

Mental Health of Older Adults, Addressing **A GROWING CONCERN**

M.T. Yasamy, T. Dua, M. Harper, S. Saxena

World Health Organization, Department of Mental Health and Substance Abuse

Background

The world population has never been as mature as now. Currently, the number of people aged 60 and over is more than 800 million. Projections indicate that this figure will increase to over two billion in 2050. People aged 60 can now expect to survive an additional 18.5 to 21.6 years (1). Soon the world will have a higher number of older adults than children. Contrary to common sense perceptions, the majority of older people live in low- and middle-income countries, and some of the fastest rates of ageing are occurring in these areas (2, 3).

The United Nations uses the benchmark of 60 years of age or above to refer to older people (UNFPA, 2012). However, in many high-income countries, the age of 65 is used as a reference point for older persons as this is often the age at which persons become eligible for old-age social security benefits (1, 2). This higher age category is less appropriate to the situation in developing countries including Africa where life expectancy is often lower than that in high-income countries (4).

Older adults face special health challenges. Many of the very old lose their ability to live independently because of limited mobility, frailty or other physical or mental health problems and require some form of long-term care. Early on, in the beginning of the millennium, it became clear in the USA that about 20% of adults aged 55 and over suffer from a mental disorder (5). Subsequently, global statistics showed this to be an almost universal problem (6). Mental health problems of older adults are under-identified by health care professionals and older people themselves, and older people are often reluctant to seek help.

Underlying factors of mental health problems in older adults

A multitude of social, demographic, psychological, and biological factors contribute to a person's mental health status. Almost all these factors are particularly pertinent amongst older adults.

Factors such as poverty, social isolation, loss of independence, loneliness and losses of different kinds, can affect mental health and general health. Older adults are more likely to experience events such as bereavements or physical disability that affect emotional well-being and can result in poorer mental health. They may also be exposed to maltreatment at home and in care institutions (7). On the other hand, social support and family interactions can boost the dignity of older adults, and are likely to have a protective role in the mental health outcomes of this population.

There are more older women worldwide than older men. This difference increases with advancing age and has been called "feminization of ageing". Older men and women have different health and morbidity patterns and women generally have lower income but better family support networks (1). On the other hand both depression and Alzheimer's disease are more prevalent among women (8).

Intergenerational solidarity is declining, especially in high-income countries. In some low- and middle-income countries a grandparent is increasingly more likely to be living with a grandchild. These so called "Skipped Generation" living arrangements are becoming more common because of economic migration, and in some societies as a consequence of HIV/AIDS related deaths. The impact of this on the

perceived social stress amongst older people needs further research (1).

The drastic demographic change brings about new challenges but also potential opportunities. The socioeconomic impacts, paired with health consequences, are new concerns for the world. This creates a paradoxical situation. Changes in the social role of the elderly have an impact on their wellbeing. In a considerable proportion of countries, older adults are now in better health as compared with the past. Older adults are increasingly “expected” to be more productive and are even being asked to contribute more to their family and/or community. Conventional attitudes toward the elderly have typically been considerate of their dignity, with a few exceptions in some cultures. However, the current expected role of an elderly person seems to have changed from the role of “sage advisor” as it used to be in most parts of the world. Retirement age is increasing in many high-income countries. Older people are expected and are able to make important contributions to society as family members, volunteers and as active participants in the workforce, provided they stay fit enough for carrying out such roles. Nevertheless, improving productivity and asking older adults to provide support to communities and families must be complemented by additional support to them from society.

An important risk factor to the health and mental health of older adults, and an important human rights issue, is elder maltreatment. WHO defines elder maltreatment as “a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust that causes harm or distress to an older person”. This type of abuse includes; physical, sexual, psychological, emotional, financial and material abuse; abandonment; neglect; and serious loss of dignity and self-respect. In high-income countries where data exists, around 4-6% of older persons have experienced some form of maltreatment at home. The frequency should be even higher, as many older adults are too scared or are unable to report maltreatment. Though data on the extent of the problem in institutions including hospitals, nursing homes and other

long-term care facilities are scarce, it so far indicates much higher rates as compared with maltreatment at home. Elder maltreatment can lead not only to physical injuries but also to serious, sometimes long-lasting psychological consequences, including depression and anxiety (9).

Promotion of mental health within a healthy ageing framework

Mental health of older adults can be improved through promoting active and healthy ageing. To promote healthy ageing, the socio-economic determinants and inequalities in health need to be dealt with and additional gender and minority disparities need to be tackled. Stereotypes against active ageing are called “ageism” and need to be reversed. Ageist attitudes consider older adults as frail, “past their sell-by date”, unable to work, physically weak, mentally slow, disabled or helpless. Ageism serves as a social divider between young and old and prevents participation in society. Age discrimination has a negative impact on the wellbeing of the elderly (10). Ageing is a gradual process and there is much we can do to promote good mental health and well-being in later life. Participation in meaningful activities, strong personal relationships and good physical health are key factors. Poverty is a risk factor for the mental ill-health of older adults and needs to be taken into consideration (11). Addressing elder maltreatment is a critically important approach for the promotion of mental health among the elderly. Primary health and community care and social service sectors need to be sensitized and supported to deal with elderly abuse. Deinstitutionalization and close monitoring of the remaining institutions are important additional strategies towards better service provision for the ageing population.

Promoting healthy life styles among the general population, starting from an earlier age with strategies such as increasing physical and mental activity, avoiding smoking, preventing harmful use of alcohol and providing early identification and treatment of non-communicable diseases (NCDs) can contribute to better mental health among older adults.

Involving civil society, non-governmental and non-

profit organizations, and public-private partnerships could facilitate the implementation of health promotion strategies for older adults.

Physical health problems in older adults

Even in resource-poor countries, more older people die of NCDs such as heart disease, cancer and diabetes than from infectious and parasitic diseases. In addition, older people often have several concurrent health problems (8). Risk factors for degenerative brain disease such as high blood pressure, diabetes and high cholesterol levels are increasing among older adults (12).

Mental health has a big impact on physical health. For example, coexisting depression in people with diabetes is associated with decreased adherence to treatment, poor metabolic control, higher complication rates, decreased quality of life, increased healthcare use and cost, increased disability and lost productivity, and increased risk of death (13). Conversely, people with medical conditions such as heart disease, diabetes, asthma and arthritis have higher rates of depression than those who are medically well (14).

Mental disorders in older adults

Dementia

Dementia is a syndrome involving deterioration in memory, thinking, behaviour and the ability to perform everyday activities such as dressing, eating, personal hygiene and toilet activities (15). It generally affects older people, although it is not a normal part of ageing. A report by WHO and the Alzheimer Disease Association International (ADI) in 2012 suggests a crude estimated prevalence of 4.7% among people 60 years and over. This indicates that 35.6 million people are living with dementia (12). The total number of people with dementia is projected to almost double every 20 years. That is, to 65.7 million by 2030 and up to 115.4 million by 2050 (12). Much of this increase is attributable to the rising numbers of people with dementia living in low- and middle-income countries (Figure 1). There are significant social and economic implications in terms of direct medical costs, direct social costs and the costs of informal care. The total cost as a proportion of GDP varied from 0.24% in low-income countries to 1.24% in high-income countries (12).

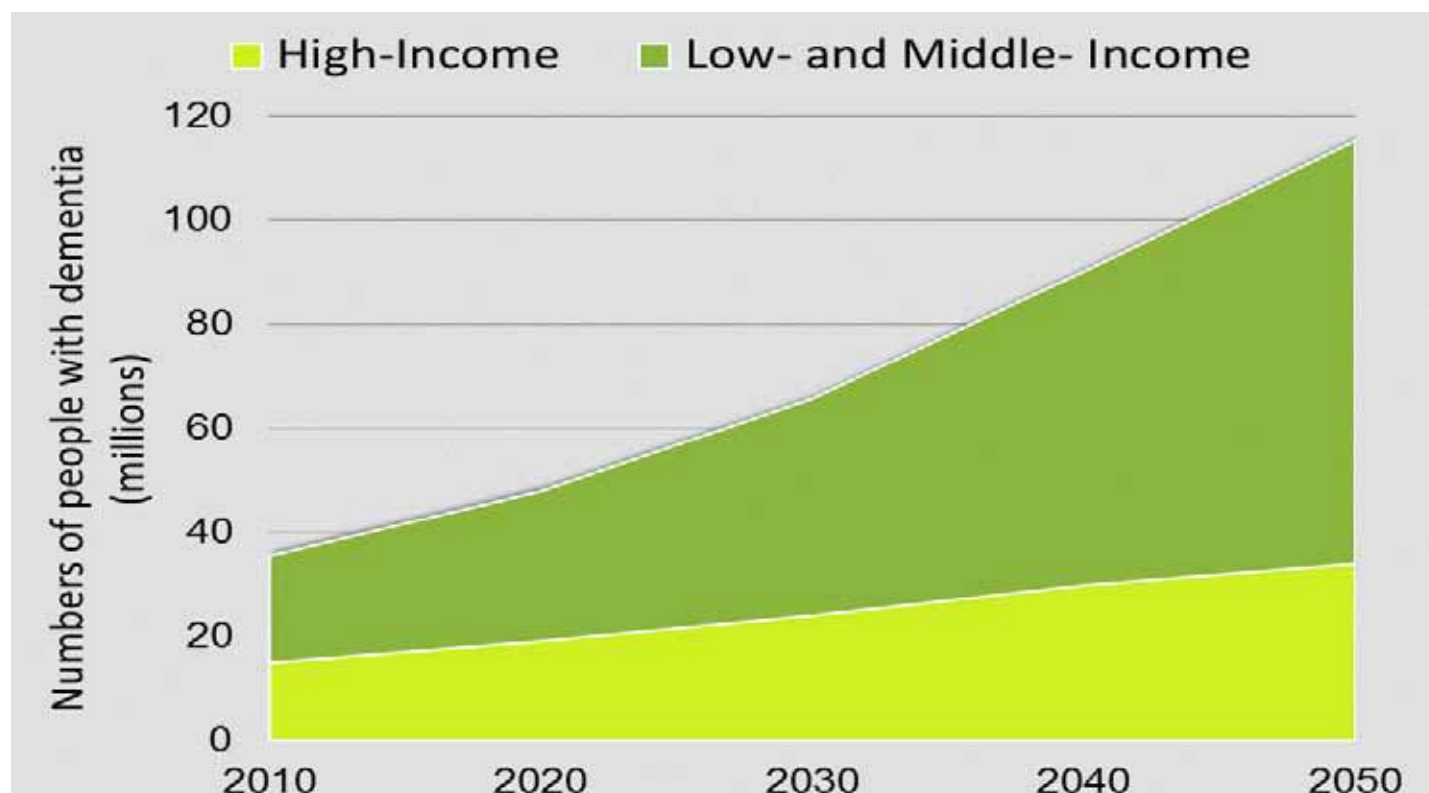


Figure 1: Increase in numbers of people with dementia, by income group of countries

Though no cure is available, much can be done for people with dementia and their caregivers. A range of pharmacological and several non-pharmacological interventions are available and can be delivered by even non-specialized health providers (15 & 16).

Depression

Depression is common in old age. According to the Institute of Health Metrics and Evaluation (IHME) 2010 data, the Disability Adjusted Life Years (DALYs) for depression (major depressive disorder plus dysthymia) over 60 is 9.17 million years or 1.6% of total DALYs in this age group (17).

Symptoms of older adults' depression differ only in part from early life depression. They may however have more somatic presentation (18). This, together with high comorbidity with other physical conditions, can create a challenge for diagnosis. Once trained properly, non-specialized health care providers can identify and treat depression among older adults. Effective psychological and pharmacological treatments exist; however, great care needs to be taken when prescribing antidepressants to this age group. Health care providers should prescribe reduced initial doses of antidepressants and finish with lower final doses (15, 19 & 20). If severe, depression may lead to suicide. Comorbidity with alcohol use disorders increases the likelihood (21).

Other mental disorders

Though substance abuse problems are thought of as young people's problems, they should not be neglected in older adults. Substance abuse problems among the elderly are often overlooked or misdiagnosed. In Europe, the number of older adults with such problems will double from 2001 to 2020 (22). According to IHME 2010 data, the absolute DALYs for alcohol disorders for people over 60 is about 1.5 million years. This constitutes about 0.3% of total DALYs for this age group (17). The corresponding figures for other substance use disorders are 338,000 years and 0.1%. Availability of maintenance treatments and better health care have contributed to an increased number of older adults who survive early onset drug use. Stressful life events such as retirement, marital breakdown or bereavement, social

isolation, financial problems, mental disorders and some chronic physical conditions are main contributing factors to substance abuse. Physiological changes associated with ageing and increased use of other medicines, especially sedatives, may make drinking in lower doses more harmful for older adults through inducing more liver damage and causing more accidents and injuries (22).

Prescribing for older adults is common. Some prescribed medicines such as benzodiazepines and opioids have a potential for abuse or dependence and this may occur within or outside a medical context.

Treatment of substance use disorders in older adults is at least as effective as in younger adults. Treatment of health conditions due to substance use, especially management of withdrawal states or substance-induced psychoses, should be delivered in a supportive and, if necessary, medical environment, with proper consideration given to interactions between psychoactive substances and prescribed medicines as well as to other health complications.

Mental disorders are more common among people with intellectual disabilities (ID). Also the number of people with intellectual disabilities who reach a sufficiently advanced age to develop dementia is increasing. The already challenged level of cognitive functioning is more vulnerable to dementia. Many high-income countries have strengthened their research activities and services for this group of older adults. Overall, this is a new area of work and so far the preference is for involving primary and community care and to prevent institutionalization (23).

Mental health of the caregivers

Older adults with dementia and depression commonly receive support from spouses, other family members or friends. Caregivers commonly go through high levels of burden, stress, and depression (24). Providing psychosocial care to them should be included in the intervention packages for mental disorders of older adults. Psychoeducational interventions such as training for caregivers that involves their active participation (e.g. role playing of behavioural problem management) are effective interven-

tions for caregivers of people with dementia. Carer psychological strain needs to be addressed with support, counselling, and/or cognitive behavioural interventions. Depression is common among caregivers and should be managed properly (15).

WHO's response to the need

WHO's programmes for active and healthy ageing have provided a global framework for action at the country level (25). WHO recognizes dementia as a public health priority and supports governments in strengthening and promoting mental health in older adults, particularly in low- and middle-income countries. WHO's flagship programme, the mental health Gap Action Programme (mhGAP) included dementia as one of its main priority conditions. The mhGAP-IG (intervention guide) includes evidence-based interventions to be delivered by non-specialized health providers in low-income settings for all priority conditions including dementia, depression, and alcohol and substance abuse (15).

The WHO/Alzheimer's Disease International report *Dementia: a public health priority*, published in 2012, aims to provide information and raise awareness about dementia. It also aims to strengthen public and private efforts to improve care and support for people with dementia and for their caregivers (26).

The latest World Health Assembly of 24 May 2013 considered older people to be a vulnerable group with a high risk of experiencing mental health problems in its report "Comprehensive mental health action plan 2013–2020". Among its requests to the Director General of WHO, the Assembly included long-term care for older people (27).

Conclusion

The number of older adults is growing fast all over the world. The socioeconomic impact of such demographic changes is adding to overall mental health consequences.

WHO is supporting governments to narrow down the service gap for mental health, particularly in resource-poor settings.

Though we still need more research on the biological, psychological and social aspects of older adults' mental health, we already know enough to make a difference.

We must improve general wellbeing through a life course approach and by promoting healthy life styles. We need to identify and treat mental disorders among this age group as early as possible. It is important to improve the social capital and involve communities and families in supporting the older adults. We need to support and engage non-profit organizations, NGOs and the peer groups of older adults. We should also establish public-private partnerships to fill the service gap.

Awareness on what has proved to be effective so far is extremely important. We need to fight against the maltreatment of older adults and abandon "ageist" attitudes by inviting the full participation of older adults into everyday life.

Many older adults still follow a life style that aggravates a lack of mental wellbeing. They need to be encouraged and educated do more physical exercise, keep socially connected, keep their brains active, reduce their weight, stop smoking or the harmful use of alcohol, and control their blood pressure, blood sugar and cholesterol levels. Most of these are plausible interventions for a good proportion of the older adults in the world.

Acknowledgement

We appreciate the comments provided by V. Poznyak, M. VanOmmeren and D. Chisholm. Armin Von Gunten and Deepti Kukreja from the WHO Collaboration Centre of Service Universitaire de Psychiatrie de l'Age Avancé (SUPAA), Lausanne contributed to an earlier draft of a relevant WHO document.

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