

PROMOTION, PREVENTION AND  
EARLY INTERVENTION FOR MENTAL HEALTH IN  
GENERAL PRACTICE

Monograph 4

**Older adults**

Overview of the literature

Developed by



The New South Wales Institute of Psychiatry



Partners in Prevention  
Mental Health and General Practice



# Promotion, Prevention and Early Intervention for Mental Health in General Practice

Series Editors:

Anne O'Hanlon, Abbie Patterson and Jennie Parham  
Australian Network for Promotion, Prevention and Early Intervention for Mental Health  
(Auseinet)

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2007

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Auseinet is funded by the Australian Government Department of Health and Ageing and located at Flinders University. Auseinet supports a national network of people in a wide variety of settings to access knowledge and stimulate discussion on issues relating to promotion, prevention and early intervention for mental health and suicide prevention across the lifespan.

Australian Divisions of General Practice (ADGP) – now known as Australian General Practice Network (AGPN) - is the peak national body representing the Divisions of General Practice across Australia. Its mission is to provide leadership and support for the Divisions of General Practice to achieve quality and vitality in primary health care.

**The opinions expressed herein are those of the authors and not necessarily those of the Australian Government Department of Health and Ageing.**

**The editors and authors disclaim any responsibility for the consequences of using this report for clinical purposes.**

This monograph can be downloaded from the Auseinet website [www.auseinet.com](http://www.auseinet.com)

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## Foreword to monograph series

General practice is a key component of the mental health workforce and this has been reflected in a range of national mental health policies over the past seven years. These include: *National Mental Health Plan 2003-2008*; *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000*; the *Better Outcomes In Mental Health Care Initiative*; and the *COAG National Action Plan on Mental Health 2006–2011*. These developments at a national level have led to a process of reform of primary mental health care in Australia and have provided the impetus for general practice to have a greater role in mental health improvement.

Furthermore, general practice and primary care have been identified as important settings by several national mental health initiatives – *beyondblue*: the national depression initiative; *Mindmatters*: the national mental health promotion initiative in secondary schools; *COPMI*: a national initiative addressing the needs of children with parents who have a mental illness; and *headspace*: The National Youth Mental Health Foundation.

Auseinet is a national initiative funded by the Australian Government Department of Health and Ageing to support the implementation of promotion, prevention and early intervention (PPEI) approaches to mental health in a range of sectors and settings. Since 2000, Auseinet has been a key agency in driving the implementation of mental health PPEI in Australia. In 2003, Auseinet selected general practice as one of four priority sectors to invest in during its second phase of funding (2003-2007). This was consistent with the identification of general practice as an important setting for mental health PPEI activities in the *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health*.

Over the past 4 years, Auseinet, in partnership with the Australian General Practice Network (AGPN), formerly the Australian Divisions of General Practice (ADGP), has undertaken a range of activities designed to build the capacity of the general practice sector to implement PPEI approaches. Activities undertaken as part of the *Promotion, Prevention and Early Intervention for Mental Health in General Practice* project have included a scoping study of PPEI in general practice (O'Hanlon, Wells & Parham, 2004), an audit of training programs that have PPEI content, and, most recently, the commissioning of external experts in the field to develop four Active Learning Modules for general practitioners (GPs).

The learning modules have been accredited by the Royal Australian College of General Practitioners (RACGP), the General Practice Mental Health Standards Collaboration (GPMHSC) and the Australian College of Rural and Remote Medicine (ACRRM). Each module comprises an evidence-based overview of the literature and a related training program. Throughout the project we have maintained an inclusive view of the 'general practice setting' (i.e. GPs, other health professionals and Divisions), but for the purpose of training and accreditation, the modules in the first instance have been designed specifically for GPs.

We believe, however, that there is value in making the overviews of the literature available to a much broader audience. Therefore, we are presenting the overviews as a monograph series that we think will be of interest to the well-established network of people and organisations that support PPEI approaches to mental health.

The *Promotion, Prevention and Early Intervention for Mental Health in General Practice* monograph series comprises:

- Monograph 1. Conceptual framework for PPEI and applications in general practice: Overview of the literature (Professor Debra Rickwood);
- Monograph 2. Managing the impact of separation and divorce on children: Overview of the literature (Australian Psychological Society);
- Monograph 3. Child behaviour: Overview of the literature (Centre for Community Child Health); and
- Monograph 4. Older adults: Overview of the literature (The New South Wales Institute of Psychiatry).

This series provides an overview of the best available evidence to date on the conceptual framework for PPEI and its application to children and older people, with specific reference to early identification of mental health problems, assessing risk factors and enhancing protective factors. The overviews also include interventions with individuals, parents, families and carers where appropriate, that can be implemented in the general practice context.

The monograph series is available on the Auseinet website [www.auseinet.com](http://www.auseinet.com).

We would like to acknowledge the many people who have been involved in bringing this phase of the *Promotion, Prevention and Early Intervention for Mental Health in General Practice* project to fruition.

We thank foremost the authors of the monographs: Professor Debra Rickwood; the Australian Psychological Society (Melbourne); the Centre for Community Child Health (Royal Children's Hospital, Melbourne); and The New South Wales Institute of Psychiatry (Sydney). We also wish to acknowledge the input of their respective Reference Groups to the literature overviews and to the modules as a whole.

Thank you to the *Promotion, Prevention and Early Intervention for Mental Health in General Practice* Project Management Group for providing general direction for the project and identifying the priority areas for the evidence-based reviews and training programs. The group reflected the interests of the project partners, Auseinet's own Management Committee, general practitioners, mental health experts, and accrediting bodies. Members during the course of the project were: Professor Lyn Littlefield, Professor Graham Martin, Dr. Chris McAuliffe, Ms. Lesley McBride, Ms. Anne O'Hanlon, Ms. Jennie Parham, Ms. Lynette Pearce, Mr. Phil Robinson, Dr. Darcy Smith, Mr. Julian Thomas, Ms. Tracy Thompson and Ms. Leanne Wells. Thanks to those members who peer reviewed and provided insightful feedback on earlier drafts of the overviews.

We would also like to acknowledge Ms. Lesley McBride for her role in coordinating the development of the overviews and training programs while she was with Auseinet. Our thanks also to Ms. Jill Knappstein from Auseinet for assisting with proofing and layout of the monograph series.

## **The Editors**

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# 1. INTRODUCTION

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*'It must be remembered that while the incidence of old age mental breakdown is high, the incidence of mental normality among old age groups is enormously high. It must also be stressed that many of the psychological traits accepted as occurring sui generis are really reactions to unsympathetic and defeatist attitudes displayed by others against the older age groups.'*

The view from 1946: Harold D Palmer, Mental disorders of old age.  
Reprinted in *Geriatrics* in 2006.

The population of Australia is ageing. It is predicted that by 2041, 5.7 million or one quarter of the population will be aged over 65 years. Many people are living longer and there are increasing numbers of 'older old' who are aged 80 years and over.

The mental health of older adults, indeed of all our community, is a product of social as well as biological and psychological factors. Mental health and physical wellbeing are inextricably connected and this is even more evident as people age. There are a number of physical diseases that are common in late life which affect the mental health of older people and there are also a number of factors that contribute to the development of mental illness in late age. Social isolation, a sense of meaning and purpose, poverty – these require community approaches and solutions. Indeed it has been argued that older people must themselves be involved in the solutions for them to be effective (Seymour & Gale, 2004).

This overview of the literature has been commissioned with two aims: firstly to examine the evidence for promotion, prevention and early intervention (PPEI) approaches to mental health in older adults with special attention to the general practice context, and secondly to support a learning module for general practitioners.

General practitioners (GPs) provide frontline mental health care to the majority of people within the community (Andrews, Hall, Teesson & Henderson, 1999) including older people living in the community and in residential aged care facilities. The focus on mental health care for older people has been based on treatment of established disorders but limited attention has been given to the promotion of good health, prevention of mental disorder and early intervention.

Becoming old in Australia does not equate with poor mental health. In the Australian National Survey of Mental Health and Wellbeing (McLennan, 1997), older adults reported the lowest rates of psychological distress and mental disorders. Persons over the age of 65 had a rate of 6% compared with 18% for the general population. However, the aged population is increasing dramatically and although the rates of mental disorder may be lower than at other points in the lifespan, there is concern that the increasing percentage of the Australian population over 65 represents a significant problem for health services. Currently 11% of the population are 65 years and over and by the year 2031, between 19% and 22% of the population will be aged 65 years and older. The greatest increase will be in those aged 70 years and over. Across the course of the twentieth century life expectancy increased by as much as 25 years. The challenge for the twenty first century is to maintain quality of life across the expanded life span (National Centre for Health Statistics, 1990).

Mental health problems, especially depression, have become an extensive public health problem (Murray & Lopez, 1996; Skoog, 2004). Mental health disorders are recognised as contributing significantly to the disease burden throughout the world through morbidity rather than mortality (Murray & Lopez, 1996) with 30% of the disability burden worldwide attributed to mental disorders. Skoog (2004) argues that mental disorders are found in approximately 30% of older adults, but that they are seldom detected or properly treated.

## 1.1 Definitions

(Source: Rickwood, 2007)

**Mental health** refers to how a person thinks, feels and acts in their day-to-day life. It is how people feel about themselves, their lives and the other people in their lives. It includes how a person handles stress, relates to other people, and makes decisions. It has been defined as a state of emotional and social wellbeing that enables people to undertake productive activities, experience meaningful interpersonal relationships, adapt to change and cope with adversity (World Health Organization: WHO, 1999). Mental health is not the absence of illness, but rather, the ability to cope and feel positive about people and events in life.

A **mental illness or disorder** is a health problem that significantly interferes with a person's thoughts, feelings or social behaviour. It is diagnosed according to standardised criteria, usually the DSM-IV (American Psychiatric Association: APA, 2000) or the ICD-10 (WHO, 1992). Some of the major types of mental illness are depressive disorders, anxiety disorders, psychoses and eating disorders.

A **mental health problem** also interferes with a person's thoughts, feelings and social behaviour, but to a lesser extent than a mental illness. Mental health problems are more common and include the mental ill health that may be temporarily experienced as a reaction to the stresses of life. While mental health problems are less severe than mental illnesses, they still can have a significant impact on a person's future opportunities and sense of wellbeing, and may develop into a mental illness if not effectively treated.

**Mental health promotion** is about improving wellbeing for all people, regardless of whether they are currently well or ill. It is about optimising people's mental health by developing environments that are good for us all. Mental health is affected by the events that happen in our normal day-to-day lives, as well as by the stressful events that inevitably occur from time to time. Mental health can be promoted by making sure that public policies support the social and emotional wellbeing of individuals and groups. All environments - social, physical, economic, and cultural - need to be supportive of mental health. Community life is important and communities need to be empowered to take the actions that they decide are needed to build their capacity to support their members. All people need to be helped to develop skills to understand, enhance and respond to their mental health needs. Furthermore, mental health services need to acknowledge that they have a responsibility for promoting the wellbeing of individuals and communities, as well as treating illness.

**Prevention** refers to interventions that have the potential to prevent the onset of a mental health problem or mental illness. Prevention interventions require the identification of risk and protective factors for mental health. These are occurrences in everyday life that can affect mental health. **Risk factors** are occurrences that increase the likelihood that a mental health problem or mental illness will develop (such as stress), while **protective factors** are those that decrease the likelihood (such as good social support). Prevention interventions can be targeted to population groups identified according to the level of risk. There are three different levels of risk applied:

1. *General or universal* – These are interventions that are targeted at the general public or a whole population group. In this case no specific risk factors have been identified, and the intervention is aimed at preventing mental health problems for everyone. Interventions are designed to reduce risk factors and/or increase protective factors that are likely to be relevant to the general population.
2. *At risk or selective* – These are interventions aimed at individuals or population sub-groups whose risk of developing a mental health problem or mental illness is higher than for the general population. Interventions are designed to reduce risk factors and/or increase protective factors for a group identified as being at higher risk, such as people experiencing physical illness.

3. *High risk or indicated* – These interventions are for people who are at very high risk of developing a mental health problem or mental illness. They are designed to reduce risk factors and/or increase protective factors for people at imminent risk of mental ill health, such as people who are victims of violence.

**Early intervention** refers to interventions appropriate for people beginning to show the early signs and symptoms of a mental health problem and people developing or experiencing a first episode of mental illness. For people at very high risk and showing early signs and symptoms, early intervention aims to prevent the progression to a diagnosable illness. For people experiencing a first episode of mental illness, early intervention aims to reduce the impact of the mental illness in terms of its duration and the damage it may cause to the person's life, and also to foster hope for future wellbeing.

## **2. METHODOLOGY**

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### **2.1 Literature search**

#### **Electronic searching of databases**

A librarian assisted researchers with electronic searches of several databases including the Australasian Medical Index, Ageline, CINAHL, Embase, PsycINFO, and Medline. Searches were commenced at 1990 and limited by English language.

#### **Additional information sourced**

- a. Grey literature (e.g., Government documents, unpublished lectures, agency reports) was searched using subject directories such as BUBL.
- b. Reference lists from books, journal publications and grey literature were scanned and references followed up.

#### **Search terms**

The electronic databases were searched comprehensively using both thesaurus terms and keywords to compensate for poor indexing. This broad search strategy was considered necessary to find all relevant literature.

A number of search strategies were used in respect of the stated aims. For example, Medline searches were:

1. Explode 'Aged, 65 and over' or explode 'Health Services for the Aged' or explode 'Aged'
2. Explode 'Family Practice' or explode 'physicians' or explode 'primary health care'
3. Explode 'Mental Disorders' or explode 'bereavement' or 'grief' or explode 'suicide'
4. Explode 'Primary Prevention' or explode 'intervention studies' or explode 'health promotion' or explode 'health education'
5. 1 and 2 and 3 and 4.

Search strategies were modified according to the controlled language particular to the database.

### **2.2 Levels of evidence**

The National Health and Medical Research Council (NHMRC) has developed a system of classifying evidence that can be applied to the development of clinical practice guidelines (NHMRC, 1999) (refer Table 1). The 'highest' level of evidence is from systematic reviews of all relevant randomised controlled trials (RCT). In these, people are randomly assigned to control and intervention groups. The second level consists of at least one randomised controlled study. Level III evidence is derived from experimental designs that cannot achieve full randomisation and Level IV comprises studies without a control group. Given the complexity of issues being studied for this overview some lack of control over various components in the studies is expected. Nevertheless, studies considered by NHMRC to be at a 'lower level' may still provide useful information and are included in this overview.

**Table 1. Levels of evidence**

<b><i>Level</i></b>	<b><i>Type of evidence</i></b>
I	Evidence obtained from a systematic review of all relevant randomised controlled trials (RCT)
II	Evidence obtained from at least one properly designed RCT
III-I	Evidence obtained from one well-designed, pseudo-randomised controlled trial
III-II	Evidence obtained from comparative studies with concurrent controls and allocation not randomised (cohort studies), case controlled studies, or interrupted time series with a control group
III-III	Evidence obtained from comparative studies with historical control, two or more single arm studies, or interrupted time series without a parallel control group
IV	Evidence obtained from case series, either post-test or pre-test and post-test

Source: NHMRC (1999, p.56)

### 3. NORMAL AGEING

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There is general agreement that there is decreased reserve in underlying physiological systems in the elderly, with less ability to withstand physiological challenges. There has been less debate or research in the area of mental health outcomes compared with physical health, although the two concepts are obviously inextricably intertwined.

Carman (1997) concludes that ageing involves a heightened susceptibility to psychological and sociocultural insult as well as physiologic insult. There are sensory declines, 'normal' changes in sleep patterns as people age and some aspects of memory decline, which may render older people more vulnerable. As a group, the elderly are also more likely to suffer stresses such as bereavement. However, as individuals, the elderly are likely to take the same amount of time (up to two years) as younger persons to physiologically return to baseline following a bereavement. Similarly, Foster (1997) reports studies showing that the elderly are no more likely than younger persons to develop psychiatric morbidity when faced with the burden of being a caregiver, and no more likely to have a depressive response to admission to a long-term care facility.

Carman (1997) notes that personality remains stable across the lifespan – unless affected by disease processes such as neurological disease. However, such degenerative diseases are more prevalent among the elderly. Carman also suggests that older people may be less adapted to change but, on the other hand, often show more 'broadmindedness' as they age.

Although there is functional physical decline with ageing, it is felt by some that there is evidence that mental health, coping, adaptation and resilience functions are surprisingly well preserved throughout most of the life span (Foster, 1997). Epidemiological studies in the US reported that older people had lower incidence and prevalence of the major psychiatric disorders (which often have their onset in young adulthood), with the exception of cognitive decline. Foster notes that stressors are 'qualitatively' different for the old as compared to younger age groups and infers that they may also manage stressors better.

This presumed resilience may represent a survivor effect given that there is higher mortality amongst those with major psychiatric disorders and Foster (1997) notes that 'survivorship often selects for these very features of adaptational competence.' Older people are more likely to rate their own health as good or excellent than are younger people, despite objective deficits. This may, of course, reflect lower expectations rather than positive adaptation. In addition it may reflect a cohort effect which will disappear when the current generation ages.

The evidence would suggest that normal ageing is not necessarily associated with increased psychopathology, and may in fact be associated with the increased resilience associated with survivorship. Nevertheless, as people age they have increased exposure to the risk factors associated particularly with depression, in association with the vulnerability conferred by other physical co-morbidities.

## **4. MENTAL DISORDERS IN OLDER ADULTS**

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### **4.1 Epidemiology**

In Australia, the 1997 National Survey of Mental Health and Wellbeing of Australians (McLennan, 1997) was conducted with a representative sample of persons living in private dwellings in all states and territories of Australia. The limitations of this survey in regards to older people included the exclusion of people with poor English skills, the lack of a representative sample of elderly people, and the lack of subjects living in residential facilities. The survey found that in the 12 months preceding the study, 6.1% of people aged 65 years and over experienced a mental disorder, and 77% of those aged over 65 years had physical conditions. The prevalence of affective disorders (depression, bipolar affective disorder and dysthymia) was 4.5%, anxiety disorders 1.7% and substance use disorders 1.1%. Given the high rates of mental disorders amongst people living in residential facilities (The Hammond Care Group, 2004) these figures are thought to be an underestimate.

American data suggests that at least one in five people over the age of 65 suffers from a mental disorder (Bartels, Dums, Oxman et al., 2002). In long term care facilities this figure rises to 80 or 90%. The most prevalent disorders include anxiety, depression and dementia with generalised anxiety disorder being the most prevalent (11%) (Sorocco & McCallum, 2006). While depressive disorders have a prevalence of 4%, the numbers in community samples who have clinically significant symptoms are as high as 20%. In adults over the age of 65, dementia has a prevalence of 5% and the rate increases to 30% in adults over the age of 85. Schizophrenia, alcohol and substance abuse, personality disorders, delirium and pain disorders are prevalent in late life.

Mental disorders may arise at any time across the life span and older adults may have persistent or recurring mental disorders that first manifest in adolescence or earlier adulthood. For example, 60% of older people who have had a prior episode of depression have at least one late-life episode, and 40% of those who have had a prior episode remain chronically affected (Bird & Paslow, 2002).

Although psychosocial factors including loss and role transitions may appear to be prominent stressors in older adults, several studies suggest that biological factors are highly significant in the development of mental disorders such as depression in older adults. In a study comparing people who develop depression in later life to those who develop depression in adulthood, there was an association with vascular disease and the risk for depression in later life. Vascular disease was found in a large percentage of patients with an onset of depression in later life. This is consistent with the hypothesis that depression in later life is a more 'biological' disorder (Hickie, Scott, Naismith et al., 2001). In a study by Kivelo, Viramo and Pahkala (2000), there was inconclusive evidence to suggest that a relapse of depression in older people was attributable to stressors or physical illness. In this study the triggers for relapse of major depression in older people with a history of depressive illness were not clear.

### **4.2 Protective factors**

The majority of older adults consider their health as good, very good or excellent despite physical disease, and the majority of older adults do not have a mental disorder (McLennan, 1997). Older adults have life experiences that can assist with the challenges they face with increasing age. Factors such as personal and social competence, family coherence and social support and personal structure are associated with resilience in older adults (Friborg, Hjemdal, Rosenvinge & Martinussem, 2003). Nilsson, Ekman and Sarvimäki (1998) identified

factors that influenced life satisfaction and subjective quality of life in older people as being: functional capacity, perceived health, good housing conditions, an active life style, and good social relationships.

In their study of 281 elderly women (aged 56-95 years) Lohr, Essex and Klein (1988) examined a model of causal links between the physical, functional, and subjective components of physical health status and life satisfaction. They found that the subjective perception of health and functional capacity seem to be of greater importance than objective factors, and that coping strategies may explain the relationship between health and life satisfaction.

### **Exercise**

Exercise is probably the most studied of the protective factors in the mental wellbeing of older adults. Exercise is also the strongest candidate for the prevention of depression (Llewellyn-Jones, Baikie, Smithers et al., 1999; Singh, Clements & Singh, 2001). Regular exercise has been found to alleviate the symptoms of depression equal to the effects of antidepressant medication (Bird & Paslow, 2002). It has been suggested that the long term effects of exercise may also alleviate two important risk factors for depression - vascular disease and falls (Blumenthal, Hart, Sherwood et al., 2001).

Recent cross-sectional studies and controlled trials have suggested that exercise, such as aerobic classes and t'ai chi, provides both physical and psychological benefits among older adults (Lautenschlager & Almeida, 2006; Li, Harmer, McAuley et al., 2001). These benefits include greater life satisfaction, positive mood states and mental wellbeing, reductions in psychological distress and depressive symptoms, lower blood pressure, and reduction in the brain pathology typically associated with dementia (Lautenschlager & Almeida, 2006).

A meta-analysis of 36 intervention studies related to physical activity and psychological wellbeing in older age concluded that aerobic training was the most beneficial and that a moderate intensity activity was the most recommended. Physical activity demonstrated improvements in self-efficacy, functional capacity, cardiovascular status, and wellbeing (Netz, Wu, Becker & Tenenbaum, 2005).

There is an absence of randomised clinical trials in the area of physical activity and cognition; however, there are observational studies that demonstrate that physical activity can reduce the risk of cognitive decline and dementia in later life (Lautenschlager & Almeida, 2006).

The promotion of health and physical activity was found to improve the mental health of a group of elderly Turkish immigrants in the Netherlands. This randomised controlled trial was conducted with 126 participants, all of whom had migrated from Turkey to the Netherlands. The intervention group had eight, two hour sessions consisting of health education focused on maintaining good health and exercise. The non-treatment group did not receive health promotional interventions. The intervention group showed an improvement in the mental health status of deprived immigrants. It is unclear whether this conclusion applies to non-immigrant populations (Reijneveld, Westhoff & Hopman-Rock, 2003).

In a cross-sectional community sample of Australian women over the age of 70, Cassidy, Kotynia-English, Acres et al. (2004) investigated the association between potentially modifiable lifestyle factors and cognitive abilities and depressive symptoms. Physically active women were half as likely to be depressed and anxious, when compared to their physically inactive counterparts. In the Cassidy et al. (2004) study, the risk for developing depression if the person has ever smoked more than 20 cigarettes per day was also confirmed, and low level alcohol consumption (less than three units of alcohol over a period of greater than two weeks) was associated with better cognitive performance. Further randomised controlled trials are needed to determine whether the management of lifestyle factors reduces the incidence of mood disorders and cognitive impairment in later life.

## **Nutrition**

Nutrition is an important contributing factor to health and functional ability especially in the elderly. Nutritional state impacts on a person's physical and psychological wellbeing (Bhat, Chiu & Jeste, 2005). In an editorial review examining the literature on the association between nutrition and geriatric psychiatry, Bhat et al. (2005) suggested that being overweight in old age is likely to have protective effects, as opposed to being undernourished. The authors suggest that older people should be seen as complex dynamic systems with potentially failing elements where one major or several minor factors interact, leading possibly to adverse outcomes.

A comprehensive review by Hickie, Scott, Naismith et al. (2001), of nutritional and vascular risk factors for late life depression concluded that folate and vitamin B<sub>12</sub> should be taken as nutritional supplements to reduce the risk of depression. There is anecdotal evidence that these vitamins can assist in the reduction of risk for depression, but this evidence is very weak and needs to be substantiated with RCTs (Hickie et al., 2001).

## **Social connectedness**

In a meta-analysis of depression prevention, older people were found to benefit from social supports (Jane-Llopis, Saxena & Hosman, 2005). Such social supports might include relationships, family contacts, community links, hobbies and interests, and spiritual faith.

It is important to acknowledge the ongoing needs for attachment and intimacy across the lifespan and that this includes needs for sexual expression. Sexual needs of the older person are often overlooked, particularly where there are issues of sexual orientation (Hughes, 2003).

Cerrato, Montorio and de Troconiz (1998) argue that older adults cope better with the stressors of old age by utilising their life experiences to determine the best strategies to adapt to changes and challenges. These differ from those experienced by other age groups, with older people presented with chronic stress situations which impact on their daily lives. The authors present an optimistic view of ageing, analysing two complementary approaches to adaptation during older age. One focuses on establishing the limits of functioning in older age (selective optimisation and compensation) and the second on emphasising people's capacity for coping with the challenges that present in older age (the 'stress model' applied to old age). Older people who deal successfully with change and who address the challenges directly by using their personal resources, restructuring the meaning of the changes, utilising social supports and maintaining a sense of control over their lives, will be less likely to develop mental health problems as they age.

## **4.3 Risk factors**

A search of the literature was undertaken for risk factors associated with specific mental disorders including depression, anxiety, and dementia, as well as those factors which impact generally on mental health and wellbeing. Studies that address depression risk factors were more numerous than other categories.

Butcher and McGonigal-Kenney (2005, p.54) summarised the risk factors for depression in older age:

*'living alone, having little or no social support, being unmarried or widowed, going through recent bereavement, enduring chronic pain, being a caregiver, having a history of depression or a chronic illness, being incontinent, fearing death, abusing substances, having a history of suicide attempts, or having a functional disability such as loss of mobility or vision (especially a recent loss).'*

## Transitions

Transitions in older adults can include retirement, grandparenthood, acquiring a disability, relocation of home, or move to a residential aged care facility. As with other points along the life span the stress of transitions can be an opportunity to adapt, and with adequate resources people can effectively manage these adjustments. It can also provide the chance for individuals to make positive and profound changes in their lives.

Transition to the care and environment of a residential aged care facility has been identified in the literature as the most significant relocation affecting older people (Lee, Woo & Mackenzie, 2002). In a critical review of the literature related to older person's experience with transition to residential care, Lee et al. (2002) concluded that the adjustment to residential care is not a discrete event in that it may be preceded by declining health, financial problems and death of a spouse.

A survey of 1,758 residents in 168 aged care homes from every state and territory in Australia was carried out by the national Challenge Depression Project (The Hammond Care Group, 2004), to ascertain the scale of the problem of depression amongst residents. Results from residents able to complete the Geriatric Depression Scale (GDS) indicate that 51% of high care and 30% of low care residents were depressed. Results from those only able to be assessed with the Cornell Rating Scale (the severely cognitively impaired) indicate that 38% of high care and 26% of low care residents are depressed. A limitation of this study was the use of the GDS-15, which is a screening instrument for depressive illness in older adults, not a diagnostic tool.

Institutionalisation and poor daily functioning have been associated with an increased risk of the development of depression in older people (Eisses, Kluiters, Jongenelis et al., 2005; Stek, Vinkers, Gussekloo et al., 2006). Depression in this group is often chronic, unrecognised, and associated with significant disability and premature mortality. Few depressed elderly people living in residential care receive appropriate management (e.g., Ames, 1990; Ames, 1993; Rovner, German, Brant et al., 1991).

## Social isolation

Cattan and White (1999) defined 'social isolation' as the objective measure of having minimal interaction with others, and 'emotional isolation' (or loneliness) as the subjective feeling of dissatisfaction with having a low number of social contacts. Not all older adults wish to participate in social connections (Commonwealth of Australia, 1999) and those who chose to have limited contact with others may not in fact be lonely or at risk of developing mental health problems.

Findlay and Cartwright (2002), in a literature review on social isolation prepared for the Queensland Government, determined that the factors influencing social isolation identified in the literature include: losses, poor health, mental illness, being a carer, geographic location, communication difficulties (including being from a non-English-speaking background), place of residence, being male and single, and transport difficulties.

Older people from culturally and linguistically diverse (CALD) backgrounds are more vulnerable to isolation and loneliness (Bennett, 1996). Findlay and Cartwright (2002) in their review of predominantly Australian literature found that it is likely that at least 10% of people aged 65 and over are socially isolated and a further 12% are at risk.

Social isolation can have physically and emotionally damaging effects, resulting in depression, suicide, poor nutrition, decreased immunity, anxiety, fatigue, and social stigma (Draper, 1996; Merrill & Owens, 1990). In a study not directly examining the issue in older adults, strong correlations have been found between social isolation and such variables as depression, self-esteem, and wellness. The strongest correlation appears to be between social isolation and social support, and between social isolation and physical and mental health disorders including depression (Vandervoort, 1999).

## **Loss and grief**

Loss and grief have been identified as the most serious risk factors for suicidal behaviour in adults (De Leo, Buono & Dwyer, 2002). Losses for older people can be frequent and cumulative and may include: loss of health and functioning including hearing and other communication abilities, bereavement, financial difficulties, loss of autonomy, loss of social networks, loss of relationships, and loss of independence.

The experience of grief and loss has been identified as a risk factor for the development of mental health problems (Bennet, 1996; Jacobs, 1993; Zisook, Paulus, Shuchter & Judd, 1997). The development of mental disorders as a consequence of loss is complex, and relates to the individual's anticipation and preparedness for the loss, past history of mental health problems, and social support (e.g., Carnelley, Wortman & Kessler, 1999; Mendes de Leon, Kasl & Jacobs, 1994). In a prospective study, Carnelley et al. 1999 investigated the impact of widowhood on depression and how resources and contextual factors that define the meaning of loss modified this effect. This was a longitudinal study conducted over three years. They concluded that a spouse's illness may result in grieving and depression prior to the spouse's death, and that those who do not experience depression during this period are most at risk of developing depression after the spouse's death.

The expression of 'normal' bereavement or grieving may differ considerably among different cultural groups and the presentation may in fact mimic a major depressive episode (Australian Psychological Society: APS, 2000). The duration and intensity of symptoms such as feelings of sadness, insomnia, poor appetite and weight loss need to be taken into account when assessing a person's grief reaction.

## **Physical illness**

There is a complex relationship between physical illness, disability and mental health problems or mental health disorders in older people. Chronic diseases that increase vulnerability to mental disorders and cognitive decline are diabetes, stroke, heart disease, lung disease or arthritis (e.g., Fillit, Butler, O'Connell et al., 2002).

In addition there have been a number of comorbidities identified in relation to mental disorders such as depression. Butcher and McGonigal-Kenney (2005) listed these as: cancer, thyroid disease, postmenopause, vitamin B<sub>12</sub> deficiency, chronic pain, malnutrition or functional disabilities.

Among older people, physical illness has been identified as a stressor and risk factor for suicide, attempted suicide and suicidal ideation (De Leo et al., 2002), though there is some controversy as to the extent to which physical illness is a risk factor for suicidal behaviour in later life. It is thought that other factors, primarily depressive pathologies, influence suicide in the older person, with physical illness also a contributing factor (De Leo et al., 2002; Henriksson, Marttunen, Isometsa et al., 1995).

Mental disorders are associated with the development of chronic conditions; for example, depression is a robust predictor of cardiovascular risk (Rutledge, Reis, Olson et al., 2006). Cross-sectional and longitudinal studies have consistently found depressive illness and disability to be related, although understanding of whether depression leads to subsequent onset of disability is limited (Ustun & Kessler, 2002).

## **Sensory impairment**

A study by Tolman, Hill, Kleinschmidt and Gregg (2005) considered the psychosocial adaptation to vision loss and its relationship to depressive symptomatology in legally blind older adults with age-related macular degeneration (ARMD). The findings support the contention that depressive symptomatology, as measured by self-report in older adults with ARMD, is mediated by one's perceived sense of individual control as it relates to intrapersonal factors underlying adaptation to profound vision loss in old age (Tolman et al., 2005).

Hearing loss is also related to depression. In a study hypothesising that the provision of hearing aids to elderly people with hearing loss might lead to better social, emotional and cognitive functioning and reductions in depression (Mulrow, Aguilar, Endicott et al., 1990), elderly male veterans were assessed using a range of measures. Eighty two percent of people studied reported adverse effects on quality of life due to hearing impairment, and 24% were depressed.

### **Loss of mobility**

Bird and Paslow (2002) cite post stroke depression as common, with prevalence estimates of 10% to 64%. It is argued that the contributing factors, including lack of mobility and reduced ability to perform activities of daily living led, to an increase in depression and was also a predictor of nursing home placement, where there are very high rates of depression.

Whilst there is literature suggesting a causal connection between mental health problems, particularly depression, and chronic physical conditions such as mobility impairment, hearing loss and arthritis, there are limited examples of effective interventions for prevention of mental illness in this area (Anderson, Hackett & House 2004; WHO, 2004).

In a review of the randomised and quasi-randomised controlled trials, Anderson et al. (2004) compared different types of pharmaceutical agents with placebo, or various forms of psychotherapy against standard care in patients with a recent clinical diagnosis of stroke, where the treatment was undertaken with the explicit intention of preventing depression. They concluded that there was no clear effect of pharmacological therapy on the prevention of depression, and whilst a significant improvement in mood was evident for psychotherapy, the treatment effect was small and from a single trial. Importantly, the reviewers concluded that there was no effect of either pharmacotherapy or psychotherapy on the prevention of depressive illness, disability or other outcomes.

### **Chronic pain**

Chronic pain is common in the lives of older adults, and interferes with a person's ability to function adequately in their day-to-day life. Chronic pain is experienced as a result of numerous physical health conditions. The literature to date has not undertaken a biopsychosocial approach, tending instead to concentrate on a traditional medical and pharmacological treatment approach.

Gold and Roberto (2000) undertook a comprehensive review of the multidisciplinary chronic pain and ageing literature and concluded that researchers estimate that 25% to 50% of community-dwelling older adults and 45% to 80% of institutionalised older adults experience chronic pain. Further, they argue that untreated or under-treated chronic pain can lead to sleep disturbances, malnutrition, increased stress, and impaired functioning and ambulation. The combination of these factors, as well as dependence and isolation, may then lead to depression and anxiety (Gold & Roberto, 2000).

In a Level III study of 318 Hong Kong Chinese elderly, Chou and Chi (2005) concluded that within this group, pain was a reliable predictor for the development of depression at 12 months after baseline assessment.

A study identifying depression in older people with rheumatoid arthritis found the optimal predictors of depression were average daily stressors, confidence in one's ability to cope, and degree of physical disability. These risks for the development of depression were seen as preventable (Wright, Barrow, Fisher et al., 1995) but many older adults accept that chronic pain is part of the ageing process and do not seek treatment (APS, 2000).

### **Caregivers of chronically ill older adults**

Older persons are often the carers for their spouses and may also provide caring roles as parents and grandparents. Wells and Kendig (1997) stated that the greatest source of help for the majority of older adults with a disability is their spouse. Whilst it is acknowledged that there are many personal rewards associated with the role of caregiver, it can also be stressful and place restrictions on financial resources, social participation and lifestyle.

In a 2003 meta-analysis, Pinqart and Sorensen (2003) integrated findings from 84 articles on differences between caregivers and non-caregivers on a range of variables. The largest differences were found with regard to depression, stress, self-efficacy and general subjective wellbeing. Non-caregivers had somewhat higher levels of physical health, although this difference was small. However, when carers for people with dementia were compared with non-caregivers this difference was large and statistically significant.

Significant support can be provided for caregivers by identifying and addressing their physical and mental health problems, providing psychoeducation about the illness of the person they are caring for, referring for respite care, and advising them of available resources and support (Sorensen, Pinqart & Duberstein, 2002).

## **5. INTERVENTIONS TO MAXIMISE MENTAL HEALTH IN OLDER ADULTS**

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The mental health of older adults, indeed of all our community, is a product of social as well as biological and psychological factors. Social isolation, a sense of meaning and purpose, poverty – these require community approaches and solutions. It has been argued that older people must themselves be involved in the solutions for them to be effective (Seymour & Gale, 2004).

WHO (2005) put forward key lessons from the evidence regarding health promotion. Two of these were: emphasising positive mental health as well as prevention and treatment, and striving to increase the individual's control over their own mental health and wellbeing. Older people, communities and health professionals often contribute to the ageist attitudes that a reduced quality of life is to be expected as we age (APS, 2000; Bowling & Dieppe, 2005).

GPs are the mainstay of interventions that target biological and psychological factors but also play a pivotal role in endorsing other interventions either through promotional and educational material, referral or direct discussion with individual patients (O'Hanlon, Wells & Parham, 2004). A belief in the positive aspects of old age and the acceptance that older people deserve to live fulfilling lives to the best of their capacity can be demonstrated by the importance of reducing pain, maximising physical health, promoting protective factors and addressing risk factors in older patients.

### ***5.1 Increasing social connectedness***

Social isolation is a risk factor for mental disorders but what interventions can alter a person's sense of connection with others? Findlay and Cartwright (2002) report that interventions that may reduce social isolation include: providing a central access point to services, providing at-risk individuals with telephone support line referrals and numbers, encouraging the development of computer skills such as emailing and Internet access, referring to support groups that are ongoing or continue for at least 20 weeks, and providing practical advice and referrals for issues such as transport, housing and social networks.

There is also evidence that encouraging people to connect with telephone based support services, such as Telecross and Lifeline in Australia, can reduce isolation and suicidal ideation in the elderly (De Leo et al., 2002).

### ***5.2 Suicide prevention***

Suicide is a problem in the older population with approximately 90% of older people who attempt or die by suicide in Australia having a mental disorder, usually depression, which has been inadequately treated (Draper, 1996). It is acknowledged that suicide intention in the elderly is more resolute, employs violent methods and is less frequently preceded by a suicide attempt. Preventative measures should be targeted at high risk groups with vulnerability (Commonwealth of Australia, 2000).

Given the strong association between depression and suicide in older people (particularly older men), increased vigilance, early intervention, understanding of risk and protective factors and appropriate treatments for depression are considered effective suicide prevention strategies (De Leo et al., 2002).

Many people who die by suicide have had established health care providers, and many of these had been in contact with their practitioner shortly before the death, suggesting that the detection of suicidal patients is inadequate (Luoma, Martin & Pearson, 2002). High risk

management guidelines for elderly suicidal patients in primary care settings published by Brown, Bruce and Pearson (2001) present an algorithm recommending a detailed assessment of risk for suicide using standardised assessment measures.

However, the critical review of evidence-based literature, the *Guidelines for Preventive Activities in General Practice* (Royal Australian College of General Practitioners: RACGP, 2005) concludes that in the area of suicide 'there is a lack of evidence for the routine screening of patients using a screening instrument.' However, they recommend opportunistic screening of patients who have risk factors for suicide. Hall, Mant, Mitchell et al. (2003) note that the incidence of suicide has decreased in older men and women in association with exposure to antidepressants.

### **5.3 Screening and detection**

There is limited evidence for the usefulness of screening for mental disorders in older people. The RACGP recommends opportunistic rather than universal screening. This is not to say that mental disorders, particularly depression, may not go unnoticed among older persons seen in primary care settings; for example, late life mood disorders are significantly under-diagnosed, particularly in primary care (Harman, Brown, Ten et al., 2002). However, there is little evidence that screening is linked to improved outcomes; for example, Callahan (2001) and Unutzer, Katon and Russo (1999), showed that efforts to improve late-life depression treatment, using screening and health care practitioner feedback and education, did not result in consistent improvements in depression.

Some have argued that GPs need increased skills to engage older people and assess for mental disorders (Sirey, Bruce & Alexopoulos, 2005), while others have focused on improving screening tools and treatments for depression by primary care providers (Bartels, 2003). MacMillan, Patterson and Wathen (2005) recommend just two questions for identifying depression:

1. *Over the past 2 weeks, have you felt down, depressed or hopeless?*
2. *Over the past 2 weeks have you felt little interest or pleasure in doing things?*

The RACGP has endorsed screening tools for mental disorders in at risk older people (RACGP, 2005). Its guidelines recommend assessment protocols for identifying depression and dementia in elderly patients that include a full history and physical examination, a functional assessment using Instrumental Activities in Daily Living (IADL), and a cognitive assessment using Mini-Mental State Examination (MMSE) or the General Practitioner Assessment of Cognition (GP-COG).

Specific at risk groups may be targeted for screening in general practice. For example, a recent study (Almeida & Pfaff, 2005) examined sleep difficulties in the elderly within the context of general practice. In this correlational study it was found that those who reported sleep difficulties were significantly more likely to be depressed than those without sleep problems. They concluded that GPs should screen for depression whenever older adults complain of sleep difficulties.

Other high risk groups are suggested by the *Guidelines for Preventative Activities in General Practice* (RACGP, 2005). Case finding and early intervention is recommended for depression and dementia when people are exhibiting increased risk (such as a family history of Alzheimer's disease) or high risk (such as past history of depression, elderly presenting with memory impairment). Further, Mackinnon, Khalilian, Jorm et al. (2003) recommend screening for dementia and depression when physical illness, dementia-like symptoms and social isolation and other stressors are present in older people presenting to their general practitioner.

Whilst many authors support the role of GPs in screening for mental disorders in older adults, their role in providing mental health treatments is also important. Sirey et al. (2005) suggest that GPs should be equipped with knowledge for initiating treatment for first episodes of mental disorders, knowledge of available referral options, and skills in engaging older patients in treatment for mental disorders. Some studies have suggested that collaborative care or shared care, that involves other mental health professionals and teams in assessment and treatment, has been shown to be effective (Unutzer, 2000).

#### ***5.4 Optimising physical health***

The role of physical health in mental disorders of older people may be more substantial than previously thought. High rates of mental disorder such as depression amongst older adults with physical illness highlight the need not only to be alert for mental disorders in this group but also the compounding risks of poor physical health. GPs have a pivotal role in providing good clinical care to older people. Physical illness early in life may be an important risk factor for mental disorders in older adults.

The role of cardiovascular, metabolic and, more recently, inflammatory risk factors in the development of mental disorders in older adults has opened up the possibility of primary prevention. Although there is a need for more detailed study, it seems likely that factors determined earlier in life such as lifestyle, level of education and illness profile, are directly related to the development of mental disorders in later life. Two current areas of research are late onset depression and dementia.

There is some evidence that late onset depression has a vascular origin, poor treatment response to antidepressants and a specific disability of executive function. Further work is needed to explore the effectiveness of primary prevention in mid life (Hickie et al., 2001).

The decline in the incidence of stroke heralds a reduction in the prevalence of vascular dementia (Jorm, 2000; Rabins, 1992). Some dementias are clearly related to specific modifiable risk factors such as brain injury and disease processes or infection. The direct relationship of dementia to cardiovascular and cerebrovascular disease and diabetes, suggests that implementing strategies to reduce the risk of these diseases will result in a reduction in dementia.

A recent study suggesting that Alzheimer's disease may be linked to environmental factors in childhood, including infections, raises the possibility that research may be directed towards prevention (Gatz, Reynolds, Fratiglioni et al., 2006).

#### ***5.5 Providing educational material***

A variety of patient education techniques are described in the literature, both for mental illness and for other disorders. These include the provision of pamphlets, a library from which the patient can borrow books, group and individual patient education sessions and the provision of Internet sites or computerised education. Few of these have been rigorously evaluated.

It is widely recognised that the provision of patient education improves mental health in patients with chronic and serious acute physical illness. Hawley (1995) reviewed the outcomes of psychoeducation for patients with arthritis. The psychoeducation included Cognitive Behavioural Therapy (CBT), psychotherapy, support groups, provision of materials (pamphlets, books and computerised instruction), and individualised instruction. Improvement in depression, pain, self-efficacy and self-management behaviour was reported, although effect sizes were small. A computer-based patient education program provided by a nurse in a randomised controlled trial improved depression and anxiety scores in patients with newly diagnosed cancer (Rawl, Given, Given et al., 2002). Dew, Goycoolea, Harris et al. (2004) describe improved anxiety and depression scores in patients and improved depression and

hostility scores in caregivers among 20 patients with heart transplants and their caregivers who were provided with a multifaceted web based intervention.

Patients with mental health disorders express a need for patient education (Chien, Kam & Lee, 2001). In relation to mental health reform in better resourced countries, WHO has recommended that 'the public needs to be educated.' Kronmuller, Saha, Karr et al. (2006) showed that patients with less illness knowledge in the area of depression had a less favourable illness concept, poorer interpersonal relationships and more passive coping strategies. In a review article, Keller (2004) showed that education improved adherence to medication and illness course for people with bipolar disorder. Schimmel-Spreeuw, Linssen and Heeren (2000) showed that elderly patients responded enthusiastically to education about their depression and to skills training, and had fewer depressive symptoms following the course.

There is less in the literature about patient education in primary care. In a Canadian study, Craven, Nikolaou, Allen et al. (2005) found that mental health pamphlets were not commonly displayed by the 13 GPs in their study. They also found that when a range of mental health pamphlets were provided, those on mood disorders were the most popular. Patients preferred to pick them up from the examining rooms rather than from the waiting room. Charlton (1997) provided evidence that a library of educational books for patients was well used over a period of 15 months, with mental health being the second most common subject covered by the books borrowed. Of 156 patients reporting on borrowings, 88% reported that their knowledge had increased as a result of borrowing books, and 79% reported that their behaviour had changed as a result of their reading.

It is clearly important for GPs to consider patient education when dealing with mental health problems, even in older people. Some simple strategies for GPs to provide this education include provision of pamphlets and books to patients. Referral for more intensive patient education may also be valuable.

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