

Geriatric Mental Health Ethics

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Geriatric Mental Health Ethics

A Casebook

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To the older adults in my personal and professional lives who have shared their experiences and, through their present, have given me glimpses into both the past and the future. I hope that I provided something of value in return.

And

To Dana, Sarah, and Megan—always.

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Foreword

As this thoughtful and informative volume on the ethical/legal implications of geriatric mental health treatment is being written, nearly 8,000 U.S. residents are turning 60 each day (www.census.gov/ipc/www/usinterimproj/). Just as the demographics are mandating an adequately trained mental health workforce to address this burgeoning population, the Institute of Medicine (IOM) released on April 14, 2008 the “Retooling for an Aging America: Building the Health Care Workforce” (www.iom.edu/CMS/3809/40113/53452.aspx). This report recommends that the workforce demonstrate competency in the care of older adults as a requirement for licensure and certification. It also calls on employers and regulators to expand the roles of individuals who care for older adults with complex clinical needs at different levels of the health care system beyond the traditional scope of medical practice. The author’s teaching goal of increased competence in ethical decision making and practice associated with the complexity of treating older mental health patients is certainly consistent with the IOM’s mandate and is a welcome tool in the preparation of the future mental health workforce.

Dr. Bush has written this book from an interdisciplinary and clinically based approach. Challenging learning experiences are presented at the conclusion of each chapter, and a dozen diverse case studies guide the reader/learner through the “4 A’s” of ethical decision making and practice. Using an educational approach, the reader is prepared to learn how to *Anticipate* and prepare for the ethical issues inherent in geriatric mental health, cautioned so as to *Avoid* the pitfalls of ethical dilemmas, instructed how to develop a strategy to *Address* the ethical challenges, and inspired to *Aspire* to even higher standards of ethical decision making and practice.

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As a geriatric psychiatrist, I have been faced with many of the dilemmas posed in this casebook. The knowledge and use of professional ethical codes, laws, practice guidelines, and colleagues' expertise are invaluable in my day-to-day practice. The decision-making model proposed by Dr. Bush is a construct that can be used by any mental health professional and in all treatment settings. Dr. Bush asks in his conclusion if we, as mental health professionals, are ready for the task of facing this exciting and complex challenge of treatment of the aging in this country. After reading this innovative casebook, I am inspired to face these challenges with a new perspective and encourage others along the way to be better advocates and clinicians.

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Introduction

PART I

Providing mental health services to older adults can be as ethically challenging as it is personally rewarding. Like clinical challenges, ethical dilemmas often emerge in unique and unexpected ways. Yet, I wonder if we, as mental health professionals, are as prepared to handle ethical dilemmas as we are clinical challenges? I suspect that the vast majority of us can describe the theoretical model or models upon which we rely in our clinical decision making with older adults. However, how many of us can describe *any* ethical decision-making model, let alone one that we regularly use to resolve ethical challenges in our work with older adults? Similarly, I imagine that most of us can name at least a few professional references to which we can turn to find answers to clinical questions. But, other than the ethics code of our own discipline, how many professional references can we name that provide direction and answers for our ethical challenges?

A primary ethical responsibility is professional competence, from both clinical and ethical perspectives. Like clinical competence, ethical competence requires us to challenge ourselves and each other on an ongoing basis to explore the boundaries of our ethical knowledge and confront and expand those boundaries. A primary goal of

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this book is to challenge you, the reader, to question your own ethical competence and to use the information and decision-making model presented in the book to reinforce and expand the boundaries of your ethical competence; writing the book has helped do so for me.

The primary purposes of this casebook are to (a) describe ethical challenges commonly encountered by mental health professionals who serve the elderly, (b) review resources available for ethical decision making, (c) present an ethical decision-making model, and (d) demonstrate the application of the ethical decision-making model through clinical cases. To achieve these goals, an emphasis is placed on identifying the similarities and clarifying the differences among clinical, ethical, legal, and professional contributions to complex cases. The information presented in this book is intended to apply across mental health contexts and disciplines. Advanced consideration of ethical issues that arise during the practice of geriatric mental health care, and options for addressing such issues, prepares clinicians to practice in a manner that advances the welfare of patients, families, and other consumers of mental health services.

Much of the information in this book builds on my previous writings and focuses those prior ideas and ethical explorations onto the world of geriatric mental health. In the presentation of case vignettes, the ethics codes and resources that are considered most relevant to the specific professional discipline presented in the vignette are relied upon for the analysis of the ethical issues and challenges. For example, in case vignettes that involve social workers, the Code of Ethics of the National Association of Social Workers (1996) is emphasized, although other relevant resources may be included as well. Similarly, the ethics codes of other mental health disciplines are emphasized in the analysis of case vignettes that involve those disciplines. However, the potential value of “ethical cross-training” (Bush, 2008) cannot be overstated.

This book could not have been written without the direct and indirect assistance of many friends and colleagues. Among those who most directly influenced my thinking about ethical issues in geriatric mental health are Drs. Frank Cervo and Lory Bright-Long. Through long discussions at the Long Island State Veterans Home at Stony Brook University, we examined ethical challenges related to patients/residents

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and their families, professional behavior, and policy issues. Although we did not resolve all of the problems, I believe we sparked an ongoing commitment to try, and I am grateful to Drs. Cervo and Bright-Long for it. I also want to thank my good friend and frequent collaborator, Dr. Tom Martin, for our exchanges of thoughts and manuscripts on ethical issues in geriatric neuropsychology. Additionally, I want to extend my appreciation once again to Drs. Jerry Sweet and Joel Morgan for encouraging me to begin this journey of writing/editing books on ethics some 8 years and seven books ago. Finally, I want to thank Springer Publisher Company and acquisitions editor Philip Laughlin for all of the assistance, support, and patience needed to complete a project that I hope ultimately helps to improve the lives of older adults receiving mental health services.

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Developmental Considerations

The population of older adults in the U.S. is growing rapidly, with a corresponding increase in the number of older adults evaluated and treated by mental health professionals. It is anticipated that approximately 71.5 million people will be over the age of 65 in the United States by the year 2030 (Federal Interagency Forum on Aging-Related Statistics, 2006). Additionally, it has been predicted that the number of individuals who are 85 years of age and older will double, and the number of individuals who are 100 or older will triple.

The transition into late adulthood, like other developmental transitions, is associated with physical and psychosocial changes, some advantageous and others adverse. Late adulthood, like other stages of the life cycle, offers opportunities for growth and change that enrich life. The shift in biomedical and social sciences in recent years from an illness and disease-oriented model of aging toward a more adaptive model of health and wellness reflects the positive aspects of older adulthood (Beckingham & Watts, 1995; Bowling, 1993; Kaplan & Strawbridge, 1994; Knight, 2004; Myers, 1992). However, aging, like other life transitions, includes potential threats to successful adjustment (Coleman, 1992; Erikson, 1982).

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Compared to earlier developmental stages, a primary challenge associated with late adulthood involves confronting loss (Myers, 1999; Waters & Goodman, 1990). Losses in the areas of sensory and motor abilities, cognitive functioning, social roles, financial resources, and long-term relationships are more common for older adults. Such losses may be accompanied by negative emotional changes (Erikson, 1963; Erikson, Erikson, & Kivnick, 1986; Lebowitz et al., 1997), as well as decreased resources for coping with the losses.

In addition to confronting loss, medical problems, physical pain, and medication usage occur with greater frequency for older adults. Approximately 80% of older adults have at least one chronic health problem, and about 50% of older adults have at least two chronic health problems (He, Sengupta, Velkoff, & DeBarros, 2005). Additionally, approximately 20% of older adults experience chronic disabilities, and 18% of men and 32% of women are unable to perform at least one basic physical function (Federal Interagency Forum on Aging-Related Statistics, 2006). These physical and psychosocial changes may result in increased dependence on others for assistance with daily tasks and decisions that were previously completed independently. Decreased autonomy in later adulthood can be associated with a host of emotional reactions, for both those with and without prior mental health needs. With depressive symptoms alone affecting approximately 15% of community-dwelling older adults and up to 25% of those in nursing homes (He et al., 2005), the need for competent mental health professionals to evaluate and treat older adults and their family members has never been greater, and it will increase for the foreseeable future.

From a clinical perspective, the developmental changes of late life pose unique professional and ethical challenges for clinicians who work with older adults (Hays, 1999). Individual differences in aspects of maturity, specific physical and psychosocial difficulties, cohort differences, and contextual social and treatment settings must all be considered and appropriately integrated into evaluation and treatment methods and decisions (Knight, 2004).

Treatment context may be one of the most readily apparent and distinguishable aspects of geriatric mental health services. Older adults receive mental health services in multiple clinical and

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residential settings. Although older adults are commonly evaluated and treated by mental health professionals across the same medical and mental health care settings in which younger adult patients are encountered, such as hospitals, outpatient physical medicine and rehabilitation programs, mental health clinics, and private practices, they are encountered in greater numbers in some of those settings because of the increased health problems and unique stressors associated with aging. In addition, because of the increased prevalence of chronic health problems and cognitive decline associated with aging, as well as limited personal and family resources for managing decreased functional abilities in the home, older adults also frequently receive mental health services through adult day care programs, assisted living facilities, and skilled nursing facilities. Mental health practitioners are frequently involved as consultants or integral members of the professional staff in the care of registrants or residents in such settings.

Each of these settings affects the clinical issues of concern to the patient and the clinician, and the clinical issues may evolve as the patient transitions from one setting to another. For example, a 79-year-old man with a history of diabetes may present to a private practice following amputations of both legs with significant sorrow over the loss of his legs, regret over his poor management of his diabetes, and guilt over the burden that he has become to his wife. Nevertheless, he may maintain a sense of determination to learn to use his prosthetics and other assistive devices, so that he can do more for himself at home and relieve his wife of some of the burden. However, should he not achieve his goals and instead be forced to move into a skilled nursing facility, he may feel anger and resentment toward his wife for what he perceives to be abandonment, and his determination may be replaced by a sense of hopelessness and despair. This man's emotional reaction may also increase his wife's feelings of guilt and sadness. Such psychological and interpersonal dynamics are encountered with considerable regularity for mental health professionals who work with the elderly.

Collaboration with other mental health and medical professionals is often essential to the effective care of older adults. For example, in skilled nursing facilities, it is common for residents to have their mental

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health needs addressed by multiple professionals, as well as paraprofessionals and volunteers. Consider the case of a 93-year-old woman who was living independently when her sweater caught fire while she was cooking, causing multiple severe burns that required skin grafts and a lengthy period of hospitalization. Following medical stabilization, she was transferred to a skilled nursing facility for subacute rehabilitation, with the hope that she would eventually return to her home. However, as time passed and she continued to need assistance for some of her daily activities, it became apparent that she would not be going home, at which time she became depressed. Crying episodes and decreased appetite were first noticed by her certified nursing assistant (CNA), who reported it to the nurse on duty. The nurse confirmed the CNA's impression and reported the apparent depression to the attending primary medical doctor (PMD). The PMD ordered a psychiatry consultation, at which point an antidepressant medication was prescribed. A psychologist was consulted for psychotherapy, and the social worker on the unit provided additional emotional support and located a relative who was glad to begin visiting on a regular basis. Increased involvement in recreational activities and visits from a young volunteer helped complete the interdisciplinary approach to the alleviation of the woman's adjustment-related depression.

The extent and nature of family involvement also distinguish the mental health treatment of many older adults from that of younger patients. Although some older adults find themselves increasingly isolated and lonely, others experience increased involvement of family members, which may or may not be welcome. Important clinical and ethical considerations correspond to the varying degrees and quality of family involvement.

Learning Exercises

1. He, Sengupta, Velkoff, and DeBarros (2005) found that depressive symptoms affect approximately 15% of community-dwelling older adults and up to what percent of those in nursing homes?

- a. 20%
- b. 25%
- c. 55%
- d. 85%

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2. Older adulthood inevitably includes which one of the following?

- a.** Dementia
- b.** Diabetes
- c.** Anxiety
- d.** Loss

3. True/False. Unfortunately, unlike all of the previous developmental stages, older adulthood does not offer opportunities for personal growth and changes that enrich life.