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Mental Health and Older Adults
Psychosocial OT Approaches in a
General Treatment Setting

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Learner Outcomes

As a result of this course, participants will be able to:

1. List psychiatric and mental health conditions most commonly found in older adults and describe the multiple factors that can contribute to impaired psychosocial functioning and decreased quality of life in older adults

2. Describe strategies for decreasing agitation, confusion, distress and anxiety in older adults and psychosocial OT evaluation tools and interventions to use when working with older adults in general (non-mental health) treatment settings

3. Explain ways to use OT fieldwork students to expand psychosocial treatment options in general (non-mental health) treatment settings
Mental Health Needs of Older Adults (OA) Are Frequently Overlooked In Healthcare

- Psychiatric disorders and emotional, behavioral, and cognitive problems are present in a majority of skilled nursing facility (SNF) patients (SAMSA.gov)

- However, it is difficult to precisely quantify the extent and types of problems because these conditions are not always the primary reason for placement at a SNF and are not always accurately reported in patients’ medical records

OT’s Roots are in Psychiatry (AOTA, 2014)

- Occupational therapists are trained in mental health assessment and intervention, but their skills can be underutilized in clinical practice with OA in SNFs and other physical rehabilitation (rehab) settings

- The explanation for this underuse are varied and include the complexity of geriatric care and the fact that therapists’ roles in older adult rehab, as dictated by third party reimbursement guidelines, tend to emphasize building physical strength and flexibility and improving activities of daily living
A majority of OA OT clients meet the criteria for a DSM V psychiatric diagnosis or have substantial psychosocial concerns because of:

- Later in life onset of:
  - Dementia
  - Depression
  - Anxiety

- Pre-existing serious mental illness including bipolar disorder, schizophrenia, post traumatic stress disorder and substance abuse

- Psychosocial concerns related to aging

**DMS V Dementia-now called major neurocognitive disorder**

- **Partial list of criteria**: acquired short and long-term memory impairment, with at least one additional comment impairment (abstract thinking, judgment, etc.) that interferes significantly with work, social activities or relationships with others (APA, 2013)

- Dementia is a major public health concern with considerable costs to society, family and caregivers

- Managing behavioral symptoms such as agitation, aggressiveness, or resistance to care, are customary with the diagnosis and occur throughout the disease stages

- Agitation causes family upset, heightens risk of assaultive behavior and resultant injury, increases the need for caregiver time and decreased quality of life for the OA (Lysack et al. 2013)
DSM V-Major Depression-Now called persistent depressive disorder and includes both major depressive disorder and the dysthymic disorder.

◆ **Partial list of criteria**: low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, feelings of hopelessness, lasting for at least 2 years

- Major Depression in skilled nursing facilities (SNF) may be as high at 25%-35% of all patients (SAMSA.gov)

- Reactive depression (subtype of persistent depressive disorder) is also common among SNF patients and OA who have experienced disease or trauma because of the new and unfamiliar environment or challenges require OA to rethink ways in which life and ADLs will occur (SAMSA.gov)

  - Adjustment can take a few weeks to several years. Depression is a common reaction to this adjustment
  - The consequences of untreated depression are serious and include increased risk of additional disability and even death

DSM V-Anxiety (Generalized Anxiety Disorder)

◆ **Partial list of criteria**: the presence of excessive anxiety and worry about a variety of topics, events, or activities occurring more often than not for 6 months

- Anxiety disorders in SNFs may be as high as 55% of SNF patients (SAMHA.gov)

- Anxiety in OA patients is associated with many negative physical, functional, psychological and social consequences including decreased physical activity, social interaction, quality of life and increased activity avoidance

- Anxiety and its consequences impair rehabilitation and recovery and is associated with loss of independence and identity (Lysack et al. (2013))
Pre-Existing Major Psychiatric Disorders

- The number of individuals with major psychiatric disorders, e.g. schizophrenia, bipolar disorder, beginning early in life, residing in SNFs today surpasses the number in psychiatric hospitals (SAMSA.gov)

- Anecdotally, the numbers of patients being admitted to SNFs with a primary and major psychiatric diagnosis seems to be increasing. Many are placed in a SNF as “long term residents” if they can no longer be cared for by aging family members

Even without meeting criteria for a DSM V psychiatric diagnosis changes in performance skills associated with aging has a major impact on the mental health of OA

Motor Skills  
Process Skills  
Social and Communication Skills
Motor Skill Changes

- Decreased motor coordination, leading to difficulty multi-tasking and decreased sense of efficiency
- Slower reaction time, leading to decreased confidence
- Unstable balance, leading to decreased risk taking and trying new activities
- Diminished energy, leading to frustration

Process Skill (Perception) Changes

- Increased sensitivity to hot and cold, leading to discomfort
- Increased sensitivity to pain, leading to recoiling from everyday touch
- Diminished vision, leading to less interest in reading and watching movies and inability to recognize others
- Diminished hearing, leading to less socialization
- Diminished ability to taste, leading to enjoying food less
- Decreased sensory sensitivity, leading to sensory deprivation (Levy, 2011)
Process Skills (Cognitive) Changes

- More difficulty assimilating disparate parts into wholes under conditions of speed, leading to difficulty distinguishing between what is salient and not salient in a task
- More difficulty ignoring irrelevant details
- Slower processing, taking longer to learn

All leading to disengagement (Levy, 2011)

Cognitive Aging

- 70 & 80 year olds are understandably anxious and worried about “losing my edge” because of slowed information processing and memory.
- “They recognize that memory is the neural sum of who they are, who they have been & who they hope to be and to lose memory is to lose their sense of identity” (Levy, 2011, p.120)
Social and Communication Skills Changes

- Experience of loss, leading to isolation
- Flatter affect, leading to less interaction
- Increase in rigid thinking, leading to less friendships
- Dampened enthusiasm or concern leading to less participation (Levy, 2011)

Social and Communication Skills Changes

- Loss of intensity of responses and facial expressions, leading to other people thinking the person is disinterested
- Less feelings of amusement, contentment and happiness (Levy, 2011)
Social and Communication Skills Changes

- Diminished energy might slow recovery from hurt or depression.
- Diminished ability to remember recent events may make it more difficult to respond to events with the appropriate emotions.
- Concerns about health issues, money, family problems, or possible disaster may decrease resiliency. (Levy, 2011)

Social and Communication Skills Changes (surprising changes)

- Less shyness
- Emotions are more complex and experienced more intensely
- More control of emotions from practiced strategies of ignoring, forgetting and distracting
- Significant decrease in the emotion of anger and more acceptance. (Levy, 2011)
Client Factor Changes

- Increased ability to fall and stay asleep
- Increased digestive upset
- Decreased bowel and bladder control
- Increased aches and pains

All leading to possible irritability and isolation

Feelings Generated by Changes

- Fear
- Anger
- Hopelessness
- Sense of loss
- Threatened
- Vulnerable
- Rejected

- Focused on the past
- Miserly
- Abandoned
- Misunderstood
- Invisible
- Dependent
- Powerless
Feelings Potentially Leading to Challenging Behaviors

- Denigrated
- Frustrated
- Hesitant
- Cautious
- Impulsive
- Reactionary
- Defiant
- Rejected
- Inconsistent
- Agitated
- Resistive
- Uncomfortable
- Agitated
- Restless
- Confused
- Victimized

All Of This Is A Call To Action For OTs As We Treat The Whole Person

- The Center for Medicare and Medicaid (CMS) has recently provided some extra support for psychosocial intervention
- Adding abilities care and sensory modulation model approaches can effectively improve the mental health of all OA OT clients
- OT fieldwork students can provide much support for psychosocial intervention

continued
CMS Mandates “Person Centered Care”

◆ Care must be:
  - Tailored to all relevant considerations - physical, functional, psychosocial
  - Relevant to needs, interests, culture and background
  - Consider risk factors, current conditions, past history and present symptoms
  - Demonstrate assessment of unmet needs (CMS.gov)

CMS

◆ Sept 25, 2001: Contractors may not use ICD-9 codes for dementia alone as a basis for determining coverage
◆ Medicare Benefit Policy Manual Chapter 15 – The skills of a therapist are not required for the development of a maintenance program and training the patient or caregivers
◆ But since the Jimmo vs. Sebelius. 2013, settlement agreement – the improvement standard has been eliminated.
◆ Medicare will pay for services if they maintain the patient's current condition or prevent or slow further deterioration (CMS.gov)

This allows OTs to provide a broader range of services
Consider Adding an Abilities Care Model Program

- Based on the work of Claudia Allen, OTR/L, the Cognitive Disabilities Model (an abilities care model) guides OTs to identify patients’ cognitive levels with a screening tool called the Allen Cognitive Level assessment or by use of the Allen Diagnostic Module.
- The tool reveals cognitive disability and a cognitive level that is categorized into six hierarchical levels of function, representing increasing ability to attend to and use the available task environment.
- The levels delineate behaviors ranging from gravely disabled (level 1) to normal cognitive function with the ability to think abstractly, plan, strategize etc. (level 6).

(Allen, Earhardt, Blue (1992)

Foundations for Abilities Care

Cognitive Disability Model
- Measures what a person is capable of.
- Focuses on adapting the environment and training caregivers.
- Facilitates function and safely, rather than restoring lost function.
- Aims to provide activities within the patients’ ability to promote a sense of meaning and not distress patients.

(Tailored Activity Program
- Consists of a designed activity that the patient finds pleasurable and is adapted to his/her current abilities.
- Eight OT sessions over 4 months in a home setting or multiple OT sessions in a SNF to help the patient master the activity.
- Train caregivers in use of 3 activity prescriptions.
- Results in decreased negative behavior and caregiver burden.

(Gitlin et al. (2009).)
Lens of the Abilities Model

- See the **person** “within”
- Identify remaining **abilities**
- **Modify** tasks, environments and approaches
- Teach successful **strategies and approaches** to caregivers

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Case Example

**SNF Abilities Care Model**

- CNA stated patient **unable to engage in task** more than 2 minutes; activities staff states difficulty engaging in planned activities **with passive participation**
- Noted to have increased **confusion, wandering, difficulty communicating needs and following directions, and disruptive behavior**, placing her at risk for resident to resident altercations
- **Weight loss noted** and taking medication to stimulate her appetite
- Daughter states **visits are more difficult** and less **meaningful** (G.Tucker-Rughi MS, OTR/L, Ensign Services)
Abilities Care Model-Case Example

- Identified at Allen level 3.6
- Sought information from the family on past interests and hobbies, accessing positive procedural memories to promote function
- Chosen meaningful activity based on past interests was flower arranging
- Provided 16 SNF-based OT sessions over 4 weeks (flower arranging)
- Adapted task parameters to enhance performance and participation in meaningful activities and ADL tasks
- Trained family on the benefits and use of activities during their visits
- Trained the Activity Director in task gradation
- Used context cues in the dining room to improve mealtime behaviors
- Trained nursing staff / family / activities staff on effective cuing strategies, task set-up, and communication techniques

(G. Tucker-Rughi MS, OTR/L, Ensign Services)

Abilities Care Model-Case Example

- **Baseline** – Attends to unmodified activity for up to 2 minutes
- **Goal** – Engage in adapted meaningful task for 20 minutes with 20% verbal cues
- **Status at Discharge** – Able to attend to modified flower arranging task after initial set up for 20 minutes with 20% verbal cues

- **Baseline-Min Assist for grooming** with 50% verbal cues
- **Goal** – Grooming with modified set-up and SBA with 20% verbal cues for sequencing while standing at sink.
- **Status at Discharge** – SBA for grooming with use of appropriate set-up, striking visual cues and 25% verbal cues for sequencing

(G. Tucker-Rughi MS, OTR/L, Ensign Services)
Consider Adding a Sensory Modulation Program

- Use of prescribed sensations to calm or alert patients to increase comfort and participation
- Addresses:
  - Sensory over-responsivity
  - Sensory under-responsivity
  - Sensory craving/seeking
    All Common in OA

Use Adolescent/Adult Sensory Profile Assessment

- To identify “Sensory Profiles”:
  - sensation seekers
  - sensation avoiders
  - sensation sensitive
  - or have low registration
    (Brown & Dunn, 2002)
  (or some combination of the above)
Sensory Profiles are directive, e.g.:

◆ High score in sensation seeking:
  ❖ These people tend to create additional stimuli or look for environments that provide sensory stimuli, so may offer gum, use bright colors and dramatic shapes to gain patients’ attention

  If low score in sensation seeking:
  may offer lightly scented products and read to patients to soothe  
  (Brown & Dunn, 2002)

Sensory Profiles are Directive, e.g.:

◆ High score in sensation avoiding:
  ❖ These people are overwhelmed or bothered by sensory stimuli, so introduce new foods and smells gradually, offer clothes that are heavy or weighted, reduce volume of auditory stimuli.

  If low score in sensation avoiding:
  Use light touch rather than deep pressure, vary the volume and rhythm of sounds  
  (Brown & Dunn, 2002)
Sensory Profiles are Directive, e.g.:

◆ High score in sensation avoiding:
  ❖ These people will shut down if too much intensity or variability is going on in the environment. So offer unscented soaps, get rid of clutter in rooms, work in rooms where you can shut the door.

If low scores in sensation avoiding:
Take breaks or rest during movement, reduce lights (Brown & Dunn, 2002)

Sensory Profiles are directive, e.g.:

◆ High score in low registration
  ❖ These people will not engage unless activities and environments provide the necessary intensity or variability, so make visual cues more salient, underline, bold and use colors. Label drawers

If low score in sensation seeking:
Offer bland foods, encourage consistent steps, routines in daily activities (Brown & Dunn, 2002)
Specific Sensory Modulation Interventions Developed For:

- Self-injurious Behavior
- Stress
- Emotion dysregulation
- Suicidality
- Mania/hypomania
- Dissociation and flashbacks
- Sensory defensiveness
- Sensory distortions
- Poor reality orientation
- Impaired sleep

(Champagne (2014).

Very Inexpensive and Helpful Approach

- Patients:
  - Distracted?
  - Sleepy?
  - Confused?
  - Withdrawn?

Patients and caregivers can be trained to pair sensations with mood to self calm or self alert
Psychosocial OT Fieldwork
Students are Psychosocial Program Extenders

◆ ACOTE requirement 3.1.7.: “Ensure that at least one fieldwork experience (either Level I or Level II) has as its focus psychological and social factors that influence engagement in occupation.” (AOTA, 2014)

◆ Some universities still require psychosocial (PS) level I and level II fieldwork (FW)

◆ Some students want to complete PS level II FW even if not required

◆ PS FW students do not need to learn everything about a physical rehab practice as they will still have a “phys dys” experience, so students can focus on psychosocial approaches

Benefits of Hosting PS Level II FW Students, they:

◆ Do not need to be supervised as closely as “phys dys” FW students as they will not necessarily be performing difficult transfers or other physical rehab skills

◆ PS FW students will bring current knowledge of PS best practices

◆ Will enhance the culture of the facility and the knowledge base of the rehab staff

◆ Upon graduation, will increase employment applicant pool.
PS FW Students

◆ Can assist with rehab case load, but are not held to same productivity standards
◆ Can potentially create program development time for the fieldwork educators
◆ Can work with the facility Activities Director
◆ Can lead groups
◆ Can work with families and caregivers
◆ Can provide additional PS “value added” services that are not typically reimbursed

Psychosocial OT Groups Approaches

◆ Self - Concept
◆ Self - Awareness
◆ Values Clarification
◆ Assertiveness training
◆ Pain management
◆ Relaxation Skills
◆ Training to encourage autonomy and responsibility
◆ Anything that is truly meaningful
Call to Action for OT

◆ Mentor frontline caregivers about patients’ mental health needs

◆ Teach, model, design and implement tailored activities that engage patients’ capabilities

◆ Lead facility wide committees, educational programs to address the mental health needs of patients to increase well deserved quality of life for the later years in life

Thank You

Do not hesitate to contact me if you want me to email you the protocol for psychosocial level II FW at a SNF