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MENTAL HEALTH AND OLDER ADULTS

CHAPTER 1: INTRODUCTION

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Interest in evidence-based geriatric mental health knowledge and effective practice interventions has never been greater. The purpose of the following literature reviews in mental health is to provide needed information to a diverse social work audience including faculty, students, and practitioners who teach, do research or work in the mental health field. Upon examination of the empirical literature, we found gaps in the current knowledge on effective mental health interventions or limitations on generalizability to diverse settings: for example, home health care, naturally occurring retirement communities, home visiting and faith communities, meals-on-wheels, senior centers, older ethnic minorities, racial/health disparities, older GLBT population, and community-based geriatric mental health settings to name a few. Where empirical content is available, data have been included in the literature reviews.

As the population of the United States ages, a growing number of older adults will have mental health problems ranging from mild or subthreshold conditions such as minor depression and subthreshold anxiety, to severe and persistent mental illnesses, such as severe and recurrent major depression and schizophrenia, all known to reduce quality of life.

Current estimates of mental illness rates in older adults range from 15 to 25%, and the number of older adults with a serious mental illness is expected to climb from about 4 million in 1970 to nearly 15 million by 2030 (Administration on Aging, 2002). In addition to mental disorders common in all age groups, there are cognitive problems that, while not unique to older adults, occur with increasing frequency with age. These cognitive impairments exist on a continuum from normal age-associated memory decline (AAMD) to mild cognitive impairment (MCI) to dementias, such as Alzheimer's disease and vascular dementias. These mental illnesses are further complicated by frequent comorbidity with medical problems, substance use problems, and social problems such as loss of loved ones and changes in living situation.

Taken together, mental illnesses among older adults constitute a major and growing public health problem. This increase in the number of older adults with mental health problems is expected to far exceed the capacity of the mental health system to deliver needed services resulting in large numbers of individuals with unmet mental health needs. Even now it is estimated that less than a quarter of older adults with mental

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health needs ever receive treatment—a problem that exists across a range of service settings from community/outpatient settings to hospital settings to residential and long-term care facilities (Kaskie & Estes, 2001). One estimate places this number as low as 2.5% receiving care from traditional mental health services and another 2% receiving mental health assistance from their primary care physician (Blazer, 2002).

Part of the failure to provide adequate mental health services is due to the fact that many older adults are reluctant to seek such services or to spontaneously report mental health problems because of various barriers such as potential costs, transportation, stigma, denial of problems, service access barriers, language barriers, or a lack of culturally appropriate professionals and programs. Older adults may not receive adequate mental health care, even when a problem is identified, because of fragmented mental health services or to gaps in mental health services. Finally there is a serious shortage of professional staff with adequate training to meet the mental health needs of older adults and their caregivers (Gellis, 2006).

Given the fact that older adults are living in the community for more years than they were in past, it is increasingly likely that mental health care will be provided in community settings, many of which are non-specialty, general mental health programs. Social workers have a key role in providing therapy and case management to older adults and their caregivers and in delivering psychoeducation and prevention services to the community. Most mental health practitioners, including social workers, who are not participating in specialty geriatric concentrations are provided with little exposure to practice with older adults, either in their classes or in their field internships, yet they are likely to be called upon to provide services to older adults after they graduate (Rosen, 2005).

In the series of literature reviews, we summarize the evidence (based on the existing scientific literature) on the prevalence, course, co-morbidity, assessment, and effectiveness of a range of empirically-supported treatments (pharmacological and psychosocial) for depression disorders, anxiety disorders, schizophrenia, and the co-occurrence of depression and dementia in older adults. "Evidence-based" refers here to a process rather than an intervention. "Effectiveness" refers here to an improvement in health or mental health outcomes produced by a clearly delineated intervention. The aim of these reviews is to promote greater attention to mental health issues in old age in social work curricula.

Our searches were conducted on the following databases: PubMed (1997-2007/December); PsycInfo (1972-2007); Ageline (1978-2007); and EbscoHost Research—Academic Search Premier (through 2007). In addition, we looked up citations from articles located in the electronic searches. Google Scholar was also searched using the parameter of November 2007 through February 2008 to identify recent publications that would not have been otherwise cited. Unpublished literature was not included in the review. For computer searches we used the following terms: aged, elder*, old*, late life,

geri*, long term care, dementia, Alzheimer*, depress*, mood disorder, anxiety, schizophrenia, assessment, treatment, intervention, and randomized controlled trials.

Our reviews include studies of adults 65 years or older. For the majority of the reviews, the population discussed includes community-dwelling noninstitutionalized older adults except for the review on dementia. Our initial strategy was to first examine systematic review articles to locate relevant studies; second we looked at meta-analyses; third we appraised other reviews of the literature; fourth we assessed randomized controlled trials (RCTs), or if these were unavailable, other types of studies reported in English language peer-reviewed journals. Articles were included only if they reported on the assessment and treatment of older adults with either depression, anxiety, schizophrenia, or depression in dementia. The reviewed studies in geriatric mental health were generally evaluated using the Agency for Health Research Quality (AHRQ) system for levels of evidence in research quality:

- LEVEL A: randomized controlled clinical trials.
- LEVEL B: well designed clinical studies without randomization or placebo comparisons.
- LEVEL C: service and naturalistic clinical studies, combined with clinical observations, which are sufficiently compelling to warrant use of the treatment technique or follow the specific recommendations.
- LEVEL D: long-standing and wide-spread clinical practice that has not been subjected to empirical tests.
- LEVEL E: long-standing practice by circumscribed groups of clinicians that has not been subjected to empirical tests.
- LEVEL F: recently developed treatment that has not been subjected to clinical or empirical tests.

The main emphasis of the reviews was on RCTs (Level A). These levels of evidence do not directly describe the quality or credibility of the evidence. Rather, they indicate the nature of the evidence being used. In general, an RCT has the strongest credibility (Level A); yet, it may have weaknesses that diminish its value (Level B), and these should be noted. In general, Level C studies carry less credibility than level A or B studies, but credibility is increased when consistent results are obtained from several level C studies carried out at different times and in different places. Decisions must often be made in the absence of published empirical evidence. In such circumstances it is imperative to use expert opinion based on knowledge and clinical experience (designated as evidence Level E).

This Mental Health and Aging resource review is designed to be a resource and to provide links to other resources for faculty teaching the advanced mental health practice curriculum in master's level social work programs. The specific topics included in this module were selected because of their prevalence among older adults, the distinctive challenges they present to diagnose and to treat in older adults, their impact on caregivers and service providers, and the existence of controversies about the nature of the conditions and even their presence in older adults. Both anxiety disorders and mood disorders are quite prevalent among older adults, as are depressive disorders and generalized anxiety disorder. Social workers in any setting that serves older adults need to be able to screen for, evaluate, and provide treatment for these problems. Anxiety, depression, and psychotic symptoms all provide diagnostic and treatment challenges for several reasons:

- Older Adult Reluctance: Older adults are reluctant to mention relevant symptoms to health care providers. They may lack insight into the presence of the symptoms, which often happens in the case of psychotic symptoms; they may be concerned about stigma associated with mental illness; they may feel that the symptoms are just a normal part of aging; or they may believe that the symptoms are of physical rather than psychological in origin, e.g., related to a medical illness or fatigue.
- Diagnostic Issues: These kinds of symptoms may be associated with a variety of general medical conditions and a number of medications, including alcohol and other non-medical drugs. For example, it is difficult to distinguish the apathy of an individual with dementia from depression or negative symptoms of schizophrenia.
- Pharmacological Treatment Issues: These problems can be complicated to treat with medication because of concerns about drug interactions and side effects. Additionally, older adults do not metabolize drugs as efficiently as younger individuals and thus may need lower doses of medication. At the same time, a common reason for lack of response to antidepressant medication is failure to prescribe an adequate dose of antidepressant.
- Nonpharmacological Treatment Issues: There is a paucity of research on the response of older adults to nonpharmacological treatment. Although there has been research on interventions like problem solving therapy, cognitive behavioral therapy, and interpersonal therapy, few studies have compared the efficacy of

different approaches, and almost no studies have examined interventions among older minority adults.

Each section in this Mental Health Review contains a chapter that functions as an annotated outline of lecture notes with teaching and practice resources, selected readings, and a case study exercise; Power Point slides that follow the lecture notes; and a narrative literature review of the research upon which the lecture notes were based. The slides and lecture notes can be used in their entirety as a stand-alone presentation on the topic, or specific slides can be copied and pasted to add aging content to existing presentations in a particular area. In fact, adding to existing lectures and presentations is the way that this material will presumably most often be used. For this reason, we did not include background material, such as DSM criteria for the disorders, detailed explanations of the mechanism of action of medications, or discussions of the basic methods of different therapeutic approaches. The final chapter outlines next steps in the study of older adults with mental illnesses, followed by an appendix providing a separate list compiling all the resources mentioned in the individual chapters. We hope this module will provide user-friendly resources for non-gerontology faculty who recognize the importance of adding aging content to their mental health courses, as well as, perhaps a few resources and ideas for faculty specializing in geriatric mental health.

References

Administration on Aging. (2002). *A profile of older Americans*. Washington, DC: Department of Health and Human Services.

Blazer, D. (2002). *Depression in later life*. (3rd ed.). New York: Springer Publishing.

Kaskie, B., & Estes, C. L. (2001). Mental health services policy and the aging. *Journal of Gerontological Social Work*, 36(3/4), 99-114.

Gellis, Z. D. (2006). Mental health and emotional disorders among older adults. In B. Berkman (Ed.), *Oxford Handbook of Social Work in Health and Aging* (pp. 129-139). New York: Oxford University Press.

Rosen, A. (2005). *The Shortage of an Adequately Trained Geriatric Mental Health Workforce*. Testimony to the Policy Committee of the White House Conference on Aging. Retrieved February 18, 2006, from http://www.whcoa.gov/about/policy/meetings/Jan_24/Rosen%20WHCOA%20testimony.pdf