Community Mental Health Care for the Elderly—a Look at the Obstacles

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Synopsis

Despite the recent attention given to mental disorders in the aged and their higher risk for organic mental disorders, older people rarely receive specialized mental health treatment.

This paper reviews recent research on some of the major obstacles to the use of treatment by the elderly. These include claims of "ageism" by health care professionals, the negative attitudes and behaviors of older persons toward mental disorders and their treatment, and the failure of general practice physicians to recognize or treat symptoms of mental disorders in their elderly patients or to refer these patients to geriatric mental health specialists.

It is suggested that increased public education in geriatric mental health is urgently needed for potential patients, their families, and their general physicians.

DESPITE AN INCREASED PREVALENCE OF organic mental disorders and the risk of depressive symptomatology associated with age-related loss, the use of specialized mental health treatment by older persons remains low (*1–5*). Although serious deficiencies in reimbursement policies that cover mental health treatment of older persons as outpatients are part of the problem (*6*), a variety of other obstacles to use of treatment services have been identified. I will review recent research on these multiple obstacles to more effective treatment of community-dwelling older persons with mental disorders.

While much has been written about the high prevalence of mental disorders among long-term care residents (*7–9*), in fact, more than 95 percent of persons over 65 years of age live in the community and are not in institutional care. Thus, the responsibility for care of persons in this group falls on the majority of mental health and general health professionals who are not affiliated with long-term care facilities.

But how many older persons currently receive specialized care or treatment for mental health symptoms? The answer, according to research on the rates of use of mental health professionals by older persons, is alarmingly few. The extent to which older people underuse existing mental health services is apparent from a number of reports. Estimates are that only 4–5 percent of community mental health center patients are older than 65 years (*10*), and it also has been estimated that psychiatrists in private practice spend only 2 percent of their time with elderly patients (*11*). In my own studies on the characteristics and treatment of older patients in a psychiatric emergency department (*12,13*), only 5 percent of the visits were by persons older than 65.

Does this low use rate reflect a low prevalence of mental disorders in this age group? Older people have been assumed to be at risk for mental disorders such as depression and dementia, but the results of the recent studies of the five-site Epidemiologic Catchment Program by the National Institute of Mental Health (NIMH) actually indicates a low prevalence rate of all types of mental disorders for the over-65 group (*2,3*), despite an increased prevalence of cognitive impairment. The surprisingly low prevalence rate for the diagnosis of major depressive disorders has also been reported in at least one other epidemiologic study (*14*).

Naturally, these results merit serious debate, given their implications for policy decisions regarding mental health treatment for older persons. Certainly one concern is whether the unique nature and presentation of geriatric mental disorders (especially depression) was adequately addressed in the design and interpretation of these epidemiologic studies.

There is also evidence from the NIMH study, however, that these potentially lower prevalence rates do not entirely account for the underuse of mental health specialists by the aged. Shapiro and co-workers (*4*), in the NIMH report on use, found that the elderly were, by far, the lowest users of mental health specialists. Moreover, these data were based on the use of mental health services for individuals *with* a recent disorder classified in the American Psychiatric Association's manual. The most extreme example was for the Baltimore site where only 0.6 percent of persons 65 years and older with a recent disorder reported a visit to a mental health specialist in a 6-month period. This proportion compares with 9.3 percent for the 45–64 year age group, 9.1 percent for the 25–44 year age group, and 9.1 percent for the 18–24 year age group and is good evidence of underuse of mental health specialists by the elderly relative to other age groups. It is also good evidence that a potentially lower prevalence rate for mental disorders in the elderly does not entirely account for their rare visits to mental health specialists.

Why do so few elderly in need of mental health treatment actually receive it? Previously, the underuse of mental health professionals by community elderly has been attributed largely to "ageism"—age discrimination among health care practitioners (*15,1*).

Although ageism has not been empirically demonstrated, there has not been a shortage of explanations for its occurrence. Gaitz (*1*), for example, has suggested that many health and social service professionals view aging as an inevitable decline and deterioration in functioning. It has been charged that some believe that mental disorders among the elderly are not "true" illnesses and that custodial care is what older people really need. It has also been proposed that many psychiatrists believe that the elderly are too old for therapy because they are resistant to change, untreatable because of arteriosclerosis or senility, and especially poor candidates for psychotherapy (*6–18*). Further, it has been argued that general physicians fail to detect many mental disorders in the elderly and that physicians even enter into a "silent conspiracy" with their elderly patients to ignore behavioral disorders (*19*).

Without disputing the existence of ageism, however, it is important to recognize how the characteristics of older people may interfere with their opportunity to receive appropriate treatment for mental disorders. A variety of additional obstacles need to be considered, including the attitudes and behaviors of older people, their interactions with health care providers, and some very real difficulties in the recognition and differential diagnosis of mental disorders in this age group.

For any person, the decision to initiate help for an emotional problem undoubtedly depends upon a number of factors including the severity of the problem; its perceived impact on the person's life; belief in the efficacy of therapy in relieving these problems; attitudes towards mental disorders, mental health professionals, and mental health treatment; access to services; and the financial costs associated with them. For older people, several of these factors may assume a greater salience. These include generational attitudes or stigma surrounding "mental illness," fears of institutionalization, and resistance to acknowledging loss of capabilities. For many elderly, the very motivations to be independent and in control of their lives that once were adaptive and socially rewarded, may actually be impediments to proper care.

Attitude Survey

To examine some of these attitudes, I recently conducted a survey of 88 elderly senior center participants (*20*). This survey assessed the prevalence of symptoms of depression and cognitive impairment in this group, their use of health professionals, and their attitudes and practices regarding mental health treatment. Rating scales for depressive symptomatology (*21*) and cognitive impairment (*22*) revealed a 29 percent prevalence of mild to moderate symptoms of depression, and a 17 percent prevalence of cognitive impairment. Yet, only 3 percent of the total group indicated that they had seen a psychiatrist or a psychologist in the previous year. Further questioning revealed that the majority (63.1 percent) indicated that they would not tell any health professional about severe symptoms of depression in the future, preferring instead to keep them to themselves or tell only a family member or friend. Only slightly fewer (41.7 percent) would not tell a health professional about severe symptoms of dementia.

By comparison, 71.8 percent *would* tell a health professional about symptoms of a heart attack. Moreover, when asked which professional they would consult if they were to seek help for the same symptoms, almost 90 percent of this group would not contact a mental health professional even if treatment was desired, preferring instead to see their family physician about the problem. Even more striking was the finding that a similar

majority thought that the general physician was the "most effective" professional for the treatment of described symptoms of depression or dementia compared with psychologists or psychiatrists.

Although this survey was not an epidemiologic prevalence study, and a similar comparative study with younger age groups would be valuable, these findings may partly explain the documented lower use of mental health specialists by older persons (*4*). Clearly, the attitudes and behaviors of older persons themselves can constitute a considerable obstacle to the treatment of mental disorders by mental health specialists. The results of this study indicate that, even if ageism were practiced by mental health professionals, the overwhelming majority of community elderly would not even come into contact with a mental health professional to experience it.

The results of this survey also indicate the great responsibility placed on the general practice physician to recognize mental disorders in community elderly. The situation was revealed by the stated preferences of older persons, as well as by an additional finding that older people who were depressed reported a significantly greater number of physician visits in the year prior to the study (*23*). This tendency was also revealed in the NIMH ECA use data that indicated a much greater tendency for older people with mental disorders to seek help from providers of general medical care (*4*). Thus, it appears that older people not only come into frequent contact with their physicians but trust them and believe that they have the most help to offer for emotional problems. This observation would seem to indicate that increased collaboration with general physicians would greatly enhance treatment efforts directed at older persons.

Despite their potential, however, general practice physicians have not frequently referred older persons to mental health professionals. Part of the problem may be attributed to traditional biases of many nonpsychiatric physicians toward mental health professionals or the belief that general practice physicians should provide total care for their patients, or both. Of course, there is considerable merit in the provision of mental health care by general practice physicians, given the shortage of trained geriatric mental health specialists and the increasing numbers of physicians. A major problem, however, concerns the extent to which such physicians have been recognizing and treating mental disorders in their older patients to begin with.

To study this problem further, I next interviewed 140 elderly patients waiting in 14 physicians' offices in the Philadelphia area (*24*). The prevalence of symptoms of depression and cognitive impairment were assessed with rating scales (*21,22*), and the patients were asked questions about their presenting complaints and their use of health care professionals, including mental health specialists.

Of the 140 persons, 32 displayed some evidence of mental disorder, 18 (12.9 percent) with symptoms of depression, 8 (5.7 percent) with evidence of cognitive impairment, and 6 (4.3 percent) with evidence of both. However, none of these 140 patients had reported visiting a mental health professional in the past year, and only 1 person had a presenting complaint that even remotely resembled a mental health problem (sleep difficulty).

To see how these physicians handled their elderly patients who did have evidence of mental disorders, all physicians were interviewed concerning the patients identified as having evidence of mental disorders. They were also interviewed about an age-matched comparison group of their patients who scored absolutely lowest on the rating scales—that is, those with the least evidence of depression or cognitive impairment by the criteria. The physicians at this point had no knowledge of the exact purpose of this study.

Analysis of the physicians' interview responses revealed that the psychiatric symptoms of many patients identified as having evidence of mental disorder by the research criteria were not recognized, diagnosed, or treated by their physicians. Although the physicians noted symptoms of mental disorders in 21 of the 32 patients (65.6 percent), only 4 were diagnosed as depressed, and only 5 were treated for the symptoms (antidepressant medication for 4, counseling for the other). None of these patients were referred to a mental health professional for evaluation or treatment. Even more surprising, however, was the finding that there was no significant difference in these results compared with those for the patients who scored lowest on our scales. For this group, mental health symptoms were reported by the physician in 15 (46.9 percent) of the patients, and 2 actually received a diagnosis (depression) and were treated (anti-depressant medication). Thus, patients scoring absolutely lowest on our scales were as likely to be diagnosed and treated for a mental disorder as were patients with the highest scores.

Conclusion

What should we conclude from these results? Clearly, general practice physicians have not been adequately recognizing, diagnosing, or treating their elderly patients who do present with mental disorders. Moreover, they have not been referring such patients to mental health professionals. Why? While it is possible that physicians simply are not oriented toward psychological difficulties in patients of all ages, it is also possible that this failure reflects a more specific bias toward the nonrecognition of mental disorders in the elderly. It could be argued, for example, that many physicians view behavioral problems in older patients as reflecting old age or "senility," and thus they are considered untreatable. Perhaps a deeper understanding of this problem could be gained through further research into physicians' abilities to detect mental disorders in patients of different age groups. It is also possible that many physicians, faced with the demands of a busy practice, do not take the time to inquire about psychological problems when taking a social history for an initial medical visit or during routine office visits. This tendency could also be reinforced by a pessimistic attitude toward treatment success. While these points deserve serious consideration and certainly support the need for improved and continuing medical education in geriatric medicine, geropsychiatry, in particular, it may not be accurate or productive to place all the blame, or even a good portion of the blame, on the behavior of general practice physicians.

There are other aspects to the physician-older patient interaction that need to be considered, including the older patient's presenting behavior. After all, only 1 patient of 140 in the study described previously specifically identified a mental health complaint when interviewed. Clinically, in fact, it has been reported that a major problem facing physicians with large geriatric practices are those patients who present with a variety of somatic complaints that do not seem to have a physical basis (*25–27*). This phenomenon, which has been termed somatization, often reflects an underlying depressive disorder (*28–31*). Somatization creates considerable diagnostic difficulty for physicians. Routine treatment for these complaints often does not correct the problem. At best, the same patients later return with different complaints. Suggesting that the physical problem may be psychologically based, on the other hand, often results in the patient's expressed anger and attempts to seek the attention of another, more sympathetic physician. Many patients in this study had more than one physician, with some reporting three and four different physicians.

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Empirical evidence of somatization can be found in several reports. Several somatic complaint items were included in the first study on community elderly (*20*). In that study, depressed persons reported significantly more of these somatic complaints than nondepressed persons. In two other studies, depression scores were found to be related to somatic complaints in both widowed and depressed elderly persons living in the community (*28, 32*).

To evaluate the magnitude of this phenomenon, I conducted a more systematic study on somatization among 127 community-residing elderly (*33*). The Geriatric Depression Scale (*34*), a rating scale that excludes somatic complaints, was administered to assess depressive symptomatology. To assess health status and somatic complaints, the interview also included many questions of the Cornell Medical Index (*35,36*). There was a strong relationship between depression score and the number of somatic complaints, with depressed persons reporting approximately four times the number of somatic complaints as those persons scoring lowest on the depression scale. Significant associations with the depression score were found for answers to most of the somatic complaint items in all four medical systems assessed—cardiovascular, musculoskeletal, respiratory, and nervous systems. The depression score was almost as powerful a predictor of somatic complaining as the reported number of chronic medical illnesses.

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These results reveal yet another obstacle, in this case depression, to the recognition and treatment of mental disorders in the elderly. The elderly patients' reluctance to admit psychological problems, coupled with the depressed older patients' tendency toward somatization, creates considerable difficulties for the general practice physician. These tendencies may also compound a potential bias of physicians to treat somatic complaints routinely for fear of missing a genuine physical disorder, and yet ignore potential emotional problems as being unimportant, untreatable, or merely a natural consequence of growing older.

Frequently, of course, somatic complaints in the elderly do in fact indicate the presence of physical disease. At least 80 percent of persons over the age of 65 have at least one chronic medical disorder (*37*). This observation, combined with the frequent co-occurrence of mental and physical problems, presents another very real obstacle to the detection of mental disorders in this age group. Psychological problems, both antecedent and consequent to medical disorders, can interact with disease to affect morbidity and mortality, in general making differential diagnosis difficult.

Frequently reported clinically, this interaction problem has been recognized in several studies among elderly patients in a variety of settings. Freedman and co-workers (*38*) found elevated depression scores in groups of older medical patients. In a study of community elderly (*39*), it was found that people with self-reported poor health were also more likely to be depressed. In my own work, I have documented the numerous medical abnormalities found among elderly patients in a psychiatric emergency department setting, particularly those diagnosed as having dementia (*13*).

In another, more recent study specifically designed to look at depression in older persons with chronic medical illness, I interviewed 201 elderly senior center volunteers and found a strong association between the presence of one of nine recent chronic medical conditions and scores on the Geriatric Depression Scale (*40*). Here a subgroup of healthy elderly were found to have considerably less depressive symptomatology (15.5 percent with symptoms of depression) compared with the elderly with a recently developed disorder (35.5 percent with symptoms of depression) or with a previous and recent disorder (48.2 percent with symptoms of depression). Recency of a medical disorder was more associated with depression than was any particular type of disorder. Unfortunately, these few studies only represent a beginning. Until further research is conducted on this complex problem, clinicians must rely on experience and intuitive judgement when making these difficult diagnostic decisions.

Available Options

What options are available, then, to improve the use of mental health services by community elderly? First, mental health professionals need to develop more expertise in the recognition, diagnosis, and treatment of mental disorders among the elderly. The increasing media attention on the problems of aging as well as the numerous publications and conferences that have recently been devoted to geriatric mental health are creating greater opportunities for this learning to occur.

Another crucial step involves outreach, which can occur in a variety of contexts. Public education for prospective patients and, perhaps more importantly, their families would serve to increase awareness of the early signs and symptoms of mental disorders in the elderly. It would also serve the important purpose of changing public attitudes toward mental disorders in older persons, more specifically to increase awareness of the distinction between normal aging and disease processes. More difficult issues can also be identified through education efforts directed at family members whose older relative is having behavior problems. Currently, combined emotions of anger, guilt, and fear often affect family members' judgments concerning an older impaired relative. An understanding of these issues can assist family members with decisions concerning treatment alternatives. This

knowledge is critically important, since considerable strain is placed on the family as caregivers of an older person with a mental disorder (*41*).

It is also critically important that efforts to increase the number of people being treated be reinforced by efforts to improve treatment efficacy. Demonstrated improvement in the mental health status of older persons would be of considerable importance in convincing mental health specialists, physicians, family members, and older persons themselves of the value in treating and being treated for mental disorders. Currently, a variety of traditional and nontraditional treatment options for older persons are being discussed, recommended, and implemented (*42*). Practitioners have a great need to know how to match treatment modality to patient needs effectively. They also need to know what results realistically can be expected with different treatments for different disorders.

A most important educational and public relations initiative can be directed at general practice physicians. In addition to continuing medical education programs which do influence some physicians, personal contacts must be initiated and developed with general practice physicians, especially those with large geriatric practices. This often can be the single most important step toward increasing the physicians' awareness of mental disorders in their elderly patients and, hopefully, their recognition, diagnosis, and treatment, or referral of identified patients.

Once communication and confidence have been established, general practice physicians would benefit from having a geriatric mental health specialist available to help with difficult diagnostic and treatment or placement decisions for many of their elderly patients. The confidence many older persons place in their general practice physicians and the older persons' initial fears of mental health professionals make the general practice physician an important colleague. Without this collaboration, the mental health specialist may never get to see many older persons who could benefit from the variety of treatment options that currently are available for geriatric mental disorders.

In sum, the demographic changes in the next decades could increase profoundly the number of older patients seeking psychiatric services. Currently, however, older persons greatly underuse specialized mental health services, and this trend will continue unless corrective steps are taken. Mental health professionals must become more aware of the numerous barriers to mental health

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treatment for the elderly. Seriously deficient reimbursement rates for mental health visits are unquestionably part of the problem. While other barriers may be created by existing attitudes and practices of health care professionals, the most difficult barriers to overcome may be those unwittingly created by the attitudes and behaviors of older people themselves. The frequent co-occurrence of mental and physical disorders in older persons also makes differential diagnosis extremely difficult. Perhaps the most important single step towards increased treatment for older persons with mental disorders involves increased collaboration between geriatric mental health specialists and general practice physicians who are in an excellent position to offer early recognition and collaborative treatment or referral.

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