

Impact of Social Isolation Among Older Adults Living with a Mental Health Diagnosis

By Heidi Billittier, MSW
Director of Older Adult Services
Compeer of Greater Buffalo

Risk of social isolation and resulting loneliness becomes increasingly more prevalent as we age, lose friends and family, and navigate chronic health conditions. Situational factors including diminished social and familial roles, together with physical limitations increase the incidence of isolation and loneliness. For individuals living with mental health challenges, the impact of loneliness can be devastating. Isolation coupled with mental health challenges may result in loss of social connectedness and purpose, as well as heightened symptoms and subsequent hospitalizations. Additionally, the prevalence of depression, anxiety, and myriad mental health diagnoses common among older adults suggests that we may be positioned for a large-scale crisis as our population's median age continues to rise (Valtorta & Hanratty, 2012).

Older adults who experience isolation and loneliness are at greater risk for developing symptoms associated with dementia and cognitive decline as well as physical and emotional manifestations. Loneliness is associated with an increase in sleeplessness, eating disorders, suicidal ideations and attempts (Mann et al., 2017) all of which are associated with an increase in



Heidi Billittier, MSW

morbidity. Isolation places older adults at greater risk for experiencing elder abuse including: physical, emotional, financial abuse, and neglect. Elder abuse occurs less often when individuals are connected to their families, communities and social networks (Bonnie & Wallace, 2002).

Mental and medical health care providers are realizing the value in prescribing social interventions together with traditional therapies as a means to eradicate the symptoms associated with loneliness. So-

cial interventions may include: continuing education, social day programs and supportive, caring friendships that encourage older adults with and without mental health challenges to remain engaged in their communities. Giummarra et al. (2007) interviewed health professionals together with older adults and found that social and emotional connectedness was strongly associated with overall health while the absence of those connections indicated an increase in physical symptoms.

Programs that provide social support, for example, seek to reduce isolation and loneliness for older adults who are living with a mental health diagnosis by providing companionship; supportive, caring friends are uniquely positioned to act as a catalyst between the individual and their community. Evaluations suggest that the supportive friend model holds value for older adults as a conduit for positive change. The supportive relationship claims to promote social connections that extend beyond the relationship and into the community, thus building a sustainable support network for the individual (Drury, 2014, p. 125-28). Additionally, individuals who visit their program friends regularly are likely to notice changes in behavior, health and/or personal hygiene, all of which might indicate that the person is experiencing a mental or physical health crisis. Social support programs, such as these, may provide training so that volunteers are able

to identify potential problems, and report back to the organization for appropriate linkage and referrals.

Caring friends are often in a position to help strengthen an individual's ties to their community by reintroducing them to activities they once enjoyed, or perhaps by sharing new experiences. Activity theory suggests that older adults who remain engaged in activities previously enjoyed, even with modifications, tend to experience full lives into and through late adulthood (R.J. Havighurst, 1961).

Humans need social connections. Whether they are one-to-one, in groups, or via technology, the supportive relationship aims to encourage personal growth and foster feelings of self-worth. As an option to face-to-face friendships, technology has been introduced as an effective means to communicate with isolated individuals. Telephone support, or "befriending" is a cost-effective tool for providing regular contact and encouragement for isolated older adults. A study by Cattani, Kime, and Bagnall (2010), demonstrated that telephone support not only alleviates loneliness but provides a sense of belonging, lowers stress and anxiety, increases confidence and encourages engagement not only with the caller, but with the community at large. Currently some programs are incorporating the

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A Geriatric Substance Abuse Recovery Program

By Orah Burack, MA
Verena R. Cimarolli, PhD
Gregory Poole-Dayana, MS
Irene Liu, MSW,
Margaret Bondy, MSW and
Roberto Perez, MSW

Substance abuse among the geriatric population is often overlooked or ignored, despite the finding that almost a fifth of older adults misuse drugs and/or alcohol (Center for Substance Abuse Treatment, 2012), and evidence showing the detrimental impact of substance abuse on elders' quality of life. As the number of older adults in the United States increases, there is a growing demand to develop programs that can reach, recognize, and provide effective help for older adults struggling with alcohol and substance misuse and addiction.

This urgent need prompted The New Jewish Home in New York City to develop a Geriatric Substance Abuse Recovery Program (GSARP) designed to identify and support older adults with alcohol and drug misuse issues who are admitted to the organization's skilled nursing facility (SNF) for post-acute rehabilitation following a fall, hip fracture, surgery, or other medical event.

Post-acute rehabilitation units of SNFs are uniquely positioned to serve as a gateway to alcohol and substance abuse

screening and recovery for the aging population. Older adults stay in these inpatient rehabilitation settings for a period of time to regain physical strength. This length of stay gives substance abuse health professionals an opportunity to build trusting relationships with older adults in post-acute settings, and to increase the likelihood that these older adults will be willing to participate in abuse-related interventions both during their stay and upon discharge back to the community. Post-acute care is also an important intervention point because substance-use problems can interfere with successful rehabilitation. Unaddressed substance misuse, when compounded with insufficient rehabilitation, could lead to re-hospitalizations for such conditions as fall-related injuries.

The Geriatric Substance Abuse Recovery Program

The New Jewish Home created GSARP in 2014 to help identify and address alcohol- and substance-abuse issues among older adults. The program is designed to screen all incoming post-acute patients for drug and/or substance-abuse issues, and to offer a program that integrates medical rehabilitation and substance abuse counseling services for those who are identified as prospective program participants. Additionally, GSARP par-

ticipants are connected to community-based substance abuse rehabilitation programs and are encouraged to attend these programs once they return home from the post-acute setting.

GSARP's brief intervention lasts for the older adult's entire stay in the post-acute setting. During that stay, a substance abuse counselor meets with the individual on a regular basis. Program components include:

- Identifying older adults struggling with substance abuse issues.
- Assessing the older adult's addiction and support needs.
- Developing a comprehensive, individualized care plan to meet each person's in-house needs during the post-acute stay. Care plans include psychology consultations, substance abuse counseling, group and individual therapy, family therapy, and community-based self-help groups, such as Alcoholics Anonymous, which meet on-site.
- Reaching out to involved family and friends and including them, with the older adult's permission, in the rehabilitation process.
- Connecting program participants with community services before discharge to

ensure continuity of the recovery process once the individual returns home.

- Developing a discharge plan with community supports, such as individual counseling, family therapy, self-help groups (Alcoholics or Narcotics Anonymous), or even in-patient substance abuse rehabilitative programs.

Efficacy of the Geriatric Substance Abuse Recovery Program

A pilot study was conducted during the first eight months of the GSARP program to examine program feasibility and efficacy (Cimarolli, Burack, Poole-Dayana, Liu, Samaroo, & Bondy, 2017). Ninety-nine (80%) of the 125 patients identified during the screening process as having drug or alcohol abuse issues agreed to participate in GSARP and 25 refused. The mean age of participants was 65 years of age; 67% were male and over 50% were minorities (28% Hispanic and 23% African American). Members of minority groups were more likely than white older adults to refuse program participation.

Among older adults who took part in the initial screening, alcohol was the most prevalent misused substance (91%), followed by illicit drugs (23%), and prescription drugs (9%). Over 20% of screened

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patients reported abusing more than one substance. Almost all older adults who were screened (94%) had been long-term substance abusers and a majority (72%) also had a mental health diagnosis such as depression, anxiety, or dementia.

To monitor recovery and track outcomes, program participants were called for phone interviews 30 days post discharge. Twenty-nine program participants were reached for the 30-day follow-up phone calls. One-month after discharge, 69% of telephone call participants with alcohol abuse issues, and 64% with drug abuse issues, reported that they had not relapsed. Almost three-quarters of phone call participants (73%) reported that they did not have difficulty following their discharge plan and half (50%) reported that they were continuing with Alcoholics

Anonymous and/or therapy.

Participants reporting that they did not follow discharge plans listed the following reasons: lack of transportation, not understanding the discharge plan, and dissatisfaction with available community services. During the 30-day post-discharge telephone interview, 70% of participants rated their program satisfaction as “excellent” or “good.”

A new 18-month follow-up study, currently in the data-collection phase, will compare information from the medical records of GSARP participants to medical records data collected on individuals who were referred to the program but refused participation. The study is supported by a grant from the Catherine Weldon Donaghue Medical Research Foundation to The New Jewish Home, and is led by Verena R. Cimarolli, senior health services research associate at the

LeadingAge LTSS Center @UMass Boston and senior research fellow at The New Jewish Home.

Guided by the Andersen Behavioral Model of Health Services Use, the study will:

- Examine whether GSARP participants have better rehabilitation outcomes when compared to GSARP refusers. The specific rehabilitation outcomes under study are improved physical functioning and likelihood of returning home as opposed to being readmitted to acute care.
- Identify individual characteristics and health behaviors associated with successful rehabilitation outcomes.
- Identify individual characteristics associated with program participation/refusal. The initial study found that the majority of patients approached about GSARP

agreed to participate. However, participation rates were lower among minorities.

Further examination of factors associated with program participation may inform strategies to increase program participation, which may potentially lead to more optimal rehabilitation outcomes and, ultimately, improved quality of life of older adults with alcohol and substance misuse issues.

Margaret Bondy, is Director of Social Work Manhattan Division; Orah Burack, is Senior Research Associate; Irene Liu, is Content Development Manager; Roberto Perez, is Substance Abuse Counselor, at The New Jewish Home. Verena R. Cimarolli, PhD, is Senior Health Services Research Associate, LeadingAge LTSS Center at UMass Boston; and Gregory Poole-Dayana, is Chief Operating Officer, at Wartburg Hospital.

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the home be a one-floor home to ensure any changes are accommodated? Does the home have big enough doorways and turning radius around corners to accommodate wheelchairs if needs change as the individuals age? Are the bathrooms accessible to the individuals currently, and what types of changes need to be made for the bathrooms to be accessible should ambulation change as the individuals get older? Will the individuals be able to remain in the current home, or will they need to be transferred to a different home should ambulation needs change? Are there appropriate exits and entrances should ambulation needs change (i.e., ramps)? Does the home need a wheelchair van?

Ongoing Assessment by Credentialed Professionals

The ongoing physical and behavioral needs of older adults are assessed and monitored regularly by professionals such as physical therapists, Speech and Language Pathologists (SLPs), nurses, primary care physicians, behavior analysts, and psychiatrists.

Physical therapists assess regularly the person's ability to navigate his or her current environment, and make recommendations for environmental changes to increase safety and independence for each person. Primary care physicians and nurses assess the ongoing medical and healthcare needs of the adults to ensure

their current environment can meet all healthcare needs.

SLPs can provide support in both feeding issues and communication strategies. The SLP will regularly assess individuals to ensure their current diets are appropriate and will make recommendations for diet modifications based on changes with the individual. For example, if an individual who was previously on a regular diet develops difficulty chewing or swallowing, the SLP can do an assessment and may recommend a change in food texture or liquid consistency.

Behavior analysts monitor and assess any behavioral changes and may develop appropriate behavioral interventions, based on the principles of Applied Behavior Analysis. These may include antecedent-based strategies, such as the implementation of a visual schedule for an individual who did not need that type of intervention in the past. These may also include consequence strategies, such as appropriate reinforcement systems to maintain positive behaviors. Behavior analysts will review data on behavioral changes and make updates to behavioral intervention strategies based on the behavioral data.

Psychiatrists, in combination with the rest of the IDT, review behavioral data and medical changes for the individual, making appropriate medication recommendations based on this information. The behavior analyst shares information regarding any behavioral changes, sleep information, and presents all relevant data in graph format so the psychiatrist can

observe trends. All medication changes are discussed with the individual and guardian/representative, as well as presented to a Human Rights Committee (HRC) to ensure the least restrictive interventions are being utilized.

Comprehensive Staff Training

Training of direct support staff in the proper care and teaching strategies for older adults is very important. Training on all important job duties, including providing personal care, teaching skills, and following behavior support plans is done using a behavior skills training model (BST). BST includes a verbal description of the skill, a succinct written description of the skill, a demonstration of the skill by a competent trainer, and the trainee performing the skill with feedback from the trainer, until the trainee is competent with the skill (Parsons, Rollyson, & Reid, 2012). By training direct support staff on all necessary job duties utilizing this model of training, the residential provider can be sure that support staff are fully competent in the delivery of services to the adults being served.

Summary

Many aspects of care need to be considered when providing residential services to older adults with ID and autism. While taking care of the person's physical health is extremely important, ensuring the environment in which they live is ac-

commodating and accessible is just as important. As such, residential providers need to continually assess the environment of their homes in addition to the individuals who live in those homes.

It is equally as important to have a highly qualified team of professionals working collaboratively to ensure that exemplary care is being provided at all times. This, in addition to well-trained direct support staff working with individuals, will help ensure the greatest outcomes for the older adults can be achieved.

Correspondence concerning this article should be addressed to Maggie Haag, M.Ed., BCBA, LSW, Senior Director of Adult Services, Melmark Pennsylvania, at maggie-haag@melmark.org or Karen Parenti, M.S., PsyD., Executive Director, Melmark Pennsylvania, at karenparenti@melmark.org, or to Melmark Pennsylvania, 2600 Wayland Road, Berwyn, PA 19312.

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