

Editorial

Mental health & substance use: Challenges for serving older adults

In 2012, 810 million adults aged 60 and older constituted 11.5 per cent of the world population. The older adult population will grow to one billion by 2020 and to two billion by 2050, or 22 per cent of the world population, with 400 million of them 80 years and older¹. Growth in the number of older adults is a cause for celebrating tremendous improvements in health and other quality of life indicators across the globe. This rapidly advancing “silver tsunami” also brings serious challenges to many countries’ already overburdened pension and healthcare systems. The unprecedented growth of the 85-and-older group presents a serious challenge as 25-30 per cent of them have some degree of cognitive impairment¹. Healthcare and social service systems in both developing and developed countries are not adequately equipped to care for the growing number of older adults with Alzheimer’s disease and other neurocognitive disorders, and the toll on older adults’ informal support systems is just beginning to be understood. Another significant challenge of an ageing society that has been largely hidden from public view and receives little attention from policymakers is mental health and substance use (MH/SU) care for older adults. This editorial addresses the scope of older adults’ MH (focusing on depression and anxiety) and SU problems, the current state of evidence-based practice, and recommendations for care.

Prevalence of mental health and substance abuse in older adults

Mental health and physical/functional health problems are closely associated. Extensive research shows that chronic diseases such as diabetes and hypertension are risk factors for depression and anxiety, and untreated mood and/or anxiety disorders, often through such adverse health behaviours as physical

inactivity, sleep disturbances, smoking, and drinking, are risk factors for serious health problems such as heart disease. Rates of mood and anxiety disorders are higher among older adults with poor physical health. Many stressors in late life, including loss and grief, decreased social support, social isolation, and financial hardship and worries, also contribute to physical, functional, and mental health problems.

According to the World Health Organization’s World Mental Health (WHO WMH) Survey Initiative, the estimated 12-month prevalence of major depressive episode (MDE) is 5.5 per cent in 10 developed countries (Belgium, France, Germany, Israel, Italy, Japan, Netherlands, New Zealand, Spain, and the US) and 5.9 per cent in eight developing countries (Brazil, Columbia, India, Lebanon, Mexico, South Africa, Ukraine, and China)². In most developed countries and in Brazil, the 18-34 yr age group had the highest prevalence, and the 65-and-older group had the lowest prevalence. In India, the age difference was significant but not monotonic, with the highest prevalence in the 50-64 yr (7.9%), followed by the 35-49 yr (6.3%) and the 65-and older age group (5.2%)². Many more older adults suffer from depressive symptoms that do not meet the full diagnostic criteria for MDE. Subsyndromal depressive symptoms in older adults are also associated with significantly increased functional and psychosocial impairments, and without treatment, can result in full-blown MDE³. Untreated depression is also reflected in the high suicide rate among older adults. Although depression (and anxiety) is twice as prevalent in older women than in older men, suicide is much more prevalent among older men. Data from 97 countries show that the median (range) suicide rate (per 100,000 population) was 19.6 for males aged 65-

74 yr, 29.3 for males aged 75+ yr, 4.6 for females aged 65-74 yr, and 5.0 for females aged 75+ yr; Eastern and central European countries have the highest rates, and Caribbean and Arabic/Islamic countries have the lowest rates⁴.

WHO-WMH data from 17 countries (India excluded) show that estimated lifetime prevalence and projected lifetime risk at age 75 of any anxiety disorder is as high as that of any mood disorder in many countries. Although the prevalence/risk rates of anxiety disorders varied widely (31% in the US to 4.8% in China), older than younger adults had lower prevalence rates in all countries, except Italy and China where no age group difference was found⁵. A study of anxiety among older adults in seven countries (China, India, Cuba, Dominican Republic, Venezuela, Mexico and Peru) also found that urban-dwelling older adults were nearly three times more likely than their rural counterparts to experience anxiety. These age- and gender-standardized prevalence rates also varied greatly across countries, ranging from 0.1 per cent in rural China to 9.6 per cent in urban Peru⁶.

Use of alcohol, tobacco, and illicit and non-medical prescription drugs decreases with age⁵; however, substance use has a greater impact on older adults as age-related changes slow alcohol and drug metabolism. Alcohol also interacts with many prescription/over-the-counter medications that older adults take for their chronic medical conditions, and the interaction of medical conditions, functional impairment, and alcohol can cause or exacerbate harmful effects in older adults. Heavy alcohol consumption can lead to memory loss and depression. Alcohol-attributable death is as high as 10 per cent of all deaths among males 60 years and older, and regardless of age, alcohol use can also cause significant harm to other people and society, including increased healthcare and law-enforcement costs⁷. Tobacco use also takes a heavy toll and is a major contributor to morbidity, mortality, and healthcare costs. While social norms and laws in some countries have contributed to reduced initiation and smoking cessation, tobacco use remains common among older adults in many countries.

Illicit drug use is generally more prevalent in the US than in the other countries⁸. In 2007, 9.4 per cent of the 50-59 yr age group in the US had used an illicit drug (*e.g.*, marijuana, cocaine) or a prescription drug non-medically (opioid analgesics most commonly)

in the preceding year⁹. Among older past-year illicit drug users, nearly 12 per cent met DSM-IV criteria for a past-year drug use disorder; among older past-year non-medical prescription opioid users, 9 to 10 per cent met DSM-IV criteria for a prescription opioid use disorder.

Evidence-based practices and barriers to assessment and treatment

Older adults respond at least as well as younger adults to MH treatment. The evidence-based geriatric MH practices cover mental health outreach services; psychological and pharmacological treatments; integrated service delivery in primary care; and mental health consultation and treatment teams in long-term care¹⁰. Many randomized clinical trials have found that combined pharmacotherapy (*e.g.*, antidepressant and anxiolytic medications) and short-term, structured psychotherapy (*e.g.*, cognitive behavioural therapy, problem-solving therapy, interpersonal therapy) or psychotherapy alone are highly effective¹¹. Research on treatments for older substance abusers has focused predominantly on alcohol problems. These studies suggest that treatment is effective, especially for older women, and that a longer length of stay in treatment results in better outcomes^{12,13}. Incorporating interventions such as motivational interviewing and other non confrontational and supportive treatment that address age-specific psychological, social, and health concerns, and cultural values and preferences in treatment plans is recommended for older substance abusers¹⁴. Tobacco use cessation should be part of the treatment plan for any older adult who uses these substances.

Though evidence-based care is available, most older adults neither seek nor receive treatment because of multiple barriers. Low-income older adults often lack the financial and social capital resources and transportation necessary to get treatment. Lack of education and strong stigma about mental health problems often cause older adults and their informal support systems to deny or hide these problems. In some cultures, alcohol use may be tolerated as long as it does not seriously harm the drinker or others. Many healthcare and social service providers lack specialized training in identifying and treating MH/SU problems. Another barrier is fragmented health, MH/SU, and social services. Geriatric MH/SU workforce shortages and poorly funded MH/SU care systems are chronic issues in both developing and developed countries.

Improving MH/SU services for older adults

Most countries do not invest sufficiently in public education, training/research, and development of MH/SU prevention and treatment programmes. Existing resources tend to be ineffectively utilized as these are concentrated in mental health hospitals rather than in community-based, integrated care settings. Moreover, the tremendous disparities in resources that exist between high and low/middle income countries call for innovative solutions for bringing evidence-based practices to larger segments of the world's population suffering from MH/SU problems. Given the medical/biological, psychological, social, and economic aetiologies of MH/SU problems, multisectoral approaches are necessary to provide evidence-based mental health services for the underserved. To benefit all age groups, the 66th World Health Assembly's mental health action plan calls for macro-level actions to (i) strengthen effective leadership and governance for mental health; (ii) provide comprehensive, integrated, and responsive mental health and social care services in community-based settings; (iii) implement strategies to promote mental health and prevent MH/SU problems; and (iv) strengthen mental health information systems and improve research capacity¹⁵. Among many MH/SU initiatives, the WHO provides assessment instruments for mental health systems and information on cost-effective, feasible mental health interventions that countries can utilize on a large-scale basis to strengthen their mental health care systems. The WHO Mental Health Gap Action Programme¹⁶, launched in 2008, uses evidence-based technical guidance, tools, and training packages to expand service provision, especially in resource-poor areas, and to build non-specialized health care providers' capacity using an integrated approach that promotes mental health at all levels of care.

Efforts to increase older adults' access to psychosocial interventions for MH/SU problems should focus on integrating ageing, health, and MH/SU services and using technology to deliver services. Information on MH/SU screening and assessment tools and evidence-based psychosocial interventions should be disseminated to health clinics and social care settings serving older adults. The US Institute of Medicine recommends that all primary care clinicians, nurses, care managers, allied health care professionals, and social service providers who care for older adults receive training in evidence-based treatment of MH/SU disorders¹⁷. Successful programmes in India, Chile,

Pakistan, and Uganda^{18,19} also point out that clinical capacity can be increased by developing a workforce of health coaches and lay community health workers trained to provide screening and brief interventions for geriatric MH/SU disorders. Telemental health services can provide treatment and prevention to patients in remote locations at substantially lower costs with significantly fewer service providers. Telemental health services also address the strong stigma older adults often hold about MH/SU problems, since they can receive help in the privacy of their home.

Although preventing and treating MH/SU problems among millions of older adults are huge tasks, the time is ripe for capitalizing on knowledge about and experience with evidence-based practices. Alleviating suffering among older adults with MH/SU problems is an ethical imperative. Older adults should not suffer from preventable or treatable mental health and substance use problems. Treatment will also prevent excess disability in affected older adults. Taking steps now will also help prepare for the growing numbers of older adults who will need MH/SU services in the future.

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