Behavioral Health Needs of Older Adults in the Emergency Department

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KEYWORDS

• Geriatric psychiatry • Psychiatric emergency • Late-life depression and suicide • Agitation • Late-life substance abuse • Late-life anxiety

KEY POINTS

- Behavioral health disorders are common among older adults and frequently lead to presentation to the emergency department for evaluation and management.
- Many medical illnesses can manifest as behavioral health emergencies in older adults; a thorough history and targeted physical examination, laboratory evaluation, and imaging studies are critical to diagnosis and treatment.
- Understanding past psychiatric history, baseline cognitive status, living situation, social supports, and safety concerns are key to effective management in the emergency department setting.
- Input from caregivers can provide the emergency department provider with important clues regarding baseline functioning, triggers for behaviors, and help to inform behavioral management.
- Planning disposition for older adults in the emergency department with behavioral health concerns can be challenging for a variety of reasons, including limited mental health resources.

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INTRODUCTION

Care for behavioral health disorders has increasingly shifted from inpatient settings to ambulatory environments in recent decades, with the emergency department (ED) becoming a common site for managing behavioral health problems in individuals of all ages, including older adults. An estimated 15% to 25% of older adults suffer from a behavioral health disorder,[1–3] and older patients with these disorders disproportionately use the ED.[4,5] Access to care for behavioral health disorders outside the acute setting is often lacking owing to underrecognition, inadequate numbers of trained medical professionals, and limited insurance coverage.[3] In fact, nearly 60% of older adults with a behavioral health condition may go without any form of treatment.[6] As a result, when behavioral health emergencies arise in older adults, ED providers are often on the front lines in their evaluation and management. With these access barriers and the rapid growth of the older adult population, it is critical that ED providers be prepared to manage behavioral health disorders. This article focuses on general approaches to the behavioral health emergencies of substance abuse, depression and suicidal ideation, anxiety and panic, agitation, and psychosis in older adults.

GENERAL APPROACHES

History and Physical Examination

When encountering an older adult with a behavioral health emergency, obtaining an accurate history and performing a thorough physical examination are critical to exclude acute medical illnesses and develop a treatment plan. Depending on the patient's presentation, these steps may be challenging. The patient may not be able to provide clear details owing to intoxication, psychosis, or dementia. Physical examination also may be impractical in the agitated patient. Formal or informal caregivers, family or close contacts, or primary medical providers to provide collateral history and recent observations may yield useful information.

Key data to obtain include both medical and nonmedical issues that could trigger the observed behaviors or symptoms, past psychiatric history, and the individual's cognitive and functional baseline. **Table 1** lists medical issues that can trigger behavioral health symptoms and useful historical clues. Cognitive impairment increases risks for mood and behavioral symptoms and complicates a person's ability to manage previously well-controlled mental health issues, making a history of memory loss another valuable historical clue. Nonmedical issues include recent significant life events, such as the loss of a loved one or a change in residence that can provoke behavioral health symptoms. Past psychiatric history is of particular importance because some psychiatric disorders, like depression or generalized anxiety disorder, may be recurrent or can commonly develop in late life, whereas others, like schizophrenia, rarely develop in later life. Late-onset psychosis warrants a search for underlying medical causes, mood disorders, or cognitive impairment.[7]

When cognitive impairment is suspected or confirmed, additional history from caregivers about the context of the behavioral symptoms can provide significant value. For individuals with behavioral and psychological symptoms of dementia, behaviors are often a form of communication. As such, input from caregivers may provide clues as to the triggers for behaviors and help to inform treatments. For agitation in particular, seek precise descriptions of what occurred. This includes what actions "agitation" describes, from verbal or physical aggression, like swearing or hitting, to restlessness or wandering. Additionally, details regarding the events preceding the behaviors—whether the individual was awoken from sleep, having personal cares