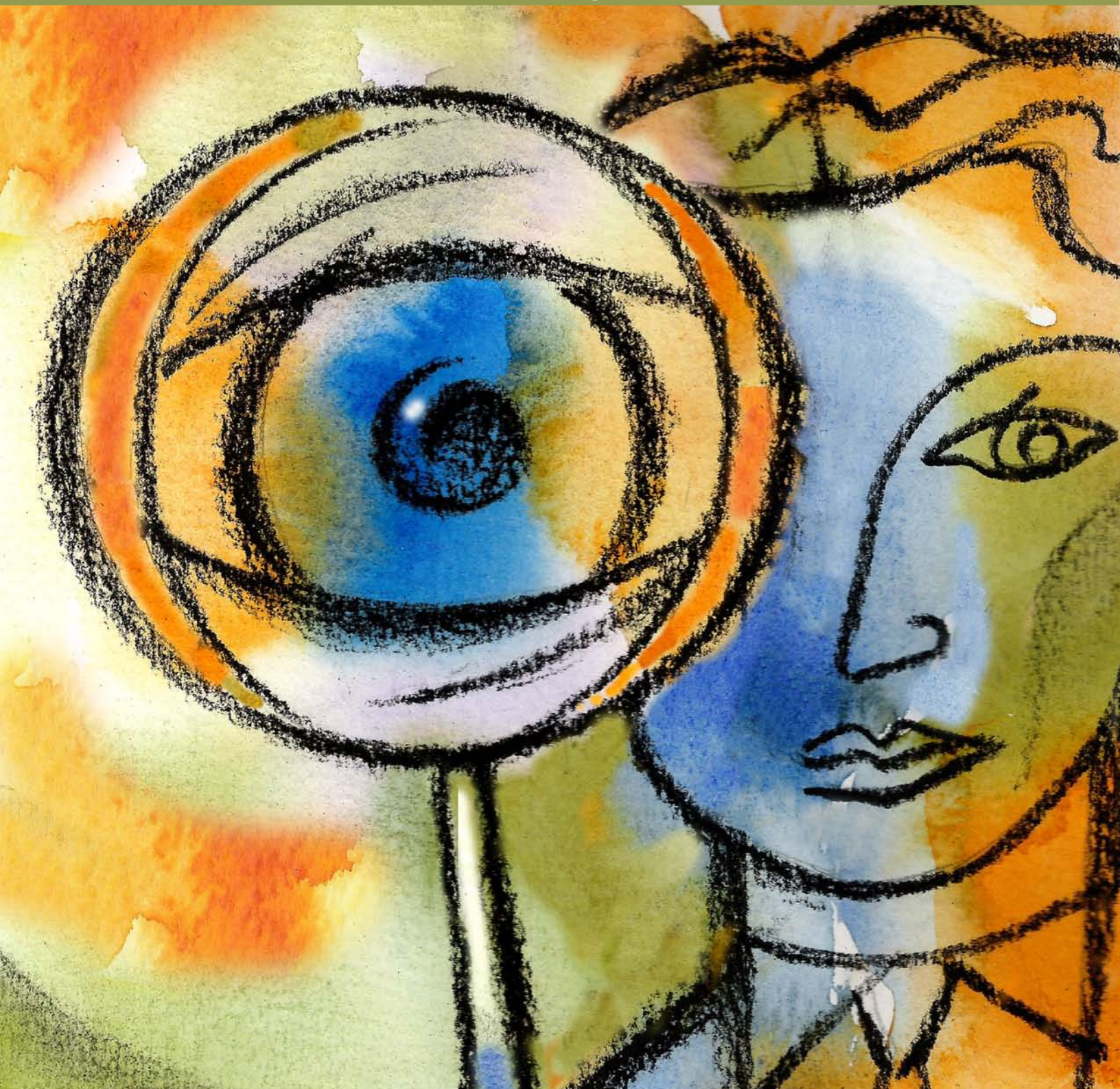


Tips and Techniques for Supporting Residents with Mental Illness: A Guide for Staff in Housing for Older Adults



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JEWISH COMMUNITY
HOUSING FOR THE ELDERLY

Tips and Techniques for Supporting Residents with Mental Illness:

A Guide for Staff in Housing for Older Adults

This guide contains basic information about the most common mental illnesses; case studies; and tips, techniques and suggested language to help people manage complex behaviors and demanding situations. It is not intended to be all inclusive, nor should the guide be used as a substitute for seeking guidance or assistance from a mental health professional.

This guide is written to address the mental health issues that often face residents in housing for older adults. It should be noted that this guide cannot address the specific mental health needs of the many cultures and language groups living in these communities. Beliefs and behaviors vary from culture to culture and this must always be considered when thinking about what is “normal “ behavior and what may indicate a mental health issue. For instance, a discussion of the “spirit’s” presence in the apartment of one culture may have a different diagnostic implication from the same discussion with a resident of another culture.

This guide is made possible by a generous grant from Combined Jewish Philanthropies - Boston Jewish Community Women’s Fund. The initiative came about when Jewish Community Housing for the Elderly (JCHE) resident service coordinators reported that they did not feel prepared to work closely with residents suffering with mental illness. A bit more research revealed that all staff, from executive directors to dining services, to accounting, to compliance, to maintenance embraced the idea of learning how they could ease the burdens of those residents with mental illness by understanding more about their illnesses and how to effectively work with them. JCHE approached members of the staff from Jewish Family & Children’s Service (JF&CS) who had been a resource in the past. Together, JCHE and JF&CS submitted the grant proposal and were funded.

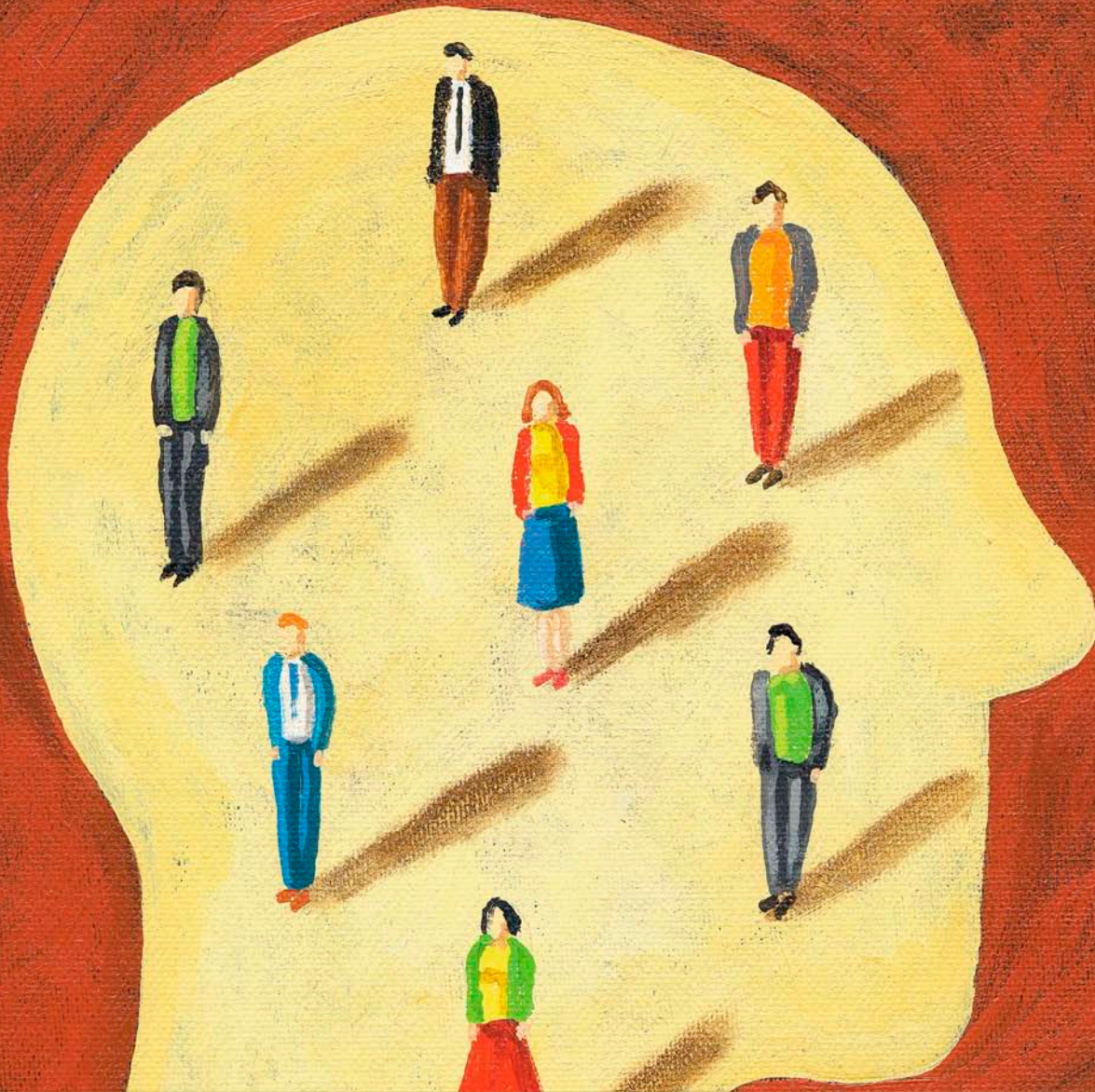
About JCHE and JF&CS

Established in 1965, Jewish Community Housing for the Elderly (JCHE) is a non-profit, non-sectarian organization that provides safe and affordable housing for low-income older adults. Housing is coupled with supportive services and life-enhancing programs that enable residents to live as independent and full lives as possible. As of early 2012, approximately 1,500 residents live in their own apartments in six JCHE buildings in Brighton, Newton, and Framingham, Massachusetts. With nearly 1,000 seniors on the waiting list, there is a six-month to six-year wait for an apartment, depending on the specific building and apartment size.

For almost 150 years, Jewish Family & Children’s Service (JF&CS) has been Greater Boston’s leading and trusted provider of comprehensive human services. JF&CS helps people of all faiths, races, and ages with the challenges of life. A caring presence in the 130 communities it serves, it is proud to be the place that new mothers, young families, people with disabilities, fragile elders, and the chronically poor can turn to for vital and personalized services. As one of the largest nonprofit organizations in the United States, JF&CS serves approximately 30,000 people annually.

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Who Might Benefit from Using this Guide?

This guide is written for those who interact with people who have mental health issues. It is not intended to be an all-inclusive study of mental illness, but rather a resource to refer to when faced with challenging behavior or, for a better understanding of the older adult living with mental illness/disorder. The context and staffing examples are from our experience and the trainings conducted at Jewish Community Housing for the Elderly. However, the tips, techniques, tools and suggested language outlined in the guide can be used

in other settings and by a variety of individuals. The contents can also be used to train para-professionals, non-professionals, family members and others who interact with people who may be exhibiting troubling behavior or mood changes.

The tips, techniques, tools and suggested language outlined in the guide can be used in other settings and by a variety of individuals.



Common Questions

What behaviors should prompt staff to intervene?

The following behaviors are cause for investigation and follow up, particularly if the behavior is not typical of the resident.

- Talking to one's self as a new behavior and/or making paranoid comments
- Any behavior that affects staff or other residents' right to the peaceful enjoyment of their homes like bullying, harassing, accusing, physical violence, or making threats
- Repeated calls to staff and/or emergency personnel (i.e. police, fire, ambulance)
- Decrease in personal hygiene (e.g. strong body odor, signs of incontinence)

When is it time to involve community partners (mental health services, police, protective services, spiritual leaders...)?

- If a resident acknowledges being depressed, anxious or in psychological distress, with her/his permission, refer her/him to a mental health professional or organization for a full assessment and treatment if indicated or, if appropriate, to a spiritual leader.
- If you have concerns about the resident's ability to care for her/himself safely, encourage the resident to agree to let you speak to a family member or the her/his care provider (primary care physician, therapist, or psychiatrist).
- If the resident refuses to allow you to contact anyone and you feel s/he might be at risk, contact your state's or local area's protective service unit.

- If the resident is in a mental health crisis, making suicidal or homicidal statements, physically assaultive or acutely delusional, contact your local mental health emergency system or the police (911) immediately.

How do I access local mental health services?

Your local contacts such as the Area Agency on Aging, Council on Aging, family service agencies, the police and/or fire departments, health clinics, visiting nurse associations and hospitals will have contact names and numbers for local mental health resources. Make these connections and introductions before you need them. Invite the local mental health services to your office/building for a visit. Ask them to make a presentation to your staff and residents about how to contact them and how they can help.

When do I set boundaries and expectations?

The end is in the beginning!
The beginning of our
relationship with a resident
(and her/his family) is crucial

to setting the tone of our work together. It is important for all staff to establish appropriate boundaries (i.e. not to overstep our job and responsibilities). When boundaries and expectations are not clear, the resident is set up for disappointment and staff may become the target of the resident's anger and frustration.

For example, a resident service coordinator went far beyond her job to help a resident who moved from another state and appeared overwhelmed. She assisted the resident by purchasing some small items for which she was reimbursed. The resident, who has some significant mental health issues, became enraged and hostile when the resident service coordinator declined to continue picking up items at the store for her and referred her to other services for assistance with some lengthy applications. The resident continues to badger and insult the resident service coordinator.

Families need to know what services are available by building staff and to be directed to other community resources when appropriate. Residents and their families should be told at move-

When boundaries and expectations are not clear, the resident is set up for disappointment and staff may become the target of the resident's anger and frustration.

in what to expect and, under what circumstances, the housing may no longer be appropriate. It is much easier to have these conversations before the need arises.

Notes

[illegible]



Essentials

The essentials include: basic assessment skills, de-escalation techniques, helpful ways to communicate with someone exhibiting a troubling behavior, and a handy list of the contact information for local mental health professionals. Be sure to update the list periodically as resources for mental health care sometimes change.

Basic Assessment Skills

Basic assessment skills are critically important when interacting with residents on an ongoing basis. Making these kinds of assessments takes practice, especially if you only see residents occasionally. Do you observe any significant changes? If so, it may be time to take action. Ask yourself the following questions.

A. Appearance

- Is the resident dressed appropriately for the weather? (e.g. wearing a parka when it is 90°)
- Are his/her clothes stained or dirty?

- Does s/he have an odor (e.g. cigarettes or alcohol; body odor; urine; excessive perfume)?
- Is s/he wearing the same outfit for several days in a row?
- Is the man unshaven or does he have an untrimmed beard (that is a change from his usual appearance)?
- Is the woman wearing unusually excessive make-up?
- Has s/he forgotten her/his cane, walker or other assistive device?

B. Speech

- Is it fast-paced, agitated or hesitant with long pauses?
- Is it too loud or too soft?
- Is what is being said logical?
- Does s/he stay on topic or keep changing topics?
- Does s/he speak clearly or mumble?
- Does s/he have difficulty answering questions?
- Is s/he using inappropriate language (e.g. swearing more than usual)?

C. Physical

- Is s/he pacing, fidgety, or agitated?
- Is s/he wringing her/his hands with anxiety?
- Does s/he have involuntary tongue or mouth movements or tremors?
- Does her/his face lack expressiveness?
- Does s/he smile or laugh while saying something very sad or worrisome?
- Does s/he stand too close to you?

D. Eye Contact

- Does s/he make normal eye contact?
- Is s/he staring at you so you feel uncomfortable?

E. Mood

- Does s/he appear sad/depressed or anxious?
- Is s/he crying uncontrollably?
- Is s/he unusually angry, hostile, or fearful?
- Does s/he report being upset, worried, fearful?
- Is her/his mood unusually elevated?

F. Cognition

- Is s/he oriented to date, time, and location?
- How is her/his short and long-term memory during normal conversation?
- Does her/his judgment seem intact (e.g. going outside without a coat in a snowstorm)?
- Does s/he express paranoid ideas (e.g. someone is out to get her/him)?
- Is s/he missing deadlines for rent checks or paying the wrong amount?

If you note changes or have concerns in any of the above areas, the first step is to make a determination if the resident presents as an immediate risk to herself/himself or others. If that is the case, follow the steps listed in the section on “When is it time...”. If not, make a reminder to yourself to:

1. Check in on the person in a few days,
2. Ask other staff members if they have any concerns about the resident.
3. Consider presenting the situation at a “Residents at Risk” meeting (see Resident at Risk section).

If you are still concerned the next time you see the resident:

1. Encourage the resident to see a physician.
2. Set up a meeting with the resident, who may be accompanied by a family member, service provider, or friend, to express your concern. If the resident does not agree to meet, ask her/him to permit you to contact a family member or service provider
3. Bring the concern about this resident to a “Residents at Risk” meeting.

De-escalation or “Talking Someone Down”

It is important to consider some possible reasons why a person might behave in a hostile or aggressive way. Factors may include:

- Frustration
- Disappointment
- Memory loss
- Fear
- Confusion
- Psychosis, especially paranoia
- Change in physical ability
- Lack of sleep
- Acute illness or medication reaction
- Intoxication (alcohol or drugs)
- Feeling powerless, real or perceived
- Insecurity
- Loss of control
- Lack of choices

Regardless of the source of the anger, it is important to know how to de-escalate a resident’s behavior. Here are a few tips:

- Do not lie or make up stories to get out of a difficult situation. This may create more problems.
- Keep safe! Do not meet with an angry resident in a closed, small space. Sit closest to the door and with access to a phone.
- In extreme situations, call for help to another staff person or to 911.

In terms of verbal communication, “I” or “we” messages often reduce tension. Some key phrases to convey respectful listening are:

- “It sounds like it is important to you that ...”

Regardless of the source of the anger, it is important to know how to de-escalate a resident’s behavior.

- “It sounds like ... is important to you.”
- “I would like to help you. Shall I set up a time with you now or shall we wait?”

At least 80% of communication is non verbal, so body language is very important. Here are a few body language tips to aide in calming a person with angry or aggressive behavior:

- Stand at a 45° angle rather than facing the person.
- Do not frown or shake your head when the other person is speaking.
- Try to keep your arms by your sides.
- Maintain eye contact but avoid staring.

Tips & Techniques and Suggested Language Speaking with Someone Who is Angry or Upset

Tips and Techniques	Suggested Language
Use a respectful tone and call the person by name.	Mr. Jones, I hear that you are very upset and I want to help. Can we talk?
If someone is verbally abusive, tell her/him you will be able to help her/him better if s/he tries to calm down.	Mr. Jones, it is hard for me to listen when I hear screaming and swearing and I really do want to hear your concerns.
If s/he raises her/his voice, lower yours.	I really want to speak with you about this.
Try not to interrupt and apologize if you need to do so.	Mr. Jones, I have to go in a minute so excuse me for interrupting but I would like to suggest some possible solutions for this problem before I have to leave.
Set limits; do not tolerate abusive language or actions.	If I you continue to swear at me, I will need to end this meeting.
Listen and ask questions and restate what the person is trying to express to clarify and avoid misunderstandings.	So Mr. Jones, if I understand correctly, I am hearing that Mr. Brown's banging on the wall is more than you can put up with anymore.
Acknowledge the importance of her/his concern and express an interest in working with her/him to resolve the problem.	Mr. Jones, we certainly want you to have peaceful enjoyment of your apartment. It is difficult to help you because no one on the staff has heard the banging. We need to figure out a way to resolve this.
Try to redirect and reframe the discussion into a problem-solving conversation rather than a blaming or accusing session.	I hear that you are very angry at Mr. Brown and staff, but we can't take any action unless we have observed a lease violation. But we can certainly have another conversation with Mr. Brown about his habits and whether he is hanging pictures or doing something else that involves banging on the wall. Mr. Jones, do you have thoughts on how we might solve this problem?
Ask questions about the situation.	Does the banging occur at the same time of day? Is it different on weekends? Have you had any other problems with Mr. Brown that I should know about?
At the end of the meeting, summarize what was discussed and try to get an agreement about "next steps." Arrange follow-up.	So Mr. Jones, I think we have agreed that you will call me or the on-call staff at night or on weekends if you hear the banging and we will try to come upstairs as quickly as possible. In the meantime we will have a talk with Mr. Brown. Please do not discuss this with him yourself. We will work together on this problem that is understandably upsetting to you. Let's meet again in a couple of days. Okay?

Staff Collaboration: "Residents at Risk" Meetings

JCHE uses the procedure outlined in this section to work with "at risk" residents. Residents whose behavior has been worrisome, problematic, or who may have a lease violation are discussed. Meetings are generally held monthly, unless more frequent meetings are necessary, and include all relevant staff. The focus is on working with the resident who is "at risk". Typical issues may include hoarding, poor sanitation or hygiene/odor, drug or alcohol abuse, or mental health/dementia issues. "At risk" residents with the potential for eviction are handled in a timely manner and with compassion.

Resident at Risk Meeting Guidelines:

- One staff person directs the meeting.
- Another staff person takes notes that are distributed after the meeting.
- Residents who have been presented at prior meetings are discussed and their progress is reported.
- A plan is then made for future action.

If a resident is found to be a hoarder, or has apartment sanitation or substantial odor problems, that resident is "at risk" for possible eviction. A staff person is assigned to follow up with the at risk

resident. S/he may visit the apartment, follow up with a letter as appropriate, and may make regular visits (weekly, monthly, or quarterly) to check on the status of the apartment and the resident. When a problem is resolved, visits cease. However visits for hoarding behavior usually continue. Progress reports are made at the monthly meetings.

New "at risk" residents are then presented and a plan is made for intervention. Staff agrees on a unified approach to a particular resident issue. Each staff member brings her/his own area of expertise or experience to the table making for a balanced approach to problem solving, and resulting in a common approach to the problem.

In more difficult situations, the Executive Director, Director of Resident Services, Property Manager, Social Worker, or other professional meets with the resident, who may be accompanied by a family member, service provider, or a friend.

Working with Residents and Families

Family dynamics are extremely complex and vary from family to family. Some families are willing and available to help provide the best care for their elders, while other families may be abusive, neglectful, intrusive, and/or controlling. Residents who have

long-term mental illness may be estranged from their families. If this is the case, staff cannot assume or expect that the family will be willing to participate in any sort of intervention. Families of those with mental illness have likely been dealing with the illness for many years and may be suffering from “burnout.”

Some family members do not accept that the older adult has a mental health problem. They may be in denial because the reality is too painful to accept. They may deny that there is a problem despite overwhelming evidence. Someone who is in denial is typically avoiding facts that they find painful or that they believe will be painful to others.

Family dynamics are extremely complex and vary from family to family.

When a family member, guardian or other responsible party is willing to help, it is important to remember that people with mental illness maintain the right to make choices about their

lives and their care unless a court has appointed a guardian. Even if their choice seems to be inappropriate, everyone retains the right to self-determination unless the person presents a danger to herself/himself or others. With the resident's permission, housing staff, family and care providers working together can often help improve the quality of life for the resident.

Dementia presents a particular challenge. It is painful for family or friends to witness cognitive decline. The changes may be gradual. Family members and others may adjust by taking on more of the resident's daily tasks like bill paying, shopping, cooking and cleaning, to mention a few.

Families sometimes hesitate to seek help from housing staff because they are fearful of jeopardizing tenancy or have promised the elder

that they will never place her/him in a nursing home. It is important to inform family and friends that early to moderate stage dementias can often be managed in housing with the proper supports in place and coordination of care.

Notes

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins or other markings on the paper.

Case Studies

The case examples chosen for this guide are a composite of real scenarios. Names and details have been altered to maintain anonymity. This section of the guide deals with common mental health issues of older adults, a description and prevalence of the illness, tips and techniques and suggested language for working with the person with the behaviors.

Hoarding

Mr. W moved in four years ago with many, many boxes. Although his first annual inspection was seven months after he moved in, Mr. W assured the staff that he was not finished unpacking and that he would be putting more things away and “thinning” his collection of newspapers. At the second annual inspection, it was clear to staff that Mr. W was a hoarder, but there were still walkways through the piles of newspapers to the windows, doors and Mr. W’s bed. Staff checked in on him periodically and let him know that he needed to reduce the clutter in his apartment. At the third annual inspection, Mr. W’s apartment was more cluttered than ever before with open food containers, canned goods, papers, vacuum cleaners and toiletries to the point where it was no longer possible to safely reach the apartment windows and doors (means of exiting). Staff worked with Mr. W using the three pile method (i.e. things that are critical like medication and soap, things that are sentimental or valuable like jewelry or photographs, and things that are unnecessary like old newspapers and magazines). Staff went weekly to Mr. W’s apartment and removed at least one box of items Mr. W had filled of things he did not need like old newspapers and items that no longer worked.

When staff talked with Mr. W about his risk for eviction, he agreed to talk with a counselor. The counselor uncovered that Mr. W only started hoarding after his wife died. The counselor spent time working through some of Mr. W’s sorrows. Staff continued to help Mr. W de-clutter his apartment by developing a plan and time line. While the apartment will never be free of all unnecessary items, he is able to keep it in a livable and inspection-passable condition.

Description and Prevalence

Hoarding is defined as the accumulation of, and failure to dispose of possessions that take over living space so that the individual can no use those spaces for the purposes for which they were intended. Furniture, including beds, may be so piled with things that there is no place to sit or lie down and passages become increasingly narrowed so that doorways, windows and emergency exits are barely accessible. It is estimated to affect 2-5% of the population and is more common in older people. Treatment is very difficult as the hoarder often has little insight and resists efforts to reduce her/his clutter. Hoarding behavior remains a poorly defined mental illness that has a great deal of overlap with other disorders.

Hoarding behaviors may be long-standing or may begin after a significant loss such as the death of a spouse.

Because of the resident’s connection and/or attachment to the possessions, s/he should be a part of the process of their disposal. Expect this to be a time-consuming process. Regular follow up with staff is needed to avoid back-sliding.

As hoarding is common in housing for older adults, and there is much written about it, this guide does not attempt to cover the topic with great detail. Please see the bibliography for more resources.

Tips & Techniques and Suggested Language Speaking with Someone Who Hoards

Tips and Techniques	Suggested Language
Always speak respectfully and refer to the resident’s possessions using her/his language.	Mr. B, I see you are very attached to your “collection” but we need there to be a clear passage to the door.
Do not make negative remarks about her/his things while being clear about the lease violations involved.	We know that you have been collecting these items for many years, but we need your help in reducing the collection so that you meet all safety standards.
Have one person who is in an enforcement role and another in a supportive role.	I know this is hard for you Mr. B. but HUD requires us to conduct a full inspection. Mary will be able to help you figure out how to pass the follow-up inspection in two weeks so we don’t have to pursue eviction.
Try to involve the resident in reducing the clutter rather than just ordering a clean-out.	So Mr. B, we need to figure out a way of clearing a path to the doorway. What are your thoughts about how we can do this?
Suggest that people who are more needy could use some of the possessions.	We can look for a homeless shelter that could use your extra appliances, and you will know your things are doing something good for someone less fortunate.

Depression

Case of Adjustment Disorder

Mrs. A, a widow, moved to housing after living in Florida for more than 30 years. Her only relative, a niece, felt that Mrs. A should move back to the area where she spent her youth. Mrs. A hated being alone in her apartment and soon began spending many hours with the resident service coordinator and the maintenance staff. She was often teary and talked about missing her life in Florida. She asked for help with everything from finding lost paperwork to arranging her furniture. Often she had trouble finding her way back to her apartment. Mrs. A refused a mental health consult and a suggestion of counseling. One staff member was assigned to Mrs. A so she knew to whom she could go to "talk." The staff member discussed interests and hobbies and connected her with a small group activity as well as a knitting project she could do on her own. In six months, as Mrs. A felt more in control and part of the community, she stopped seeking out staff.

Depression is often overlooked in older adults. There is an assumption that if an older person has suffered one or more losses, that depression is a normal response.

Case of Moderate Chronic Depression

Mrs. S has lived in housing for many years. She is currently in her mid-80's, has one unmarried daughter and few close friends. Her friends keep in touch by calling her on the phone and her daughter visits weekly. Mrs. S attends almost no activities in the building, which she had occasionally participated in previously. She has a home health aide and home delivered meals.

Mrs. S talked to the staff about having the "blues" in the past, always lasting for several weeks. She describes these as having started about 40 years ago, when her mother and husband both

died on the same day. However, when Mrs. S talks about her earlier years, when she and her husband ran a small grocery store together, she appears to have few happy memories from those times.

Mrs. S is on numerous medications for heart disease and diabetes. Her doctor does not recommend additional medications for depression. Recently she has also lost some of her vision because of macular degeneration, making it difficult for Mrs. S to read or do jigsaw puzzles, two of her favorite activities. We connected Mrs. S with a clinical social worker who makes home visits every few weeks for supportive counseling and with a low-vision foundation. They send books on tape and gave Mrs. S a telephone with large numbers and playing cards and bingo cards with large print. She now has a friendly visitor, who comes weekly to talk and play cards and bingo with her. The visitor also does puzzles with large pieces with Mrs. S.

Case of More Severe Depression

Mrs. B is 90 years old. She is an active member of her community, an avid reader and keeps up with the news. Her daughter lives in the area. After her husband died she began to lose her appetite. She lost 20 pounds and stopped engaging in building activities. She complained about the food in the dining room and blamed the menu for her weight loss. Soon she refused to leave her apartment. With her permission, a resident service coordinator spoke with her daughter. Her daughter stated that Mrs. B. had a history of depression and had previously been treated successfully with medication. However, because of her advanced age and other medical conditions, it was more and more difficult to find the proper medication for her. Her psychopharmacologist recommended electroconvulsive therapy (ECT), formerly known as electroshock. After two weeks of receiving treatments, her mood improved as did her appetite.

Tips & Techniques and Suggested Language Speaking with Someone Who is Depressed

Tips and Techniques	Suggested Language
Express concern and give a specific example of why you are concerned.	Mr. J, I have been concerned about you lately. We haven't seen you downstairs in the computer center for quite a while now.
State your belief that no one should suffer needlessly.	I am so sorry you are having a difficult time. I know you are dealing with many issues, but you don't need to go through this alone. Help is available and I will be happy to work with you to find it.
Offer encouragement and support if the first referral does not work.	Sometimes it takes a couple of tries to find the right medication and/or therapist, but I know that sticking with it can make a huge difference. I want to see you feeling better, so let's keep working together to get you the help you need.
Discreetly check in with the person and offer encouragement if you see her/him taking some positive steps.	Mr. J, it is so good to see you in the computer room again! We've missed you.

Description and Prevalence

Depression is a serious medical illness with many causes and symptoms: physical, psychological and genetic. It is a significant public health problem which is treatable, but most older adults do not receive the services they need.

- Depression is not a normal part of aging.
- Depressive symptoms are found in up to 20% of older adults who live in the community, and up to 50% of those living in nursing homes.
- Only one in six elderly people with clinical depression gets diagnosed and treated for the illness.
- The suicide rate for white men over the age of 85 is 2.5 times the rate for men of all ages.
- Between 75-80% of older people will get better with treatment that combines medication and talk therapy. Approximately 65-70% improve with medication alone, while 60% get better with psychotherapy alone. For the oldest, most frail patients, talk therapy is most effective, possibly because they have been very isolated.
- Electroconvulsive Therapy (ECT) involves the electrical induction of seizures in the brain and is proven to be effective for older adults with severe depression who may be unable to tolerate or have not responded to psychiatric medications.

There are many consequences of untreated depression:

- Lack of adherence to medical instructions
- Slower recovery from medical illness
- Decreased quality of life
- Decreased self care
- Decreased social relationships
- Increased isolation
- Increased use of health services and medications
- Increased risk of suicide and overall mortality
- Possible premature nursing home admission

Depression is often overlooked in older adults. There is an assumption that if an older person has suffered one or more losses (e.g. a loved one, independence, a home, health or physical or cognitive ability), that depression is a normal response. This is not the case.

The following is a list of changes to note when depression is suspected.

- Depressed mood most of the day
- Loss of interest or pleasure
- Changes in appetite and weight (a change of more than 5% body weight in a month)
- Sleep disturbance
- Motor retardation or agitation
- Fatigue or loss of energy
- Feelings of worthlessness, self-reproach, excessive guilt
- Difficulty thinking or concentrating; indecisiveness
- Recurrent thoughts of death, suicidal thinking or attempts

Notes

Anxiety

Mrs. S is a 94 year old woman who had many traumatic experiences during her years in the former Soviet Union. Her parents had been jailed, her father executed and she had spent time in a labor camp. She came to live in the United States twenty years ago.

Mrs. S cannot discard her many requests for charitable donations or mail involving prize offerings. She comes to the office for help with this several times a week. She worries about all of the people who might be suffering and at the same times worries that she might be throwing away a notification that she has won large sums of money.

Her donations deplete her small income and her anxiety causes her sleepless nights. Staff is unable to convince her that she does not need to give money to all charities and that all of the prize winnings are bogus.

Now when she brings her mail, the resident service coordinator patiently shows her the place on the mailing that shows that she would have to send money in order to receive her prize. She has begun to look for this herself, and can now discard the mailing in the presence of the resident services coordinator. Although she is still anxious, the level of the anxiety is much diminished.

Description and Prevalence

There are several disorders that fall under the category of anxiety:

- Panic disorder
- Obsessive-compulsive disorder (OCD)
- Post-traumatic stress disorder (PTSD)
- Social phobia (or social anxiety disorder)
- Specific phobias
- Generalized anxiety disorder (GAD).

Each anxiety disorder has different symptoms, but all symptoms cluster around excessive, irrational fear and dread. Being anxious or fearful when faced with danger or stress is reasonable. It is a normal part of human life. Anxiety becomes a mental health problem when:

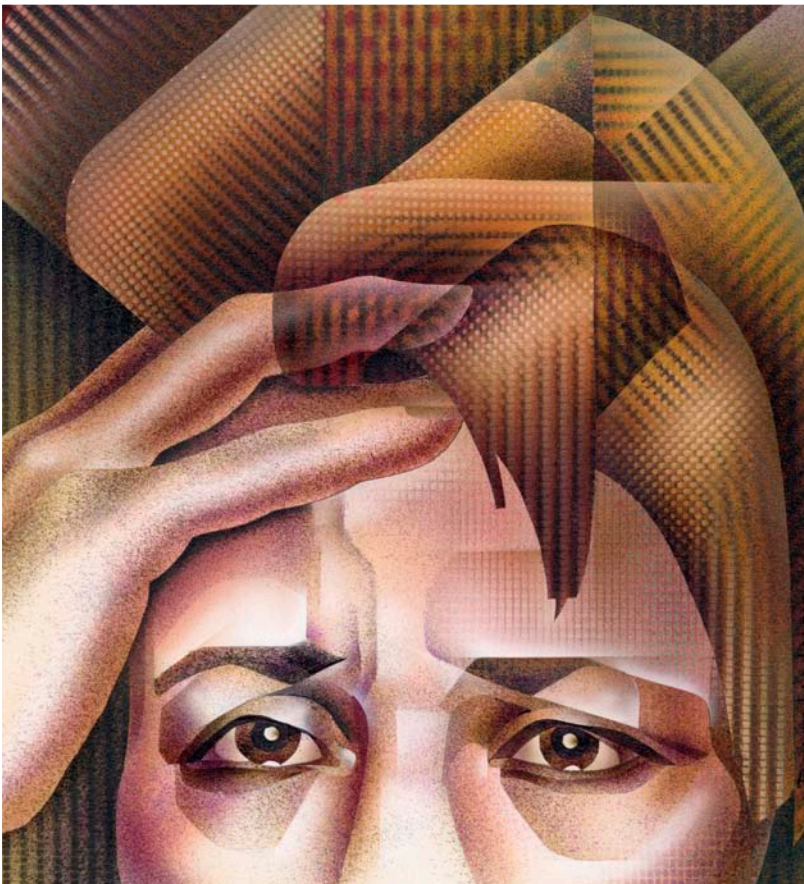
- It occurs frequently and with high intensity.
- It interferes with the older adult's ability to function and manage everyday activities.
- It occurs when there is no real threat or danger.

Unlike the relatively mild, brief anxiety caused by a stressful event (such as speaking in public or a first date), anxiety disorders last at least six months and can get worse if they are not treated. Anxiety disorders commonly occur along with other mental or physical illnesses, including alcohol or substance abuse, which may mask anxiety symptoms or make them worse. In some cases, these other illnesses need to be treated before a person will respond to treatment for the anxiety disorder.

Generalized Anxiety Disorder is the most common anxiety disorder affecting older adults. In general, anxiety disorders are treated with medication, specific types of psychotherapy, or both.

Anxiety Disorders affect up to 40 million Americans age 18 years and older (3-18%) in a given year. Up to 40% of older adults with chronic medical conditions have anxiety symptoms. As many as 71% of people with dementia have symptoms of anxiety with over 20% having a diagnosable Anxiety Disorder.

There is considerable overlap between depression and anxiety. Close to half of older adults with a diagnosis of major depression experience significant anxiety and a quarter of those diagnosed with an Anxiety Disorder also exhibit depressive symptoms. Physical complaints are common and elders often express their anxiety in terms of symptoms that might include chest pain, difficulty breathing, weakness, and pain.



Tips & Techniques and Suggested Language Speaking with Someone Who has Anxiety

Tips and Techniques	Suggested Language
Establish whether the resident is avoiding activities or tasks in which s/he used to engage.	Ms. T, I notice that you don't come to the concerts anymore. Is everything okay with you?
Establish whether s/he is excessively worrying and if anything has changed.	Mr. L, you seem so worried...Is there anything new going on with you that I might be able to help you with?
If you know s/he had a recent stressor check in with her/him as to how s/he is doing.	I know, Ms. J that your daughter and her family moved out of state and since then you haven't been coming to activities in the building. Most people would find such a move unsettling. I wonder how you are dealing with things.
Encourage treatment and reinforce the value of treatment.	Ms. J, I think the stress you are under may be increasing the headaches and sleeplessness you are describing and would encourage you to go see your doctor. There are many effective treatments to help, and I hate to see you so miserable.
Follow-up and reinforce sticking with treatment plans.	Ms. J, we haven't spoken in a couple of weeks and I wonder how it went with your visit to the doctor last week? If the doctor suggested you see someone you can talk to, I certainly think that's a good plan. Did she give you a name of someone? If not, I can help you with some recommendations.

Notes

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Dementia

Mrs. L is a 93 year old widow who has lived in her apartment for 15 years. She has a daughter and sister living in the area. She is very involved in her local religious congregation and for years was in charge of organizing refreshments for resident association programs and entertainment. Her grooming was meticulous and she exercised daily, often taking long energetic walks and participating in exercise classes.

Soon after Mrs. L's 91st birthday she began to seem overwhelmed by the task of organizing refreshments. She became quite anxious to the point where staff suggested she give up her job. On annual inspection it was noted for the first time that her apartment was cluttered with piles of paper. She didn't seem to be able to use her stove or oven properly or access phone messages from her answering machine. Occasionally Mrs. L accused staff of misplacing her possessions. Recently Mrs. L was found wandering near a local bus stop unable to find her way home.

An automatic shutoff was installed on her electric stove (<http://stoveguard.ca/>) and her answering machine was removed. The resident service coordinator has also worked with Mrs. L's sister to help her understand dementia and how to better deal with Mrs. L without becoming angry. Mrs. L now wears an identification bracelet supplied by the Alzheimer's Association. Mrs. L no longer leaves the building unaccompanied. She understands that she no longer needs to use public transportation. This also seems to have reduced her anxiety.

...

Mr. and Mrs. H had lived in housing for three years. Mr. H rarely left Mrs. H, who suffered from dementia. She began leaving the apartment at night, when he was asleep. She wandered through the building and was even found in our yard. The husband and family felt strongly that he could care for her. Staff got the family in touch with the Alzheimer's Association. They got her an ID bracelet. The family purchased a buzzing device from Radio Shack that sounded when the door opened. This awakened the husband in time for him to get his wife before she went far. The resident service coordinator got in touch with the social service agency case manager, who put more hours of service in place and also a respite worker for 2 hours/week, so the husband could re-join his weekly card game.

Description and Prevalence

Dementia is caused by the destruction of brain cells either from a disease like Alzheimer's or Parkinson's, or head injury, stroke, or brain tumor. Dementia makes it difficult to remember, learn and communicate and, after a while, for the person to take care of herself/himself. It may also change a person's mood and personality. Dementia affects approximately 13% of those aged 65 to 85, and 40-45% of

those over age 85. Often there is a multi year period when people exhibit a minor cognitive impairment in which their memory or another aspect of cognition is impaired, but they are still able to function independently. Up to 50% of people with mild cognitive impairment affecting memory develop dementia within three years. Dementia is one of the major risk factors for institutionalization.

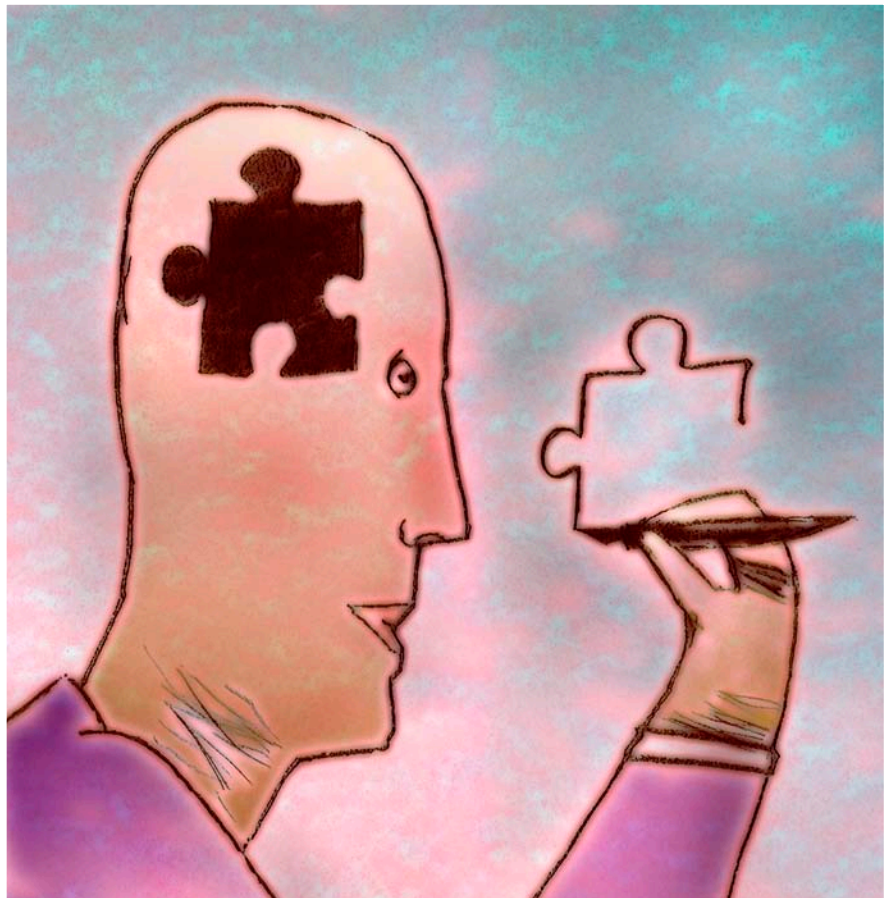
Dementia with depression

- Approximately 40% of people with dementia exhibit depression.
- Treating depression, which is often found in early or moderate dementia, results in improvement in both functioning and quality of life.
- Personality and behavior changes can develop at any stage.

Dementia with psychosis

Psychotic symptoms (hallucinations, delusions or paranoia) occur in approximately 25% of people with more advanced dementias. More than 50% of people with Alzheimer's disease manifest psychotic symptoms over the course of their illness and some have reported rates of behavioral disturbance up to 70%. Other statistics include:

- 28% experience hallucinations.
- 44% experience agitation
- 24% experience verbal aggression
- 34% experience delusions
- 18% experience wandering



Tips & Techniques and Suggested Language Speaking with Someone Who has Dementia

Tips and Techniques	Resident Says	Suggested Language
Focus on the feeling behind what the resident is saying.	I can't go in the community room now because I have to go to work.	This is such a good program; I will call your work and tell them you will be a little late. They will understand.
Do not argue.	My aide stole my watch.	Let's try to find where she may have put it.
Avoid reasoning, try to divert.	Ms. C is heading outside without a coat and it is 10° out. I have to catch the 5:00 train.	I just heard a report the train is late. While you are waiting, I hear the library just got some great new books. Will you come with me to see what came in?
Do not shame, try to distract.	How do I to get to my apartment?	That's a beautiful sweater. Is that the one you got at the holidays?
Do not lecture, instead reassure.	I'm here for the bus.	Instead of saying, "You missed the bus again," say, "No worries, the next one is ..."
Do not ask someone to remember, instead reminisce.	I don't know that girl.	Instead of saying, "Come on Mrs. P, what is her name? That's your grand daughter. I know you know it," say, "Doesn't Samantha look lovely in this picture?"
Do not say "I told you", but rather repeat.	When is lunch?	Instead of saying, "I told you already that lunch is at 12," say, "Lunch is at 12."
Do not talk down.	I drew this picture in art class.	Instead of saying, "You look so cute when you draw these pictures," say, "You are becoming quite the artist."

The most typical symptom of Alzheimer's disease is impaired short-term memory. Onset and deterioration are generally gradual. In mild dementia people can usually manage fairly well independently. A change in environment or routine, such as a hospital stay, can lead to increased difficulties and more behavioral problems.

Functional changes related to dementia that may result in behavioral and psychological symptoms include:

- Impaired short-term memory (repeating oneself)
- Forgetting appropriate public or private behavior (undressing in public)

- Misunderstanding or misinterpreting what one sees or hears
- Communication problems that may interfere with expression of needs (e.g. not being able to yell out when in pain)

A sudden onset of behavior and psychological symptoms often means the person has a new medical problem or a deterioration of an existing one. Urinary tract infections (UTI), upper respiratory infections (URI) or congestive heart failure (CHF), among others, can increase or precipitate symptoms of dementia. Sometimes behavior deteriorates when the person with dementia is constipated or has a toothache! See the section on delirium.

Notes

Is it Depression or Dementia?

Several of the symptoms of both depression and dementia are related to changes in the way we think or understand information. Knowing whether the main problem is depression or dementia is often difficult. When people are diagnosed with early stage dementia, they generally know that they are losing their memories. This loss is devastating and can lead to depression. Major Depression can include symptoms that imitate dementia.

A key technique for working with people with mild to moderate dementia is using “fiblets” or therapeutic lies to decrease the resident’s anxiety and/or to ensure her/his safety. For example, a woman with moderate dementia was no longer able to live safely independently. After a court appointed guardian arranged for the

resident to move into an assisted living facility, housing staff told the resident that her apartment was being renovated and they were putting her up at a hotel until the work was completed. She willingly helped pack some clothes and entered the assisted living. Within a few days she stopped asking about her apartment and was much less anxious than she had been previously.

Another woman with dementia came to the front desk to say that she was concerned that her children had not come home from school yet. Her homemaker was doing the laundry and the resident had come down by herself. The front desk staff told her that she should go back upstairs because school had gotten out a little late and the children were sure to be home soon. This calmed her and she was able to return to her apartment until her homemaker arrived.

Category	Depression	Dementia
Memory	Impaired concentration and worries about memory	Can't remember short-term information (e.g. what he had for breakfast)
Memory and Mood	Related - if memory is impaired, her/his mood is depressed	Not related - when memory gets worse she becomes irritable and/or dull.
Orientation	Oriented to time, place and person	Not oriented, confused
Language	Speaks, writes and uses language appropriately	Has difficulty naming objects and can not use them properly (e.g. s/he says “Hand me that thing. You hand her/him a toothbrush and s/he uses it to brush her/his hair)
Response to mini-mental (memory) status test	Feels his/her memory is worse than it is. Comments about his/her poor memory	Tries to hide or compensate for memory impairment by making social conversation or becomes irritable.

Notes

Personality Disorders

Mrs. J, a spry 80 year old twice divorced woman who had worked as a teacher at several small private schools (never for more than two years), appointed herself the head of our Resident Council, though the opinions expressed are usually hers alone and not a representation of the other residents. Several other residents have stood up to her, but she does not seem to understand, or want to, and relentlessly pursues her own agenda despite disagreements with others. Mrs. J regularly comes to a staff member’s office and is kind and sweet, often bearing small gifts of chocolates or other candies, and then walks to another staff member’s office where she begins to complain about the first staff member (referred to as “splitting”).

In an attempt to limit Mrs. J’s manipulative behaviors, we have put her on an unofficial behavior plan– attempting to create boundaries by directing her to work with a single staff member.

This reduces the incidences of splitting; to decrease her perceived power; and to ensure that she does not use one staff member’s words or actions against him or her.

Personality disorders are long-standing and maladaptive patterns of perceiving and responding to other people and to stressful circumstances. Many people living with personality disorders have experienced significant trauma in their early lives and have poor self-esteem. This makes it difficult for people with personality disorders to form and maintain interpersonal and therapeutic relationships.

Approximately one in every ten people have some type of personality disorder. The Diagnostic Statistical Manual (DSM–IV) lists ten personality disorders. If you are interested in learning more about personality disorders, see the DSM or other literature.

Tips & Techniques and Suggested Language
Speaking with Someone Who has a Personality Disorder

Tips and Techniques	Suggested Language
Set limits while offering a sense of acceptance and consistency.	I understand you do not like to go to the doctor yourself, but I am not permitted to take you.
Stress can increase problematic behaviors. For example, someone with a dependent personality disorder may exhibit increased attention seeking behaviors when faced with a new medical diagnosis.	Since receiving a diagnosis of congestive heart failure, Mrs. K has come to your office multiple times a day. Say “Mrs. K, I know how upset you are about your medical condition, but we will help you arrange the care you need.”
Minimize the effects of splitting by close communication among staff.	Discuss the case at “Residents at Risk” meeting.

Notes

Delirium

Mrs. P had early stage dementia. She called the front desk to report that there was a strange man in her apartment. The resident service coordinator and maintenance staff member went to her apartment. She calmly pointed to a chair and asked if we could make the man leave. There was no man in the chair. The resident service coordinator stayed with Mrs. P and talked to her about the man, telling her she was unable to see him. Mrs. P calmed down and said that perhaps he had left. The next day she reported seeing a man in her laundry basket. Staff called the family and suggested they take her to her physician immediately to see what might be wrong. Lab tests showed that Mrs. P had a urinary tract infection. With antibiotics, the delirium disappeared.

Description and Prevalence

Delirium is an acute or sudden state of mental confusion, with rapid changes in brain function. It is a medical crisis and requires prompt medical attention.

- Delirium is usually fluctuating and reversible.
- It affects up to 30-40% of elderly hospitalized patients.
- It is most common in older adults with an underlying dementia.
- Many disorders cause delirium, including conditions that deprive the brain of oxygen or other substances.

Causes include:

- Alcohol or sedative drug withdrawal
- Drug abuse
- Electrolyte or other chemical disturbances
- Infections such as urinary tract infections or pneumonia (more likely in people who already have brain damage from stroke or dementia)
- Surgery, hospital, rehab or nursing home stays
- Poisons

Delirium involves a quick change between mental states (for example, from lethargy to agitation and back to lethargy).

Symptoms may include:

- Confusion (disorientation) about time or place
- Decrease in short-term memory and recall
- Inability to remember events before onset of delirium
- Changes in alertness (usually more alert in the morning, less

- alert at night)
- Changes in feeling (sensation) and perception
- Changes in level of consciousness or awareness
- Changes in movement (for example, may be slow moving or hyperactive)
- Changes in sleep patterns, drowsiness
- Disrupted or wandering attention
 - Inability to think or behave with purpose
 - Problems concentrating
- Disorganized thinking
 - Speech is confused and unclear
- Emotional or personality changes
 - Anger
 - Agitation
 - Anxiety
 - Apathy
 - Depression
 - Euphoria
 - Irritability
- Incontinence

Delirium is an acute or sudden state of mental confusion, with rapid changes in brain function.

Tips For Working with People with Delirium

- Try to remain calm and keep the environment as quiet and relaxed as possible.
- Minimize the number of people involved.
- Speak slowly and clearly; do not act rushed, do not shout.
- Identify yourself each time and call the resident by name.
- Repeat questions if needed, allowing enough time for the resident to respond.
- Try to understand what the person really needs or wants.
- Educate the resident (when not confused) and family about the importance of getting prompt medical attention.
- Call 911 if the resident is unsafe or belligerent about getting help.

Tips & Techniques and Suggested Language Speaking with Someone Who has Delirium

Tips and Techniques	Suggested Language
Offer reassurance that the resident is safe.	I know you feel confused right now, Mrs. N, but I'm going to stay with you and make sure you are safe until we get some help.
Use short, simple sentences.	Want a drink of water? The ambulance is coming.

Bipolar Disorder

Mrs. P is a very intelligent, active resident and well liked by her neighbors. However, approximately once a year she begins to wear bright colors and her special pair of red sneakers. Her gait changes and her conversational style becomes flamboyant. She also begins to suspect that someone is taking things from her apartment, like books, jewelry or cash. She may also complain that staff has slighted her in some way. She is very close to her family and they see her often. Over the years staff has learned that this behavior occurs in cycles. Staff contact the family when they note these changes and the family brings her for treatment adjustment by her psychiatrist.

...

Ms. S, a 59 year old woman on SSDI, has lived with her elderly father in housing for a few years. When she appeared in common areas, she had flat affect, kept her head down, and spoke in a low tone. Ms. S had little contact with staff until recently, when neighbors began to complain about loud voices coming from the apartment on a daily basis. Staff met with the father and daughter separately; they brought along Ms. S's sister, who lived elsewhere. Ms. S came to the meeting in a low-cut blouse and short skirt. She wore garish make-up and a big blonde wig. During the session, she told us her father disapproved of the many sexual encounters she reported having had with staff members and service providers. This was the cause of their arguments.

Staff learned that Ms. S had been on psychiatric medications in the past, but was recently non compliant with medications. With her sister's help, Ms. S was persuaded to see a mental health professional for an assessment. Staff also helped her to find a day program, which she began to attend weekdays and where she was given her medications. Her sister agreed to oversee medication compliance on weekends.

Arguments stopped between Ms. S and her father. Her appearance is now appropriate.

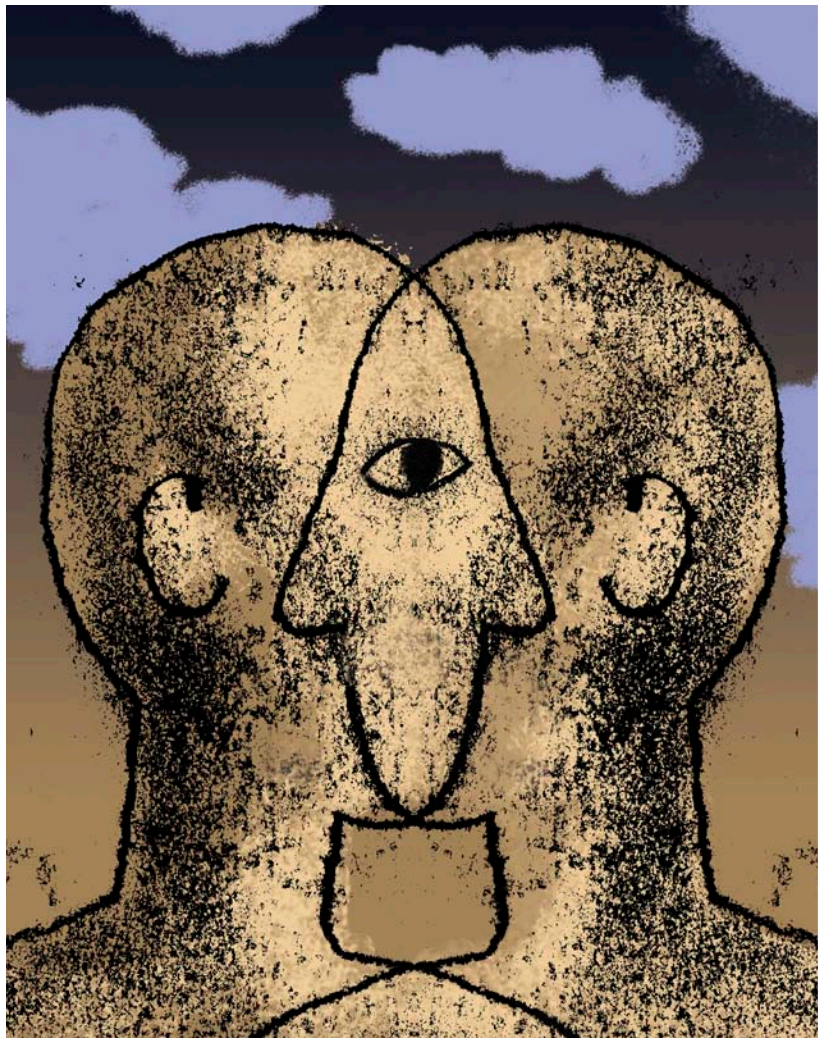
Description and Prevalence

Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes dramatic mood swings—from “high” and/or irritable to sad and hopeless, and then back again, often with periods of normal mood in between. Marked changes in energy and behavior may go along with these changes in mood. The periods of highs and lows are called episodes of mania and depression. The symptoms of bipolar disorder can be severe; however, in hypomania, behavior can appear “normal” when you don’t know the person well.

Bipolar disorder affects approximately 5.7 million adult Americans, or about 2.6% of the U.S. population age 18 and older every year. (National Institute of Mental Health).

Symptoms of mania include:

- Increased energy, activity, and restlessness
- Excessively “high”, overly good, euphoric mood
- Extreme irritability
- Racing thoughts and talking very fast, jumping from one idea to another
- Distractibility, can’t concentrate well
- Little sleep needed
- Unrealistic beliefs in one’s abilities and powers
- Poor judgment
- Spending sprees or gambling
- Increased sexual drive
- Abuse of drugs, particularly cocaine, alcohol, and sleeping medications
- Provocative, intrusive, or aggressive behavior
- Denial that anything is wrong



Bipolar Disorder can cause damaged relationships, poor job performance, and even suicide. It can be treated by medications and counseling. Like diabetes or heart disease, bipolar disorder is a long-term illness that must be carefully managed throughout a person's life.

Tips & Techniques and Suggested Language Speaking with Someone Who has Bipolar Disorder

Tips and Techniques	Suggested Language
Be supportive.	Hang in there. You are strong and have gotten through this before
Remind the resident that s/he is not alone.	There are lots of us who want to help you get back on a steady footing. Please ask if there is something I can do.
Offer reassurance and make her/him feel valued.	I know you are feeling really low right now, but I will hold on to the belief that you will get back on an even keel soon. We need your help running some of the activities.
Encourage communication with a physician.	None of us function at our best when we are not getting enough sleep. It is really important you let your doctor know you are only sleeping two hours a night.
Help the resident to be realistic about the illness.	I know you feel really good and full of energy, but in the past, this has led to a crash and we talked about how leveling out your mood was crucial to your long-term well-being.
Gain permission to speak to the resident's family and urge them to obtain help for the resident.	I'd like your permission to speak with your family because I am concerned about you.
Set clear limits on behavior in a firm but kind way.	Even though you do have a beautiful singing voice, you still may not sing in the lobby.

Tips for Working with People with Bipolar Disorder

- Encourage the resident to remain in treatment and to continue taking her/his medications as prescribed.
- Be aware of early signs of mania and depression.
- If the resident reports insomnia, that can be both a symptom and a trigger for mania. Urge her/him to speak with her/his doctor or therapist as soon as possible.
- With the resident's permission and involvement, develop a plan as to how you let her/him or a family member or doctor/therapist know if you observe signs of mania or depression.
- Encourage the resident to develop a regular routine that includes exercise and socialization.

Like diabetes or heart disease, bipolar disorder is a long-term illness that must be carefully managed throughout a person's life.

Notes

Substance Abuse

Mrs. K is an 85 year old woman from the Caribbean islands. She came to the area to join her children. She had a lively sense of humor and loved to spend time talking to staff. Her apartment was well maintained and she was well liked in the community. One evening her neighbor came to tell staff that something was wrong with Mrs. K. She was walking in the hallway clothed only in underwear and her gait was unsteady. When staff approached her she seemed unaware of her inappropriate attire. When staff entered her apartment they found clothing and food covering every surface. They also noted empty bottles of alcohol. Mrs. K stated that it was "her medicine". She was taken to the local emergency room for treatment and detoxification. Over the next several years there were infrequent episodes of bingeing alcohol abuse. A team meeting was held to plan for interventions, as her medical needs were quite complex it was decided that staff would intervene when they saw Mrs. K's grooming decline and have her see her physician as soon as possible, to avoid lengthy hospital stays. Staff also insisted on her family assisting in early interventions when needed in order for her to be able to continue her tenancy.

Description and Prevalence

Among all age groups in the United States, alcohol is the most used and abused substance. Currently, older adults generally use less alcohol and illicit drugs than younger cohorts, but this is beginning to change with the aging of the baby boomers. Many of these "younger" older adults have used alcohol and illicit substances such as marijuana and continue to do so as they age. It is predicted that by 2020, the number of people needing treatment for substance abuse will double among those over age fifty.

Substance Abuse and Mental Health Services Administration (SAMSHA) data shows that rates of illicit drug use among adults age 50-59 increased from 2.7% in 2002 to 6.2% in 2009. One out of every five adults (20%) over age 60 misuses alcohol and/or prescription drugs. Currently, non-medical use of prescription type drugs is more common than illegal drug use among those over 65. Often older adults abuse anti-anxiety medications,

sleeping pills and pain medications. Substance abuse affects up to 17% of all older adults. The risk of substance abuse increases for those who are female, socially isolated, depressed and have a history of substance abuse.

There are serious health consequences of substance abuse in older adults due to:

- High rate of other illnesses
- Changes in the way people metabolize medications as they age
- The potential for drug interactions with alcohol and prescribed medications.

Barriers to treating substance abuse in older adults include:

- Screening for substance abuse is difficult.
- The elder will often deny abuse.
- Substance use disorders in older adults tend to be under-recognized and underreported.
- Substance abuse is often mistaken as a symptom of depression or dementia.

Acute effects of alcohol and drug abuse include:

- Disinhibition (a lack of restraint)
- Impaired judgment and depression
- Depression - a common co-occurring diagnosis of substance abuse
- Suicide, a leading cause of death among people of all ages who abuse alcohol and drugs.

When a person is no longer intoxicated:

- Gear intervention toward breaking through denial of the problem
- Avoid lecturing

Tips & Techniques and Suggested Language Speaking with Someone Who is Abusing Substances

Tips and Techniques	Suggested Language
Start from a caring and affirming place.	When you are not drinking, you add so much to the community because you are such a bright and warm person.
If the resident is in a common area of the community, gently assist him in leaving; let him know you will speak to him later.	Mr. U, you need to come with me back to your apartment. I will follow up with you at another time.
If the resident is very disoriented or unresponsive, this is a medical emergency.	Call 911. Ms. A, I am calling 911 to get some help.
Focus on your concern for the resident's well-being and future tenancy while making clear what the concerns are that you or other staff have (e.g. many beer bottles littering her/his apartment; staggering, unsteady gait, increase risk for falls and smell of alcohol)	I know you do not think there is a problem, but we are concerned for your safety and well-being when you are drinking.

Psychosis

Psychosis is a loss of contact with reality, usually including false beliefs about what is taking place or who one is (delusions) and seeing, hearing, feeling, tasting or smelling things that are not there (hallucinations). People suffering from psychosis are described as psychotic. Psychosis is the most severe form of psychiatric disorder and is found in 0.2 to 4.7% of community samples.

Consequences of psychosis depending on its severity:

- A person suffering from psychosis may exhibit unusual or bizarre behavior such as wearing a hat with a wire hanger on it to receive messages.
- Severe difficulty with social interactions
- Impairment in carrying out daily life activities
- Command hallucinations can lead to injury or death (e.g. the person believes he must jump in front of a moving vehicle to save the world).

Common causes of psychosis:

- Delirium has been reported to be the third most common cause of psychosis in elderly outpatients.
- Alcohol and certain illegal drugs, both during use and during withdrawal
- Brain tumors or cysts
- Dementia (including Alzheimer's disease)
- Degenerative brain diseases, such as Parkinson's disease, Huntington's disease, and certain chromosomal disorders
- HIV and other infections that affect the brain
- Some prescription drugs, such as steroids and stimulants
- Some types of epilepsy
- Stroke

Psychosis is also part of a number of psychiatric disorders, including:

- Bipolar disorder (manic or depressed)
- Delusional disorder
- Depression with psychotic features

- Schizophrenia

Psychotic symptoms may include:

- Disorganized thought and speech
- False beliefs that are not based in reality (delusions), especially unfounded fear or suspicion
- Hearing, seeing, or feeling things that are not there (hallucinations)
- Thoughts that “jump” between unrelated topics (disordered thinking)

A new, acute onset of psychosis should be treated as a potential emergency, as it might indicate a delirium, drug reaction, or other serious medical problem. Because people who are psychotic have significantly impaired judgment and may be responding to their hallucinations and delusions, they can be a danger to themselves or others. This always needs to be evaluated and, depending on the nature of their false beliefs, may require emergency psychiatric evaluation and hospitalization.

A new, acute onset of psychosis should be treated as a potential emergency as it might indicate a delirium, drug reaction, or other serious medical problem.

Tips for dealing with psychosis

- Express concern for resident's health and well being and urge her/him to seek medical attention.
- Focus on a physical ailment and see if you can suggest the resident seek help for that.
- If there are concerns for the safety of the resident, staff or other residents, call 911.

Possible risk factors for developing psychotic beliefs:

- Impaired hearing and vision
- Social isolation, or severe depression
- Negative life events
- Financial strain
- Lower education level
- Post-traumatic stress disorder
- Language barriers

Notes

Paranoia

Mrs. A is an 82 year old widow who has lived in the building for five years. In the last several weeks she has made multiple calls to staff complaining about sounds coming from the apartment above her. She complains that the resident above her (whom she does not know) is banging on the floor so that she is woken from a sound sleep. Mrs. A insists the woman is “attempting to force her to move out because she knows she is originally from another state.” The upstairs resident is a frail 90 year old, who lacks the strength to bang on her floor and has no history of disturbing behavior. In fact, she denies Mrs. A’s reports stating she was not even in the apartment one of the nights that Mrs. A complained. Staff helped her arrange an appointment with her Primary Care Provider. After a full work up, it was determined that Ms. A had Tinnitus (chronic ringing in the ears). We purchased a white noise machine for her, which seemed to help.

...

Mrs. K reports that several people, either singly or in groups occupy her apartment. She also reports that “they” often spray poison in her apartment, install cameras to watch her, especially in the bathroom, install listening devices, threaten and attempt to steal her belongings, especially her car, and make noises to keep her awake at night. At Resident At Risk meeting, it was decided that staff would consistently respond to Ms. K with reassurance that she was safe. Calls to staff diminished over time.

...

Mrs. M is a well groomed woman who frequently reported strange happenings. It began during pest control several years ago, when she reported that a pearl necklace had been stolen. The following year, she reported that her black bras (but not her white ones) were missing. After that, Mrs. M frequently reported the presence of poison gas in her apartment, pumped



in through vents, the sink, and the HVAC unit, which she blamed on Maintenance, other residents, or unknown sources, at different times. She believed that the gasses were killing her husband, who was already ill. She continued to report missing items as well. A resident service coordinator went to help her look for her things, which were not found. She continued to complain of items being “stolen.” We changed her locks, but her behavior never improved. We changed her locks, but her calls did not diminish, despite monthly meetings with the RSC. Eventually she chose to move to another housing development.

Description and Prevalence

Paranoia falls under the category of psychosis and is characterized by organized delusions of persecution (e.g. thinking that one or more people are against them). People who suffer from paranoia are often isolated and feel that they can not depend on anyone. Paranoid symptoms are quite common in community dwelling older adults, and can represent a sudden change in the way a resident is behaving.

Tips & Techniques and Suggested Language Speaking with Someone with Paranoia

Tips and Techniques	Suggested Language
Speak in simple sentences and try to be as clear as possible to avoid misinterpretation.	Can you tell me why you are upset?
Have the resident restate what you have said if it is important to make sure you are both on the same page.	I understand that you are concerned about the electrical wiring in your apartment. Tim from maintenance will come check the wiring. Can you tell me what Tim is going to check?
Be accepting, yet firm - Delusions are very real to the person having them. State what your perceptions are while acknowledging the resident may feel differently.	I understand that you are concerned that what you smell is poison gas. I wonder if it could be the truck exhaust coming from outside your window?
Anticipate triggers – stress or change often increases symptoms. Try to give as much time as possible if you know something is likely to be upsetting to the resident such as annual inspection visit.	Mrs. J, I want to let you know we’ll be doing your annual inspection visit on the 18th of April, one month from today.
Try to have positive interactions with the resident that are not based on his symptoms. Acknowledge her/his strengths and the positives she offers.	Mrs. V, you have the most beautiful shoes. Where do you get them?

Fixed Delusions

Since he first moved in, Mr. R has complained about his upstairs neighbors. When the first neighbor – who was “too noisy” – moved out, the new neighbor was accused of constantly running water and disturbing Mr. R’s ability to rest. There was no sign of water being run continuously in the upstairs unit or any apartments nearby; often there was no one home. Mr. R’s response was that “they just stopped” or “just went out.” “They knew you were coming to check.” Mr. R began visiting his upstairs neighbor, wrote a nasty letter, and even threatened to punch the neighbor. He said he didn’t care if he was evicted, since the noise of running water was worse than death.

Staff checked any possible cause/source of noise and found nothing. Staff suggested that Mr. R keep a log of every time he heard the water running. Staff met with Mr. R to reassure him that we were doing everything possible to identify the source of the noise.

Description and Prevalence

Delusions are fixed, false ideas or beliefs that are not consistent with the person’s educational, cultural or social background, but are held to strongly despite evidence that does not support the belief. The delusions are “fixed” because no matter how good your argument is or no matter what proof you provide to show the resident that her/his belief is false, s/he insists on the delusion.

Some ideas are possible (non-bizarre), such as having a cheating spouse, or a terminal illness. Others are bizarre, such as the belief that you have some extraordinary power (often God-given). These are beliefs that are not shared within the person’s culture or religion.

Delusions vary in severity from mild (delusions are not bizarre and the person either feels little pressure to act upon the delusional beliefs and are not very bothered by the beliefs) to very severe (severe pressure to act upon beliefs or is very bothered by them). If the delusions don’t interfere with the person’s functioning s/he generally does not require treatment and often will not respond to treatment.

A hallucination involves the senses: hearing, seeing, smelling or tasting something that is not real. In delusional disorders, tactile (touch) and olfactory (smell) hallucinations may be prominent if they are related to the delusion, such as: bugs are invading, or the resident smells poisonous gas coming from the vent. Approximately 3% of people will experience psychosis (losing touch with reality through hallucinations, delusions or disorganized thoughts) at some time in their lives.

Causes of delusions include:

- Delirium
- Problems with perception (visual or auditory are common)
- Mood disorders
- Psychotic disorders (including substance-induced psychosis)
- Organic disorders (such as dementia or Parkinson’s disease))

The delusions are “fixed” because no matter how good your argument is or no matter what proof you provide to show the resident that her/his belief is false, s/he insists on the delusion.

Consider the following questions related to delusions:

1. Does the delusion place the resident or others at harm, immediately or later?
2. Is the delusion disturbing to the resident or to others?
3. How severe are the symptoms? Does the resident mention them occasionally vs. constantly? Can the resident be redirected?
4. Has the resident acted on them in the past...and how? What is the resident’s level of impulsivity?
5. Does the delusion impact or impair daily functioning and/or socialization?
6. How much reality testing has the resident lost as a result of this delusion?
7. Does the delusion affect the resident’s mood?

Supportive psychotherapy helps by increasing medication compliance, providing education and minimizing risk factors that increase symptoms.

Tips & Techniques and Suggested Language Speaking with Someone Who is Having Delusions

Tips and Techniques	Suggested Language
Do not insist the resident is wrong. Show that you respect his/her point of view and gently offer your own understanding or impression of the situation.	I do not see the ants crawling on the floor as you described. I do see some crumbs. Let’s sweep them up and see if that helps.
Try to obtain as many details as you can about the delusion.	Who is trying to hurt you? Could you think why? How might this happen?
Try not to take the accusations personally even if directed at you.	I’m sorry that you think I’ve stolen all your plants.
Let the person know that you acknowledge the feelings that can be evoked.	It must feel very frightening to think that there is a conspiracy against you.

Tips for Working with People with Delusions

- Try to develop a relationship based on empathy and trust.
- Promote effective coping strategies for stress or anxiety that may act as triggers.
- Encourage compliance with treatment including medication, counseling, avoiding alcohol.
- Promote social engagement and physical activity.
- Ensure effective collaboration with other service providers.
- Delusion is a protection and can be an escape for the person. Understanding this helps staff tolerate the person's behavior.

It can help staff to show that they care and know how difficult life may be for the resident.

- Collaboration, involving others in whatever approach is developed, is a way to stretch the support and reinforce the plan.
- Residents with delusions can be frightening and difficult to work with. Be aware of your own feelings and be sure to get some support in dealing with this. Talk to colleagues, your supervisor or a mental health professional.

Notes

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins or other markings on the paper.

Schizophrenia

Ms. M is a 69 year old woman who has lived in housing for four years. She was diagnosed with schizophrenia at age seventeen and continues to have persistent auditory hallucinations. A former heavy smoker, she is now on constant oxygen for Chronic Obstructive Pulmonary Disorder. After a psychiatric hospitalization; a result of stopping her medication, and resulting acute psychotic behavior, Ms. M was allowed to return to housing. The agreement for her return included the following stipulations: participation in an adult day program twice a week and medication compliance checks on non-program days by a home health aide. She sees a doctor, nurses and a social worker there and is now compliant with her medications and has stopped smoking. She has learned to deal with her auditory hallucinations, in which she is told to do "bad things," such as smoking, by telling the voices to be quiet and that she will "talk to them later." Ms. M is friendly with several other residents and has good relationships with staff.

Description and Prevalence

Schizophrenia is a psychotic disorder that impairs a person's ability to link thought, emotion and behavior. Schizophrenia may alter the capacity to process information, produce and understand language, problem solve, or make decisions. Memory and the ability to focus or pay attention can also be affected. Although schizophrenia is commonly thought of as an illness of young adulthood, it can both first appear and extend into later life. The criteria used for diagnosing schizophrenia are the same across the life span.

Schizophrenia among those 65 years or older is reportedly around 0.6 percent, about one-half of the estimation for the population aged 18 to 54. Women were more likely to develop late-onset schizophrenia, and paranoia as a predominant feature of the illness.

For a person to be diagnosed with schizophrenia he or she must have both positive and negative symptoms as follows:

Positive symptoms are those that people without schizophrenia will rarely experience; they are an excess or distortion of normal functions including:

- Delusions—often bizarre
- Hallucinations (e.g. hearing "voices" is the most common type in schizophrenia)

- Distorted language and thought process (e.g. loose associations, "word salad" speech)
- Behavior (e.g. sitting for hours without moving or talking)

Negative symptoms include:

- Flattened mood, poor eye contact and reduced body language
- Slow and reduced content in thoughts and speech
- A lack of goal-directed behavior; no motivation
- Social withdrawal
- Neglect of basic personal hygiene

Cognitive symptoms include:

- Impaired "executive functioning" (i.e. the ability to understand information and use it to make decisions)
- Trouble concentrating or paying attention
- Problems with using information s/he has just been given

The drugs used to treat schizophrenia can cause weight gain, diabetes, thyroid problems, and a host of other medical concerns. Close medical treatment is essential.

Tips for Working with Someone with Schizophrenia

Schizophrenia alters the way a person processes information including attention, remembering, producing and understanding language, solving problems, and making decisions.

- A thorough medical and psychiatric evaluation is crucial. Because antipsychotic medications are usually required, psychiatric monitoring is necessary. Staff should encourage a resident to contact her/his care providers if there is any change in her/his medical or psychiatric symptoms.
- Assisting a resident to form relationships with other residents in the building can help prevent social isolation and a worsening of symptoms.
- Encourage participation in exercise and social programming in the building and/or community.
- If possible, obtain permission from the resident in advance that you may contact a family member or care provider if you have concerns about his/her behavior and s/he is unable or unwilling to make the call.
- Follow the suggestions in the section of this guide: **Tips and Techniques and Suggested Language - Speaking with Someone who is Angry or Upset**

When is Eviction a Tool and When is it a Necessary Alternative?

Evacuation can be used as a tool to strongly encourage the resident to seek or accept intervention in order to effect an improvement in behavior.

Mr. D moved into housing from a home he had shared with his father. After his father's death, his spiritual leader suggested he apply for subsidized housing. Mr. D appeared "different" from other residents; all during the year, no matter what the weather, he wore several sweaters, a heavy winter jacket, and a winter hat. Initially, he spent little time in the building, spending his days at local libraries, preparing a lawsuit against his cousin over ownership of his father's house. In his younger years, Mr. D had been a writer and wrote a book. Because he had not worked for ten years, the housing staff helped him obtain SSI.

After several years, Mr. D began spending more time in his apartment. He began expressing thoughts that "young teen thugs" were threatening him from the street (while Mr. D was in his 10th floor apartment) and that the cleaning staff were "contra-rebels." All thoughts were expressed to resident service staff; messages were left on answering machines at night, or to the community service police officer, also at night when no one was present. Leaving these messages seemed to calm Mr. D's anxiety so he could sleep at night.

Mr. D also began to interact with neighbors in a distressing way. He would spray their doorways with Lysol and, if he heard neighbors leaving their apartments, he would slam his door 30-40 times. Occasionally he would bang on his next door neighbor's wall late at night.

Neighbors wrote a petition to have Mr. D removed from housing. Letters from management and meetings with senior staff

did not stop the behaviors. Mr. D was unwilling to see a mental health professional or take medications, which he felt would have bad side effects. Finally, an eviction letter was sent by the housing's attorney. After getting the letter, Mr. D applied to other housing complexes, but he soon realized there were no other housing availabilities in the near future, or perhaps ever.

Mr. D increased his nighttime calls to staff and police and began calling local newspapers and national magazines, again at night. However, the nighttime calls to staff stopped when Mr. D was directed to only call one resident services staff person. This directive and especially the fear of losing his housing through eviction stopped almost all of the annoying behaviors towards neighbors.

Sometimes, eviction is the only alternative.

Dr. Y, a former chemist in China, had lived in housing with his wife for ten years. Both spoke English; she had participated in activities prior to breaking her hip. The broken hip led to other medical issues, causing her to go to a nursing home; she died not long after nursing home placement. Dr. Y remained in the housing and soon began conducting "experiments," one of which was making "healthy yogurt" in large containers in his bathtub. Foul odors and rats followed, with all of his neighbors complaining daily. Dr. Y's daughters were unable or unwilling to curtail his behavior; meetings with housing management and the health department led to only temporary changes in behavior. Management's lawyer sent an eviction letter, and the family retained a lawyer for Dr. Y. The housing court ruled in favor of the housing, and Dr. Y moved in with one of his daughters.

Eviction can be used as a tool, but sometimes it is the only alternative.

About the Authors

Marsha Frankel, MSW, LICSW, is a clinical social worker and serves as the Clinical Director of Senior Services at Jewish Family & Children's Service. She provides clinical oversight to a number of agency programs that work with older adults including Geriatric Mental Health, Care Management and the Parkinson's Family Support Program. Marsha has many years of experience working with older adults in a wide range of community and institutional settings. She is a frequent presenter and trainer on topics ranging from Geriatric Depression to Social Bullying among Older Adults.

Gaye Freed, MSW, LICSW, has worked at Jewish Community Housing for the Elderly in a variety of positions for 29 years. In her current position as Executive Director of the Brighton Campus, she oversees a community of more than 900 older adults from at least sixteen language and cultural groups. Gaye has a Master's Degree in social work, with specialties in Gerontology and Human Services Management.

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Caren Silverlieb, MMHS, received her Master's Degree in the Management of Human Services with a concentration in Aging from the Heller Graduate School at Brandeis University. Over the last 25 years, Caren has held a number of executive management positions in community-based long term care programs, affordable housing, and assisted living. She is currently the Director of Strategic Planning and Partnerships at JCHE.

Kathy Burnes, M.Ed., received her Master's in Education from Northeastern University. Kathy is project manager of the Jewish Family & Children's Service Geriatric Institute. She develops and implements a range of initiatives that translate research into community-based practices to improve the health and well-being of older adults including programs in fall prevention, depression detection and suicide prevention, and healthy aging.

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www.samhsa.gov - Statistical or summary reports from the government about drug, alcohol and mental health issues

www.alz.org - Alzheimer's disease and related dementias

www.everydayhealth.com/alzheimers/alzheimers-hallucinations-and-delusions.aspx - Dealing with the delusions and hallucination of people with Alzheimer's disease

www.nimh.gov - National Institute of Mental Health

www.nimh.nih.gov/health/publications - National Institute of Mental Health/National Institute of Health

www.mentalhealth.org - Substance Abuse and Mental Health Services Administration-National Mental Health Information Center

www.nami.org - National Alliance for the Mentally Ill

www.nami.org/multicultural - Working in a multicultural environment

MACenter@nami.org or call 703-524-7600 - Hard copies and subscription information

www.nihseniorhealth.gov/anxietydisorders - Anxiety Disorders

www.dbsalliance.org - Depression and Bipolar Support Alliance

Mental Health Partners Resource List

Resource	Contact Name	Phone Number	Fax Number	E-mail	Notes
Police (non-emergency)					
Hospital Mental Health Unit					
Area Agency on Aging					
Health Clinic					
Council on Aging					
Mental Health Professional					
Mental Health Professional					
Family Service Agency					
Visiting Nurse Association					
Spiritual Leader					
Protective Services					

Mental Health Partners Resource List

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