

Mental Health Needs of Older Veterans

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In recent years, America has focused a good deal of attention on those younger veterans returning from the wars in Afghanistan and Iraq. Now that the American presence in Iraq has ended and its presence in Afghanistan is winding down, it is time to recognize the fact that most American veterans are old. In 2012, 46% of veteran men were over age 65 and 59% over age 60; conversely, 51% of American men over age 65 were veterans.^{1,2} Based on these statistics, a focus on the mental health needs of older veterans is an important part of population-based care. Moreover, understanding the trajectory of mental health needs over the lifespan is necessary to plan for the ongoing care of younger veterans as they age.

Six articles in this month's *The American Journal of Geriatric Psychiatry* focus on older veterans.^{3–8} They report on research addressing two themes. One is about the mental healthcare services provided to older adults by the Veterans Health Administration (VHA), the healthcare system of the U.S. Department of Veterans Affairs (VA). The other is concerned with post-traumatic stress disorder (PTSD) and related conditions and their impact across the lifespan, addressing the persistence of the effects of combat exposure into late life.

MENTAL HEALTH SERVICES PROVIDED BY VHA

Three articles in this issue address matters directly related to mental healthcare services provided by VHA.^{3–5} VA research frequently focuses on the delivery of healthcare within VHA, in part because of the wealth of clinical and administrative data that are

available to VA investigators. In doing so, the research can, in general, serve two functions: raising issues that may be generalizable to other healthcare systems and identifying targets for quality improvement.

Weichers et al.³ demonstrate that 30% of all VHA patients with prescriptions for a psychotropic medication in 2010 had no current mental health diagnosis in their medical records and, frequently, no apparent medical indication for the prescription. One of the primary findings was that this occurred most frequently among patients over age 65 and in those who did not receive mental health specialty services. The concern is that this may represent indiscriminate prescribing. It is possible that, in some cases, it could represent a well-meaning attempt to provide treatment without making diagnoses that could be perceived as stigmatizing; however, even allowing for this, there must be concerns about the specificity of prescribing without a diagnosis and about whether this sort of practice represents a barrier to appropriate monitoring and follow-up care. Weichers et al. note that the rates in VHA are similar to those reported elsewhere, and this article implicitly calls for further studies of the age dependence of prescribing without diagnoses and indications beyond VHA. More directly, the findings raise questions about the quality of psychopharmacologic treatment in VHA, especially for patients who do not receive mental health specialty care. This problem was discussed with VHA mental health leadership well before publication, and it has been included as a key issue in VHA's ongoing quality improvement programming.

Garrido et al.⁴ studied the care provided to seriously ill veterans who received inpatient consults for

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<http://dx.doi.org/10.1016/j.jagp.2014.01.014>

palliative care in one of VHA's regional networks. They note that palliative care consults in this network included evaluations of psychological symptoms such as worry, nervousness, and sadness. Their major finding was that although 44% of the patients reported psychological distress in the past week, there was no evidence from the electronic medical record that the reports led to mental healthcare, either from the palliative care team or other providers. It is possible that the hospitals' medical, nursing, and social work staff responded to the emotional needs of the palliative care patients in a way that was integrated in a moment to moment way with other components of their medical, nursing, and social work care; it is also possible that this was done but not documented in the medical record. Although this article focused on this issue as a problem within VHA, it is important to recognize that the roles of psychiatry and mental health services within hospices and palliative care are evolving on a national level. This was the focus of a special issue of this journal in 2012,⁹ and it remains an emerging dimension of psychiatric and mental health practice.¹⁰ The findings from Garrido et al.⁴ should be viewed as a call to action within VHA and should also serve as a cue to self-scrutiny for other hospice and palliative care programs.

Finally, Yeager and Magruder⁵ report on age-related changes in the psychometric properties of the PTSD Checklist, an instrument used by the VHA (and elsewhere) to screen for PTSD. They conducted a study in which both the screening test and "gold standard" clinical evaluations were conducted in a large sample of VHA patients, mostly selected at random. They report that the overall performance of the PTSD Checklist remained high across the entire sample but that there were significant differences in the optimal cut-points for identifying those who screened positive. Cut-points were 43 for veterans aged 21–49, 34 for veterans aged 50–64, and 24 for veterans aged 65–81. The findings update previous knowledge about how to identify patients with PTSD, especially in late life; this is of specific importance within the VHA. Of course, based on the current data, it is not possible to distinguish between age effects and those related to generational cohorts. Regardless, the differences are substantial, and the lower threshold should be considered in screening veterans for late-onset PTSD as well as for

monitoring those with histories of PTSD for relapses or recurrences. In addition, as suggested by the authors, the findings pose important questions about the nature of the differences between age groups (or cohorts) and whether they reflect differences in reporting styles, in the intensity with which symptoms are experienced, or in the nature and distribution of symptoms.

A LIFE-COURSE PERSPECTIVE ON COMBAT EXPOSURE

Three articles in this issue are reports of findings from the National Health and Resilience in Veterans Study,^{6–8} a research study funded by the VA through the National Center for PTSD to characterize the longitudinal trajectories of PTSD and related mental health outcomes in a nationally representative sample of U.S. veterans; these articles are best viewed together with two other recent articles from this study.^{11,12} In general, this research is noteworthy because of the highly innovative approach it used to obtain web-based data from a representative sample of veterans and because of the area of investigation.

Exposure to combat leads to increased rates of mental health conditions, including but not limited to PTSD. This effect accounts for a significant component of the nation's burden of mental illness in young and middle aged adults.¹³ However, questions remain about the extent to which the effects of combat persist into late life, specifically about how combat exposure during military service affects the mental and physical health of veterans as they age and about the extent to which the effects are mediated through the association of combat with PTSD, other mental health conditions, and the observable physical and neurologic wounds of war.

In an early report from this study, Pietrzak and Cook¹¹ used cluster analyses of the number of reported traumatic events and symptoms of PTSD, depression, and generalized anxiety disorder to identify three clusters of veterans: a "control" group with low levels of exposure to traumatic events that accounted for 60% of the sample and two clusters with comparable exposure to higher numbers of traumatic events. These included a distressed group with high levels of current mental health symptoms that accounted for 12% of the sample and a resilient

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