly

- Broadband access
- Technology assistance: what is available in your region?
- Do you have staff who can help seniors connect to telehealth services?

Collaborative Care can also Create/ Perpetuate Inequity

- PARTNERSHIPS
- How to preserve agency?
- Are communities being represented through the advisory board?
- Would we consider having an elder in an advisory role?

- SYSTEMS AND INTERVENTION
  - Infrastructure that helps us understand and intervene appropriately
  - Is there data on the communities we serve?
  - Who is showing up for visits with the elder patients?
  - Are we asking the right questions?
  - Is there a restorative justice approach to the work we are doing?

Considerations of our own Biases

- Stereotype can have a significant impact on our interactions
- What stereotypes might behave about older persons of color?
- How might those impact mistreatment and intervention?

Physical Changes with Aging and Psychopharmacology

The Body Changes with Age

- Less muscle, more fat
- Slower drug metabolism
- Increased sensitivity to certain kinds of medications
- Decreased balance
- Decreased vision
- Decreased hearing

How we Metabolize Medication as we Age

- The increased body fat resulting from the ongoing conversion of muscle mass to fat and connective tissue in old age leads to an increased concentration and uncontrolled deposition of lipophilic drugs in the fat depots of the body

Pharmacology

- 5–10% of hospital admissions among the elderly are attributable to undesired side effects of medication
- **Polypharmacy**, which is defined as the simultaneous use of five or more drugs, is a particular problem among persons aged 75 to 85
- Adverse Drug Effects: psychoactive drugs (24.8%)
- Anticholinergic drugs and sedating psychoactive drugs are risky.

Psychopharmacology and Pharmacokinetics

- Longer persistence of drugs in the body
- Stronger drug effects at lower doses
- Increased side effects and toxicity
- In elderly patients, citalopram, venlafaxine, and mirtazapine should be used instead of sertraline.
- Paroxetine and fluoxetine should be avoided

AVOID Anti-cholinergic Medications

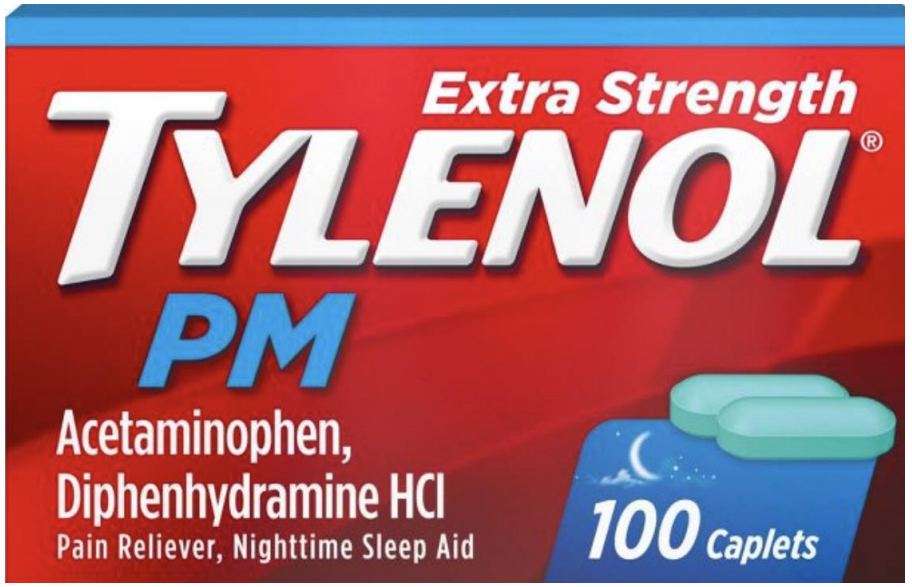
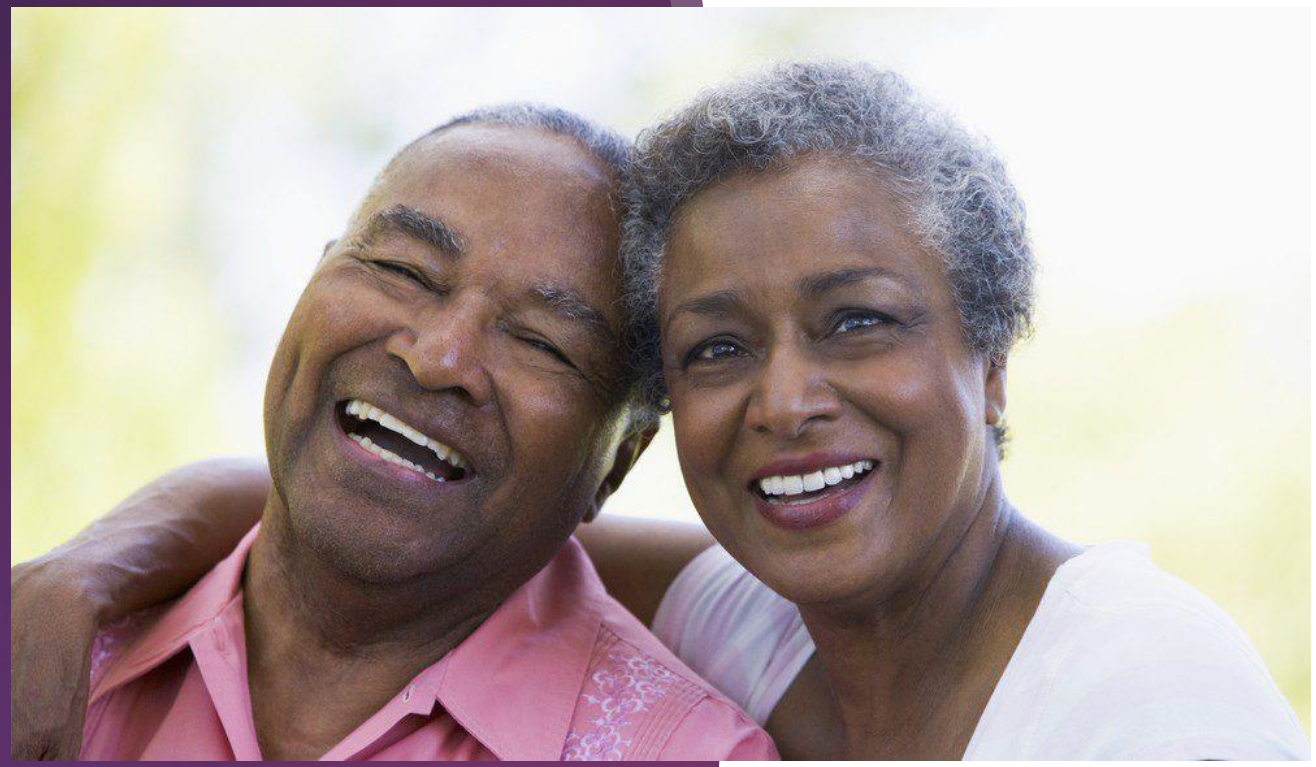


Table 2. Medication Monotherapy for the Treatment of PTSD by Recommendation and Strength of Evidence

Quality of Evidence*	Recommend For	Suggest For	Suggest Against	Recommend Against	No Recommendation For or Against
Moderate	Sertraline^ Paroxetine^ Fluoxetine Venlafaxine		Prazosin (excluding the treatment of PTSD associated nightmares)		Prazosin for the treatment of PTSD associated nightmares
Low		Nefazodone ±	Quetiapine Olanzapine Citalopram Amitriptyline	Divalproex Tiagabine Guanfacine	Eszopiclone
Very Low		Imipramine Phenelzine±	Lamotrigine Topiramate	Risperidone Benzodiazepines D-cycloserine Hydrocortisone Ketamine	Bupropion Desipramine D-serine Escitalopram Mirtazapine
No Data†					<u>Antidepressants</u> Doxepin Duloxetine‡ Desvenlafaxine Fluvoxamine‡ Levomilnacipran Nortriptyline Trazodone Vilazodone Vortioxetine <u>Anxiolytic/Hypnotics</u> Buspirone‡ Cyproheptadine Hydroxyzine Zaleplon Zolpidem

(VA/DoD 2017)



Spirituality and Elder Mental Health

Spiritual Aspects of Black Elder Mental Health

- Older African Americans who resided in the South were less likely to have any lifetime anxiety disorder, any lifetime substance disorder, and overall, any lifetime disorder than their counterparts outside of the South.
- The lower rates of lifetime disorders were thought to be attributable to higher levels of religious participation and more supportive family networks for older African Americans in the South as compared to other regions (Ford et al., 2007).

Spiritual Aspects of Black Elder Mental Health

- African Americans were more likely to utilize religious coping strategies that their White counterparts
- African Americans had a more elaborate prayer life than did Whites, including higher rates of praying for guidance and for one's health.
- A number of studies indicate that the use of prayer to cope with health concerns is especially prevalent among African Americans as compared to Whites.

(Dunn & Horgas, 2000; Mansfield, Mitchell, & King, 2002; McAuley, Pecchioni & Grant, 2000; Yeates et al., 2002)

Spirituality and Mental Health

- Faith and spirituality played a vital role in depression risk, course, and treatment in older African Americans (Jimenez et al., 2012).
- Attending religious services regularly significantly reduced the odds of a lifetime mood disorder (AOR = 0.74, 95% CI = 0.59 – 0.92) (Chatters et al., 2008).
- African Americans were more reliant on religion or religious counsel to help improve their mood because of skepticism of biological agents (Givens et al., 2007).
- African Americans felt it was important to address and incorporate their faith practices into the depression treatment plan (Wittink et al., 2009).

Spirituality and Mental Health

- The role of clergy as a mental health provider: most were thought to act as gatekeepers to mental health services (Taylor et al., 2000).
- Although many clergy were able to recognize symptoms in their congregants, they had a wide range of expertise in counseling for depression (Stansbury et al., 2009), and were found to be an important source of referral for older African Americans.

Protective Factors

- Physical activity
- Having a social life that is positive and fulfilling
- Engaging with primary care
- Processing discrimination with a supportive circle

Questions To Consider:

- Many elders who have battled substance use disorders most of their lives have ruptured relationships with children, spouses, ex-spouses, caregivers.
- Their relatives may want nothing to do with them
- What is the incentive to be sober?
- If dealing with chronic pain, what is the incentive for sobriety?
- What is the incentive for recovery?

Thank you for your kind attention!

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Resources

- Kratz T: Psychopharmacological treatment in older people—avoiding drug interactions and polypharmacy. Dtsch Arztebl Int 2019; 116: 508–18.
- www.alz.org Publications section
- Late-life Depression in Older African Americans: A Comprehensive Review of Epidemiological and Clinical Data
- https://www.cdc.gov/aging/pdf/mental_health.pdf
- Price, J. The Rising Tide of Elderly African-American Suicides, Journal of the National Medical Association, 2021
- Suicide Statistics American Foundation for Suicide Prevention

Resources

- Taylor, R, et al. Psychiatric Disorders among Older Black Americans. Innovations in Aging. 2020.
- Mayo Clinic Proceedings, "Misconceptions about Sexual Health in Older Women"