Planning Tools for
Elder-Friendly Communities

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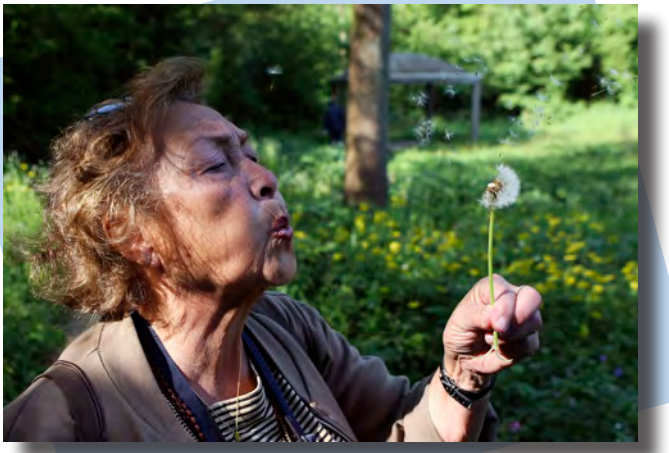
Mental Health in Older Adults:

Improving Health, Improving Access

A Community Guidebook



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PLANNING TOOLS FOR ELDER-FRIENDLY COMMUNITIES

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INTRODUCTION

There are many misconceptions about how older adults look (gray hair and stooped), how they move (slow and stiff) and what they do (knit, or re-tell old stories). In fact, older adults are very different from one another, just like citizens in any other age group. So, while we know these stereotypes aren't true for all older adults, they are still alive and well in our culture. Similarly, numerous false ideas exist regarding mental health and older adults. Some of the common myths of aging and mental health include "Feeling down and depressed is normal for an older person"; "An old dog can't learn a new trick -- Old people can't get better through counseling or learn to do new things"; and "Medicines for mental health don't work in the elderly."

Based on many years of research, we now know that these myths are not true. However, many people in our society – including some health care professionals, as well as many older adults themselves – believe them. These misconceptions may play a role in several problems in communities:

1) community practices regarding housing, health care, and general treatment of older adults can actually contribute to decreased well-being for older adults;

2) true mental health problems in older people are not identified; and

3) when these problems do exist, many older adults cannot get the mental health services they need.

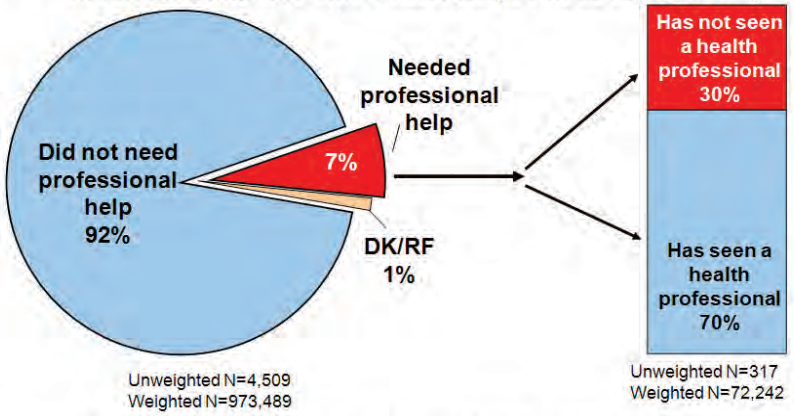
The mental health of this growing demographic group cannot be ignored. After all, by the year 2025, 18% of the people in the United States and Canada will be over 65 years old. This guidebook seeks to provide basic information about mental health problems in older adults, about the types of effective professional help available (developed through decades of research with elderly persons), about barriers to obtaining help when it is needed, and about what you can do to address these issues in your community.

The issue of access to mental health services in Indiana is a critical one. A randomized telephone survey of 4,500 older Hoosiers in 2008 provides important insights into the issue. People were asked whether in the past year, there was a time when they thought they needed the help of a health professional or a counselor because they felt depressed or anxious. While 92% reported no symptoms, 7% (equivalent to over 68,000 individuals) reported symptoms of depression or anxiety. Among those who reported symptoms, it is estimated that 20,000 individuals had not received the professional help or counseling they thought they needed (Chart One).

Among groups reporting symptoms of depression or anxiety, women were more likely to report symptoms than men (9% vs 6%); younger elders (60-64) were much more likely to report symptoms than older groups and those in fair to poor health were more than twice as likely to report symptoms than those in good to excellent health (15% vs 6%) (Charts Two and Three).

Chart 1

Percentage of people age 60+ who thought they needed the help of a health care professional because they felt depressed or anxious and have not seen one (for those symptoms)*



*People were asked whether in the past year, there was a time when they thought they needed the help of a health professional or a counselor because they felt depressed or anxious.

*People who answered "yes" were asked whether they obtained the professional help or counseling they thought they needed.

Note: Percentages may not add up to 100% due to rounding and/or missing information.

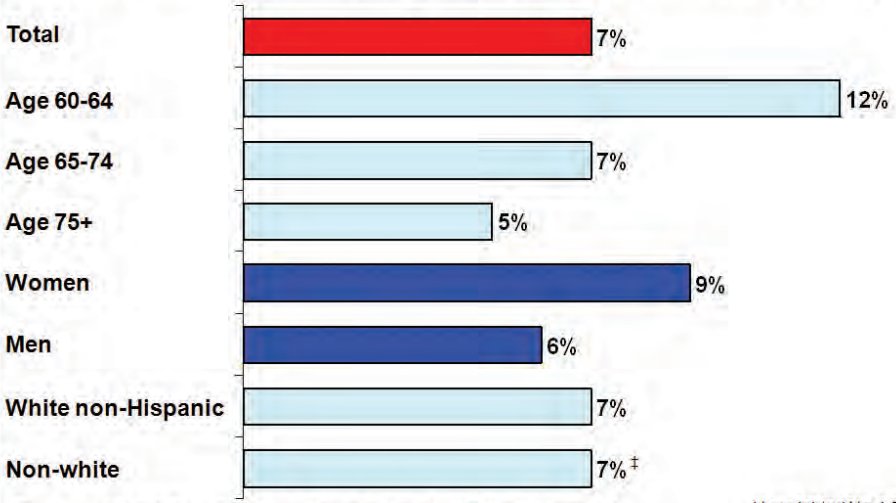
Excludes Area 2 (Elkhart, Kosciusko, LaPorte, Marshall & St. Joseph Counties) which was surveyed in 2006.

Center for Home Care Policy & Research **Source: *AdvantAge Initiative Community Survey in Indiana 2008***

The AdvantAge Initiative

Chart 2

Percentage of people age 60+ who thought they needed the help of a health care professional because they felt depressed or anxious,* by demographics



*People were asked whether in the past year, there was a time when they thought they needed the help of a health professional or a counselor because they felt depressed or anxious.

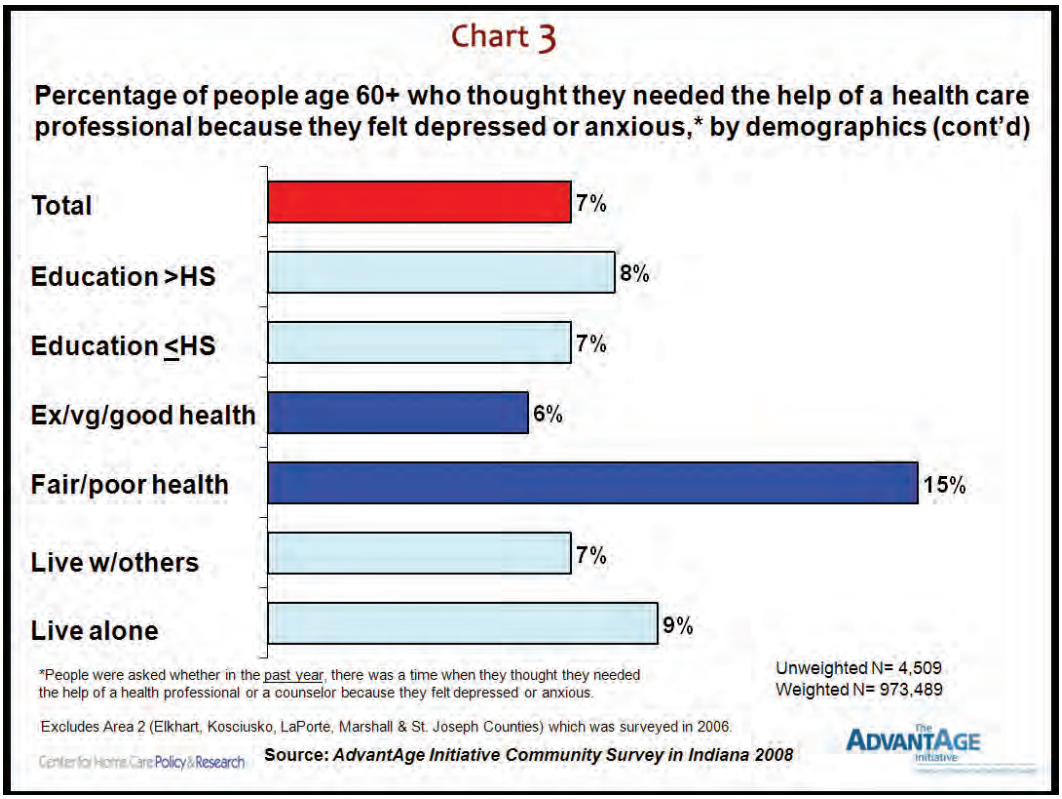
‡ This percentage is based on fewer than 20 respondents (Unweighted N<20) and should be interpreted with caution.

Unweighted N= 4,509
Weighted N= 973,489

Excludes Area 2 (Elkhart, Kosciusko, LaPorte, Marshall & St. Joseph Counties) which was surveyed in 2006.

Center for Home Care Policy & Research **Source: *AdvantAge Initiative Community Survey in Indiana 2008***

The AdvantAge Initiative



One of the more alarming findings of the survey revealed wide variation across the state in the degree of access to mental health services. In the multi-county Indiana Area 8 Planning and Service region, 13% of those reporting symptoms had not seen a professional. In south central Indiana (Areas 10 and 11), 53% of those reporting symptoms had not seen a professional for help or counseling – a variation of 40% from the lowest to the highest degree of successful access to services.

The dramatic variation in access to services was a primary reason for selecting this issue for special treatment through this publication. This Guidebook is designed to serve as a tool for those communities that employ such data to set priorities and organize a public response. It is written in user-friendly, non-academic language so that a task force or committee of local citizen-activists can familiarize itself with pertinent national research and become informed about evidence-based programs that have been developed around the U.S. to deal with this important issue. The Guidebook puts citizen planners and local professionals on "the same page" as they work together to identify and solve community problems.

The Guidebook is one of a series of publications being developed by the Center on Aging and Community, Indiana Institute on Disability and Community at Indiana University in Bloomington, Indiana, with funding from the Daniels Foundation of Denver, Colorado.

The Guidebooks focus on key "indicators" of elder-friendliness and well being that are assessed in the AdvantAge Initiative survey process. For a complete description of the survey and planning model, along with a comprehensive database of Indiana results, visit the project website: www.agingindiana.org.

While the data are Indiana-specific, the guidebook can be utilized by any local community around the U.S. that seeks to improve access to mental health services by older adults. Current companion guidebooks address other key issues: the creation of home modification coalitions; improving physical activity levels among older adults. In addition, a Guidebook on Social Marketing provides communities with key knowledge about ways to "communicate strategically" and develop messages that inform and educate public groups on important issues. The Social Marketing Guidebook is also organized around the 33 key indicators of an elder-friendly community assessed in the AdvantAge Survey.

In this guidebook, the general term "mental health problems" is used to refer to a range of psychiatric disorders and psychological symptoms. Depression and anxiety are the most common mental health problems for older adults (American Psychological Association, 1998) and have received the most research attention, and will serve as a focus for much of our discussion. However, many of the ideas and practices discussed in relation to depression or anxiety can apply to other mental health problems in later life as well (Gum & Areán, 2004). In addition, we will briefly cover cognitive impairment and dementia as common problems among the elderly that are often under-identified, but that have a major impact on the lives of older adults and their families.

OVERVIEW OF DEPRESSION AND ANXIETY IN OLDER ADULTS

Depression

Experiencing times of feeling "in a bad mood," "grouchy," or just "sad" is a universal part of being human. We all have variation in our moods, our view of ourselves, and our outlook on life. Problems arise when times of feeling sad or irritable occur more frequently or last longer than a person would like, or affect key aspects of daily life, such as relationships with others or accomplishing daily tasks. In such a case, the "bad mood" may be considered a depressive disorder by a doctor or counselor.

"Depression" refers to a combination of symptoms. According to the standard diagnostic guidelines contained within the Diagnostic and Statistical Manual, 4th Edition-Text Revision (American Psychiatric Association, 2000), the core symptoms of depression include: sad mood, loss of pleasure in usual activities, feelings of worthlessness, problems concentrating or making decisions, fatigue, sleeping problems (too much or too little), changes in appetite (overeating or under-eating), psychomotor retardation or agitation (in other words, physical movements are slower or quicker than usual, not due to physical conditions), and recurrent thoughts of death or suicide.

However, experts have noted that certain symptoms are seen more or less frequently in older adults compared with younger populations. For example, older adults might seem to be less sad, but have more cognitive problems, and more physical complaints. They may also show more social withdrawal, and an unexplained decline in abilities and vitality (Thompson & Borson, 2006).

Depressive disorders can vary in severity and how long the impairment occurs, and mental health professionals use different diagnostic terms to distinguish severity and length of impairment. For example, "Major Depressive Disorder" may be diagnosed if at least five of the core symptoms are identified (one symptom must be sad mood or loss of interest), and the symptoms are severe enough to affect daily functioning. But Major Depressive Disorder is not diagnosed if symptoms last for less than two months after bereavement. In that case, those same symptoms are considered part of normal grieving.

Research has found some interesting data about the prevalence of depression. The estimated one-year prevalence rate of Major Depressive Disorder among older adults is about one to two percent, which is lower than what is seen among younger age groups. On the other hand, so-called "minor depression" or "subsyndromal depression" (sometimes diagnosed by professionals as "Depressive Disorder, Not Otherwise Specified") occurs much more frequently.

Minor depression refers to depressive symptoms that are fewer and of a less severe nature compared to Major Depression. Researchers estimate a rate of minor depression of up to 25% in the older adult population (Thompson & Borson, 2006). Numerous studies have shown that "sub-clinical" depressive syndromes are associated with high disability, have high cost and a significant negative impact on persons who suffer (US Dept of Health and Human Services, 1999). Research has also found that the prevalence rate of minor depression in older adults is much higher than in other age groups. How is this discrepancy (i.e., low rates of major depression but high rates of minor depression) to be explained?

One explanation is that people who survive long enough to be considered "geriatric" are of hardier stock than those who die at a younger age; thus, they are less subject to a number of disorders, like Major Depression, that are associated with genetic or constitutional predispositions. At the same time, old age creates a number of challenges that require major life readjustments – challenges like declines in physical stamina, inability to get around easily, loss of jobs or other productive social roles, and isolation from friends and family who have moved away or died. Dealing with these challenges without help from others can be very demoralizing, creating a mild level of depression that nevertheless impairs the individual's ability to function at an optimal level.

This means that community members who want to help older adults overcome depressive states have two distinct tasks: learning to recognize and refer individuals with severe depression to appropriate mental health specialists, and at the same time supporting individuals with mild to moderate depression through difficult life transitions and events. The latter job is as important as the first, because evidence suggests that mild to moderate depression may become severe if left untreated, further compromising an older adult's health.

Anxiety

Sometimes feeling nervous, worried, or jumpy is a part of normal life. However, when the nervous feelings or anxious behaviors affect daily functioning and cause distress for a person, seeking a professional evaluation is important. There are a number of different types of problems that are conceptually grouped together under the "Anxiety Disorders." These include obsessive-compulsive disorder (e.g., preoccupation with cleaning, checking locks, or a fear of getting rid of things), post-traumatic stress disorder, panic disorder, and specific phobias (such as a fear of heights or a fear of dogs), as well as generalized anxiety disorder, characterized by excessive worry. There can be overlap among these disorders, as well as overlap among anxiety and depressive disorders. This guidebook will focus on generalized anxiety disorder.

Symptoms of generalized anxiety include excessive ruminative thoughts, combined with physical symptoms reflecting increased motor tension, autonomic overactivity (such as a racing heart, difficulty breathing, or sweating), and excessive vigilance (often seen as disruption in sleep or difficulty concentrating). Studies suggest that among the elderly, anxiety disorders are more common than are depressive disorders, with prevalence rates of generalized anxiety disorder ranging from about four to twelve percent (Lauderdale, Kelly, & Sheikh, 2006). As with depression, research suggests that the rate of sub-clinical anxiety symptoms is much higher than more severe, "diagnosable" disorder. The prevalence of sub-clinical anxiety is estimated at 17 to 21 percent (Himmelfarb & Murrell, 1984).

What factors can lead to depression or anxiety?

Research suggests that most depressive and anxiety disorders are likely caused by a combination of biological factors – such as inherited genes or the development of an individual's nervous system – and life event or "stress" factors. That is, people with biological vulnerability are more likely than other people to develop mental health problems when faced with challenges or difficult events. This can explain why some people develop post-traumatic stress disorder after experiencing a motor vehicle accident, for example, while others do not. The stressors that contribute to depression or anxiety in the elderly are quite similar to the stressors that we all cope with at times in life.

However, some stressful life events do occur more frequently in old age. Older adults often cope with poorer health and a subsequent decline in daily functioning and independence. The death of a loved one, restrictions on a long-held lifestyle, and changes in living arrangements are common. There may be isolation from family and friends due to a move to a retirement community or a child's home, or due to decreased mobility because of disability or illness. Known risk factors for developing anxiety or depression also include being a caregiver for someone else, having low social support from others, experiencing a trauma such as assault or robbery, experiencing cognitive impairment, experiencing financial problems, and misuse of drugs and alcohol. As discussed later in this guidebook, loss of a significant role or access to meaningful activities after retirement or disability can also create a vulnerability to mental health problems. These challenges and stressors can serve as triggers for new-onset disorders or exacerbate existing psychological problems.

Many of these stressors are also the kinds of circumstances that others can help with – whether they are mental health professionals, friends, or family members.

Other mental illness

There are other mental health problems that can exist in older adults, such as thought disorders (for example, schizophrenia), bipolar affective disorder or "manic-depression" (which is quite different from the other depressive disorders as discussed above, in terms of root causes, treatment, and course over time), and maladaptive personality traits. In addition, the at-risk use of alcohol, street drugs, or prescription medications among the elderly is an issue that has received increasing attention in the clinical and research arenas. Space constraints prevent a full discussion of these issues in this guidebook; further information may be found in the Resources section. It is important to keep in mind that when such mental health problems are suspected, it is always appropriate to seek a referral to a qualified health care professional for an evaluation and recommendations for treatment.

COGNITIVE IMPAIRMENT AND DEMENTIA

Impairment in thinking, which sometimes develops into dementia, is another important mental health issue facing the elderly. Although memory loss is often the earliest or most obvious problem identified by family and friends, other areas of cognition are also affected. For example, there can be problems with attention or concentration (such as difficulty staying on task or remaining engaged with a conversation); difficulty completing once-familiar tasks; language or speech problems; decreased judgment; and changes in mood or personality. "Dementia" refers to a condition in which at least two different areas of cognition are impaired to the extent that functioning in daily life is affected. "Cognitive Impairment" or "Mild Cognitive Disorder" refers to less severe and less global thinking problems. This condition does not always get worse to the point of being diagnosable as dementia. Both conditions are caused by changes in the cells of the brain. A range of diseases and conditions cause these cell changes; these conditions are distinguished from each other by the area of the brain and the type of cell affected, as well as the cause of the cell changes. Alzheimer's disease and vascular dementia are two of the most common.

Sometimes problems in thinking can be caused by prescription medications, infections, hormonal problems in the body, alcohol or other drugs such as surgical anesthesia. In these cases, the dementia is termed "reversible" and the thinking deficits can be cured with proper treatment. Irreversible dementias, such as Alzheimer's disease, cannot be cured. However, there are some prescription medications that have been shown to slow the progressive worsening in thinking in some dementias. In addition, these and other medications have been shown to help with the behavioral problems that are sometimes seen as a dementia gets worse.

Dementia, depression, and anxiety are closely linked. Dementia can sometimes first appear to be depression, and depression can sometimes present with memory or concentration problems as the primary concern (this is called "pseudodementia" and usually improves when the depression is adequately treated). Sometimes both dementia and depression are present; in this case, though the dementia cannot be reversed, the depressive symptoms are likely to get better with psychotherapy, environmental changes, and/or medication. In addition, research suggests that persons with dementia are at increased risk for developing significant anxiety symptoms (Lauderdale, Kelly, & Sheikh, 2006). Because of these areas of overlap and the complex relationship between dementia and mental health problems, it is important for trained professionals to evaluate an older person to arrive at a clear diagnosis, in order to guide treatment and to provide families and patients with accurate information.

SUICIDE IN THE ELDERLY

Suicide is an important issue, but is often misunderstood and under-identified among older persons. "Suicidal thinking" and "suicidal behavior" refer to thoughts and actions that reflect the intent to do harm to oneself. These usually occur in the context of very severe depression, anxiety, or another mental health problem. The highest suicide rates of any age group are among persons aged 65 years and older. A recent study showed that adults age 65 and older make up 13% of the population, but accounted for 19% of all suicide deaths in this country. Men are at especially high risk, and completed 84% of the suicides among this age group.

Sometimes suicidal thoughts and expressions by older people (such as "life isn't worth living" or "I wish God would take me") are not taken seriously by those around them or are considered "normal" for an older person to say. However, any statement about death, wanting to die, or wanting to hurt oneself should be responded to with concern and compassion by family and friends. In many cases, the older person will need to be carefully evaluated by a health care professional. Please see the resource list at the end of this guidebook for further information.

GETTING PROFESSIONAL HELP

Identifying the problem means asking the question

The first step to obtaining needed help to address a mental health problem is identifying that the problem exists. This is much easier said that done, and research tells us that identification of mental health problems in the older adult population is particularly problematic. This may be especially true for elderly persons of color (Koenig, 2007; Heller, Viken & Swindle, 2010).

Numerous studies demonstrate that depressive syndromes are generally underdiagnosed and undertreated among older adults. The reasons for this are many. First, as noted above, depressive disorder can look different among older adults, with fewer older people reporting sad mood or feelings of worthlessness when compared with younger populations. Because these are considered core features, the presence of depression may be overlooked when they are not present. Older adults and their family members often do not recognize and label "feeling low" as a possible chronic depression, and may not realize the extent to which depression can interfere with the older adult's general health and well-being. Lack of access to adequate mental health treatment options and a patient's stigma concerns

about mental health problems can also affect whether or not an older adult shares his or her suffering with others. Additional factors that can contribute to under-identification include co-occurring medical conditions which divert the attention of patient and health provider alike; stereotypes about older adults and mental health held by a provider; and the provider's own lack of training or experience with the diagnosis and treatment of mental health problems in the elderly population (Koenig, 2007). Two main reasons given by physicians for ignoring depression are a reported lack of time for adequate assessment, and uncertainty about what action to take if a depression diagnosis is suspected.

Anxiety in older adults is not as well-studied as depression, but many of the same concerns regarding under-diagnosis and under-treatment exist. Health care providers may be especially uncomfortable with prescribing medication for anxiety symptoms, due to the potential side effects and addiction risks of some of these agents. A medical doctor also may not feel confident in referring an older adult for psychotherapy to address these issues.

Regular and routine screening for depressive and anxiety symptoms by primary care physicians is one method shown to improve identification of mental health problems. This screening should make use of a valid and reliable screening tool. There are several such questionnaires that have been shown to be effective for use with older adults. These include the CES-D (Radloff, 1977) and shortened forms of this questionnaire (e.g., Andresen et al., 1994), the PHQ-9 (Kroenke et al., 2001), and the GDS (Yesavage et al., 1983). Some health care systems, such as the Department of Veterans Affairs, already have such routine screening programs in place. It is also important to provide clear guidelines to providers for the interpretation of scores and the approach for follow-up on positive screening results. The MacArthur Foundation has developed and disseminated evidence-based guidelines for follow-up and treatment of depression in a medical setting (www.depression-primarycare.org). Please see the Resource section for additional information on screening and follow-up guidelines.

At this time, routine screening for dementia symptoms is not recommended by expert consensus panels (U.S. Preventive Services Task Force, June 2003), even for elderly persons. Rather, when there are concerns about memory loss, confusion, or other cognitive problems, a cognitive assessment should be completed by a qualified professional. The Alzheimer's Association (see the Resources section) and other related organizations provide a list of warning signs that may indicate the need for such an assessment.

PROFESSIONAL MENTAL HEALTH TREATMENT: BEST PRACTICES AND RESEARCH

When an older adult is experiencing mental health problems, obtaining treatment from a health professional is often one desired approach to improving symptoms. Professional treatments for depression and

anxiety generally fall into two categories: psychotherapy, or "talk therapy," usually provided over a number of treatment sessions; and medical approaches, such as antidepressant medications. (Other medical treatments, such as electroconvulsive therapy for severe depression, are much less common and will not be discussed here.) Patient preference regarding treatment is increasingly recognized as an important factor affecting treatment effectiveness, and research suggests that engagement in mental health treatment is improved when patients are allowed to choose the type of treatment (Rokke, Tomhave, & Jocic, 1999). Studies have shown that some older adults prefer psychotherapy over medication to address psychological problems (Areán, Hegel, & Reynolds, 2001). For example, in a recent study of 1,800 elderly primary care patients being treated for depression, 51% preferred psychotherapy, while only 38% preferred antidepressant medication, when given a choice (Unützer et al., 2002). The current "best practice" guidelines for mental health professionals recommend honoring patient preferences for treatment (Schulberg, Katon, Simon, & Rush, 1998).

Psychotherapy

Psychotherapy is a treatment for psychological symptoms offered by a mental health professional, such as a psychiatrist, psychologist, social worker, or other counselor, and involves talking through problems, identifying key issues, learning new skills and ways of thinking, and/or practicing new behaviors. Psychotherapy can be conducted as an "individual" (with a single client) or as a "group" (several clients meeting together with a counselor) intervention. Psychotherapy with older adults was once believed to be ineffective, because of long-held, yet inaccurate stereotypes about older adults being unable to change. Even the famous Sigmund Freud, a physician who was one of the first to develop "talk therapy" to help people suffering from depressive and anxious symptoms, stated that "… near or above the fifties the elasticity of the mental processes, on which the treatment depends, is as a rule lacking – old people are no longer educable…" (Freud, 1924, p. 258). However, it is now clear that psychotherapy is effective with older adults (Gatz et al., 1998) and should be available to any elder seeking assistance with psychological problems.

Evidence-based treatments

In many clinical settings, there has been a growing insistence on the use of "empirically supported" or "evidence based" mental health treatments, and some third-party payers prefer the use of such psychotherapy approaches. These terms are used interchangeably and describe treatments which have been shown to be effective through research, especially research comparing the treatment to a "placebo" or inactive intervention. When testing medications, the placebo is a "sugar pill" with no active ingredients. In psychotherapy research, the "placebo" is usually some sort of contact with a counselor, such as an educational session or a general group discussion, without the specific activities believed to cause positive change.

An American Psychological Association task force has developed guidelines for evaluating the evidence base for various forms of psychotherapy (Chambless & Hollon, 1998). To be deemed "empirically-supported," randomized clinical trials must demonstrate that the type of psychotherapy in question is: a) superior to a placebo or "no treatment" condition in treating target symptoms; and b) comparable to or superior to another gold standard or evidence-based treatment in at least three large trials (by at least two separate investigators). In addition, c) the sample sizes

in the comparative studies must be large enough to detect a moderate effect size. Several therapy approaches for older adults already meet these criteria.

The primary empirically-supported psychotherapeutic treatments for use with older adults include cognitive-behavioral therapy, interpersonal therapy, and problem solving therapy (see Wyman, Gum, & Areán, 2006). Cognitive-behavioral therapy (CBT) describes a range of therapeutic approaches that focus on changing unhelpful thoughts (cognitions) and behaviors, which is assumed to result in a positive change in mood or a reduction in anxiety. In addition to discussions between therapist and patient during the therapy session, CBT makes frequent use of between-session techniques such as relaxation strategies, behavioral experiments to test unhelpful patterns of thinking, and scheduling pleasant activities.

Interpersonal therapy (IPT) is a treatment for depression, and focuses on the social context of depression. A main goal of IPT is to improve social relationships by enhancing interpersonal coping strategies.

Finally, problem-solving therapy (PST) teaches a person a set of skills to break down and solve problems in life. This approach is based on the theory that depression results from inadequate problem-solving skills, leading to feelings of helplessness in coping with everyday problems. Problem-solving therapy has been successfully conducted by a variety of different healthcare disciplines (e.g., social worker, nurse) in non-mental health settings, such as primary care (see the IMPACT information in the Resource section).

All of these approaches employ a time-limited, structured, and goal-focused approach to treating symptoms of depression and/or anxiety, and can be adapted for use with older adults with mild cognitive problems. Each has been tested in numerous studies and can be considered "evidence-based" using the above criteria.

Psychotherapy with older adults

In general, psychotherapy with older adults is very similar to psychotherapy with younger or middle-aged adults. However, most experts believe that some training and experience with elders, leading to "geriatric cultural competence," is ideal in order for clinicians to be most effective in their work with the elderly (Wyman, Gum, & Areán, 2006). Experienced geriatric providers agree that some adaptations may be needed to make the treatment maximally effective. These adaptations include taking time to socialize older adults to the process of psychotherapy, adjusting the pace of the psychotherapy to account for age-related changes in information processing, and allowing flexibility in the delivery of psychotherapy to overcome medical and physical barriers to care. Some of these adaptations are discussed below.

TREATMENT OF MENTAL HEALTH PROBLEMS IN PRIMARY CARE: BEST PRACTICES

Treatment of certain mental health problems in the primary care medical setting is increasingly viewed as an effective approach for younger and older adults alike. The importance of improving primary care mental health treatment is recognized at the highest levels of government. The final report from the President's New Freedom Commission on Mental Health (2003) emphasized that mental and physical health are not separate, but rather highly interrelated facets of overall health, and are best treated within a coordinated care system. Former Surgeon General David Satcher wrote, "Primary care practitioners are a critical link in identifying and addressing mental disorders...Opportunities are missed to improve mental health and general medical outcomes when a mental illness is under-recognized and under-treated in primary care settings." (U.S. Dept of Health & Human Services, 1999). Addressing mental health problems within the primary care setting holds particular importance for older adults, who – as noted above – suffer most acutely from stigma concerns, inadequate screening and assessment, and treatment. This "integrated care" approach can follow one of several models for the interaction of mental health care and primary care, each described briefly below. In some settings, two or more of these approaches are blended within a primary care practice.

Referral

Referal is the traditional approach, in which a patient with any mental health issue is referred out of primary care to a provider in a specialty mental health setting, such as a mental health clinic, private practice, or hospital.

Consultation/Liaison Model

This model combines on-site consultation and liaison care to patients in the primary care setting. Consultation refers to a specialist seeing patients and making recommendations to the primary care provider. In liaison models, specialists primarily work directly with the primary care provider to assist in utilizing strategies to treat the patient. While this model allows for effective treatment of mental health issues in the primary care setting, there are organizational challenges in this model, and there is no evidence that this model is truly an improvement over the traditional Referral model of care.

Co-located Care

In this model, a mental health specialist works within the primary care clinic location. The level of interaction with the medical staff can vary between settings from very little (while the mental health specialist is in close proximity, he or she is largely occupied with care of established patients) to extensive (in the Collaborative Care model, communication between mental health and primary care providers is frequent, timely, and allows for shared approaches to evaluation, treatment planning, and monitoring of outcomes).

Care Management

This approach is a type of collaborative care, in which the primary care provider remains responsible for treatment, but works closely with a care manager to effectively manage mental health problems in the primary care setting, given scheduling constraints and insurance reimbursement issues. The care manager (often a nurse or clinical social worker) assists with treatment decisions and remains in frequent contact with the patient to monitor progress, provide education and

other interventions, and address concerns.

Research in Primary Care for Older Adults

There are several large-scale studies that have documented the effectiveness of treatment of mental health problems in primary care specifically for older adults using such alternatives to the traditional "Referral" model. These studies include:

PRISM-E (Bartels et al., 2004): Adults 65 years and older in primary care were screened for depression, anxiety, and at-risk alcohol use and compared integrated care (within the primary care clinic) with "enhanced specialty care referral" (at a specialized mental health clinic) for patients in treatment.

IMPACT (Unützer et al., 2002): A collaborative care management model was used to address depression and anxiety symptoms, in combination with associated chronic illnesses when indicated.

PROSPECT (Alexopoulos et al., 2009): The PROSPECT model aims to improve the treatment of depression in primary care, utilizing clinical algorithms and training to assist primary care providers in identifying and treating symptoms, as well as treatment management and case management by co-located and collaborating health specialists (e.g., nurses, social workers, and psychologists).

The models utilized in the above studies with older adults, and the lessons learned, can be consulted when a community is attempting to improve care for older adults and when a primary care practice is attempting to improve their success in treating mental health problems among their elderly population. The IMPACT dissemination program offers training and consultation, and assistance in self-evaluation of current primary care setting (see Resource section). Other models of care for older adults, such as the VA Health Care System's Geriatric Evaluation and Management clinics and Home-Based Primary Care programs, can also be looked to for examples of cutting-edge, effective health care for the older population.

BARRIERS TO GETTING PROFESSIONAL HELP: IMPROVING ACCESS TO SERVICES

We have discussed the many approaches and settings through which older adults coping with mental health problems can get effective help. Unfortunately, we also know through the AdvantAge Survey and other research that many older adults do not get the help they need. There are many roadblocks that exist to prevent older adults from accessing these services. Barriers may include practical issues (e.g., financial constraints or transportation difficulties) or health-related problems (e.g., hearing or visual impairment, cognitive decline, or mobility). Barriers may be related to perceived stigma surrounding mental illness (beliefs such as "people who go into therapy or take medications are crazy or weak"), misperceptions of the counseling process ("I will be brainwashed and made to tell all my secrets"), or self-accepted negative stereotypes of aging ("I'm too old to change my ways") (Yost, Beutler, Corbishley, & Allender, 1986). Some elderly persons who begin

counseling will have concerns about the gap in age between themselves and a therapist who may be considerably younger.

These barriers can be addressed at several levels. In the next section, we will discuss community-level interventions. First, we will cover an important "person-level" approach.

At the person level, to assist an older adult with mental health problems who may be reluctant to engage in treatment, "socialization" or pre-treatment education can be provided. This type of education provides information about treatment options, possible side effects, and likely positive effects. In addition, stigma concerns can be assessed and addressed, such as how to address questions by family or friends about mental health appointments, whether receiving mental health treatment may affect judgments of competency in the future, and so forth. Misconceptions or erroneous beliefs can be corrected. This education can occur as a one-to-one meeting with a healthcare provider, as an informational group presentation, or via video-, web- or paper-based materials, or both. Each method has advantages and disadvantages in terms of cost, convenience, and the ability to tailor the message to specific concerns.

Research suggests that this "socialization" increases patients' attendance and engagement in psychotherapy, regardless of therapy approach (France & Dugo, 1985; Larsen, Nguyen, & Green, 1983). This may be especially important for elders who tend to be underrepresented in psychotherapy use, such as minorities. In fact, in one study looking at treatment of older adults of color, when queried about factors contributing to access to and participation in psychotherapy, the clients indicated that the pretreatment socialization was instrumental in motivating them to begin and stay in treatment (Alvidrez, Areán, & Stewart, 2005). Thus, pretreatment training or socialization can be a very powerful tool for engaging older adults in treatments for mental health problems.

WHAT CAN COMMUNITIES DO TO LOWER THE PREVALENCE OF DEPRESSION AND ANXIETY AMONG OLDER ADULTS?

The first reaction of many community members might be to think that the best solution to mental health problems is just to "leave it to the experts." While professional consultation often is wise and certainly necessary in many cases, there is a great deal that individual citizens and community groups can do on their own to improve the mental health of their senior citizens. What follows are two groups of recommendations: actions that seniors can take to maintain their own mental health; and suggestions for changes that local community groups could implement in order to provide a community environment that supports the mental health of older adults. Each of these suggestions is intended to lower the risk of developing psychological distress by maintaining health, preventing isolation, and increasing the social participation of older adults. A major theme underlying community action involves the importance of advocating health care policies that emphasize wellness, self-sufficiency, and independence.

Finally, we also believe that family members and close friends can do a better job of helping older adults access mental health services when needed. Research consistently demonstrates that those closest to older adults know when they are feeling down. What is important is taking these signs seriously and recognizing that depression is treatable and that social isolation is not a necessary concomitant of old age.

ACTIONS SENIOR CITIZENS CAN TAKE FOR THEMSELVES

Developing good health habits and skills for managing chronic illnesses

Most of us now recognize that good nutrition, regular exercise, not smoking, and avoiding excessive alcohol consumption have a positive influence on life expectancy and quality of life as we age. Self-care is vital for older and younger community advocates alike. But sometimes, chronic illness and disability are unavoidable. In these instances, what can be crucial for mental health is learning how to manage these conditions as effectively as possible. An important piece of this is learning how to be one's own best health advocate in the sometimes confusing maze of health care. For example, learning how to obtain accurate information about a condition, treatments, and outcomes as well as how to communicate information about one's concerns to a physician is important. Mastering strategies for interacting with health care providers can be a powerful first step in advocacy for one's self and one's community.

Developing social and cognitive skills that help maintain positive social relationships

A major problem with stereotypes of older adults as "over the hill" is that seniors themselves may begin to believe these stereotypes and withdraw from social life and new learning. Research consistently shows that seniors who remain intellectually active and who continually learn new skills are better able to respond effectively to the inevitable stressors and challenges in their lives (Rowe & Kahn, 1997; Zarit, 2009). Some of these stressors are interpersonal, coming from family members and friends who have problems of their own. Maintaining good relationships with family and friends can sometimes mean knowing how to withdraw from relationships that are one-sided, noxious or abusive. So, while core social skills involve truly listening to others and empathizing with them, learning key skills of assertive behavior, to define the parameters of social relationships, also can go a long way toward improving an older adult's social life.

Maintaining a sense of "self-efficacy"

The key element in the above suggestions is the belief that one is in control of one's own life and that one has the ability to make necessary changes in personal habits or relationships with others. Research consistently shows that passivity and hopelessness can be precursors for depression, and that achieving a sense of personal control is an important element in preventing depressive onset (Zarit, 2009).

BUILDING A COMMUNITY ENVIRONMENT THAT SUPPORTS OLDER ADULT MENTAL HEALTH

From many years of research, we know that certain aspects of life tend to be related to increased well-being in older adults, potentially making mental health problems less likely to emerge. There are social factors, such as finding a meaningful role and meaningful

activities in old age, and receiving adequate support from friends and family members. Options to nursing home placement and aging-in-place are concepts receiving increasing attention from policy makers and activists. Experts have also identified environmental factors that can contribute to well-being, such as careful design and placement of housing options for the elderly, the availability of appropriate recreational activities, and access to adequate transportation options.

There is much that community members can do to improve the lives of older adults by reducing the stressors that are associated with anxiety and depression and increasing opportunities for enhanced well-being. What follows now are some suggestions for community action.

Upgrading the geriatric mental health training of health care providers

As noted above, under-diagnosis and under-treatment of mental health problems in older adults is a well-recognized problem. Mental health surveys generally find that about 8% of adults over 65 have some form of mental disorder requiring treatment, but that less than 1/3 of older adults receive treatment of any kind for psychological distress. An important task for community members is to state their awareness of this problem and encourage their local medical providers to take steps to improve their ability to detect and treat mental health problems in the elderly. As discussed above, there now are empirically validated, short depression screening instruments available that can be easily administered and scored by medical staff that could alert physicians to the possible existence of a depressive disorder (Heller, Viken & Swindle, 2010). There also are best practice protocols available to help physicians treat and monitor co-morbid depression problems. And, as noted above, patient preference for treatment – psychotherapy or medications – should be honored. Thus, medical specialists in geriatrics can be hired by local practices to enhance services for the elderly population; can be encouraged to make high-quality psychotherapy services available. Community members might also press local organizations who provide training (e.g., the government aging agencies or institutes of higher education) to offer expanded opportunities for geriatric mental health training.

Improving opportunities for social inclusion and participation

Although people may lose occupational roles with age, informal roles remain viable for a much longer period of time. Such roles are usually not performed for monetary remuneration, but are important to support a continued sense of competence and esteem. Informal roles depend upon networks of friendships and voluntary activities that tie individuals to community life. The challenge for a community is to find ways for elderly citizens to perform useful social roles within the context of neighborhood, family and voluntary social organizations.

When we think about "programs" for older adults, what usually comes to mind is some form of activity or companionship program to combat loneliness, provide respite for caregivers, and keep older citizens occupied. Implicit in these endeavors is a view of older adults as individuals who are no longer likely to be active contributors to society. But it is important to remember that a society's view of older adults shapes our planning and our actions. Reframing the question from "How should older adults be cared for?" to "Can we encourage the maintenance of useful social roles by older adults?" allows us to consider

new possibilities (Heller, 1993).

Unfortunately, the conceptual orientation of many citizens toward older adults is to view them as a vulnerable population which must be protected and cared for, but not as functioning members of society whose skills and expertise should be maximized. To be sure, declines in functional abilities continually occur with age. But in some situations, the problem-solving ability of 60- and 70-year-olds may be almost identical to the performance of 20-year-olds. In fact, older adults, at least up to the age of 75, often use wisdom gained through experiences to compensate for age-related declines in solving life problems.

Indeed, despite many contemporary societies being youth-oriented, in some situations a society may do as well, or better, with older rather than younger persons in key roles. For example, pay attention to the number of older world leaders and the number of older citizens in other cultures that are regularly called upon for advice and assistance. On the other hand, in Western cultures, the reduction in community status that comes with old age can bring on a sense of uselessness or uncertainty.

There are many innovations occurring in environmental planning for older adults which are relevant to maintaining social relationships and roles, and communities can work to inform themselves of the many options. For example, planning public spaces that are accessible and appropriate for use by elderly citizens is important. Some communities have chosen to house an assisted living, nursing home or adult day care in close proximity to a children's day care center. This allows frequent interaction between the generations, and provides a meaningful role to the older adults (see Tiny Tiger Intergenerational Center on the Resources list). Community activists can also promote public education to dismantle such negative stereotypes and encourage citizens to expand their thinking around their elderly members. The major themes of such education efforts should be promoting understanding of the diversity that exists in the older population, the dilemmas that some older adults face, and the value to society of their continued participation in community life. This is not is not a message that will be hard for people to understand. After all, we are talking about our own self-interest, since those of us who survive into old age will be the major beneficiaries of any policy changes that occur.

Moving toward flexible retirement ages

It is important to recognize that retirement is not a major stressor for all workers because individuals vary in their attachment to the work role. Some workers have dull and monotonous jobs that are not particularly meaningful or emotionally important to them, so their primary adjustment to retirement is economic. On the other hand, there are others for whom work provides a sense of identity and support that is not available in other aspects of their lives. For these individuals, retirement means the loss of an important social role that is part of their self-identity.

The loss of work roles and the status associated

with these roles does not have to occur suddenly, nor does it mean that older citizens should be moved aside and considered as non-productive. Some experts advocate a flexible social policy that allows part-time employment for those who choose to continue in this role (Krain, 1995). In some countries where there are not enough skilled younger workers to fill the breach left by early retiring older workers, there has been an overhaul of forced retirement policies. These countries are experimenting with finding ways to combine partial pensions with part-time salaries as a way to attract older workers to stay on with a reduced work load. Phased retirement plans have several advantages for employers. They can be attractive to potential employees, and can be a factor in retaining skilled workers and reducing training costs associated with worker turnover. Worker morale and productivity can be maintained as new employees are introduced working alongside older workers, learning skills as well as a responsible work ethic. Phased retirement for employees also allows a gradual adaptation to retirement and the development of interests outside of the regular work environment.

While it is difficult to argue for the continued employment of older adults in a tight job market, future upturns in the economy will again require a well-trained and stable labor force, characteristics that are often found among older adults. There are already programs in France, Australia and Singapore to encourage employer-financed job training; in the U.S. there are still few incentives provided for workers to seek out the education and training that they might need to continue to work longer. Community members can consider asking local employers to institute human resource policies that set retirement decisions based on worker fitness, not on a fixed chronological age. In addition, they can encourage employers to provide continuing training and education to allow workers to periodically upgrade their job skills.

Lowering physical barriers to community and social participation by older adults

Many of us do not recognize how difficult it can be for many older adults to continue active community participation. With declining physical mobility and vision problems that impede night driving, older adults can be forced to stay home rather than attend meetings, or cultural events that are held at night. Even when public transportation is available, barriers to its use can include limited financial resources, lack of appropriate seating on crowded buses, and high steps at entrances and exits. Many of us take ease of transportation access for granted, but that is not the case for seniors who have to think carefully about how they will get to and from community events. Some senior centers and church congregations make special provision for transportation of their members, but communities more generally need to assess and eliminate the physical barriers that exist in their communities that isolate senior citizens. For example, funding can be appropriated for upgrading transportation options and events can be held in centrally-located, accessible buildings. Housing designated for seniors can be built in central, walkable areas of a community.

Housing alternatives to institutionalization and nursing home placement

While there is a wide variety of housing alternatives discussed in the literature, in fact, housing options for many older people are quite limited. Choices may be constrained by growing physical limitations and the need for additional care; financial resources; and/or the desire to maintain existing social ties and social routines. In other words, while

many older adults might prefer to "age in place" and remain in their homes, they are often forced by limited options and limited funding to consider relocation to a nursing home. However, many governments throughout the world are recognizing that relying exclusively on nursing homes or other forms of institutionalization to deal with the problem of their expanding elderly population is not a financially viable alternative. Nursing home care is very expensive for whomever is paying the bill -- the individual, an insurance company, or government funding programs such as Medicaid or Medicare.

In addition, gerontological theorists emphasize the desire of older adults to maintain autonomy regardless of whether they live in their own homes or move to special living arrangements. Autonomy means freedom of choice and action, and self-regulation of one's life space, with the minimal need to call for the assistance of others. At the same time, the elderly and their family members have distinct concerns about safety and security. Physical and psychological security involves safety from environmental threats as well as easy access to health care and emergency services. Security can also be maintained by one's social surroundings and by the sense of community and continuity that occurs with continued interaction with one's friends and neighbors. This can be very different from the environment provided by some nursing homes. Overworked and ill-trained staff sometimes find it easier to follow institutional routines that reward helplessness and dependence, rather than institute practices that maintain individual self-sufficiency and autonomy by supporting an older adult's intact abilities.

Several demonstration projects provide examples of what it would take to maintain the elderly in their homes as long as possible. In one project in Arkansas, consumers were provided a cash allowance to purchase personal assistance services for older family members. Consumers could hire family or non-family care workers. In a comparison between the two, it was found that consumers who hired family members received more services and had equal or superior satisfaction and health outcomes compared to those who hired non-relatives (Simon-Rusinowitz, Mahoney, Loughlin, & Sadler, 2005).

Another demonstration project in Japan involved a consumer cooperative that began by distributing eco-friendly foods and goods to its members (Oka, 2000). Over time, the membership of the cooperative, who were mostly women, became concerned about their own aging and the aging of others in society. They began offering in-home care services to their own members and some 20 years later, opened a small, cooperative, residential nursing home in the neighborhood, with rooms arranged as interactive suites or apartments. The home was staffed by trained community-based workers. The projects cited above are noteworthy because care was provided by family members, friends, or neighbors, within a person's own home or neighborhood. In contrast, sending a person to a nursing home can lead to an abrupt disruption of the person's social network.

Others have developed programs that focus on supporting caregivers to reduce stress and mental health problems, and thus delay or prevent institutionalization of the older person. As noted above, caregiving for a relative – usually a spouse – is known to be a significant risk factor for depression, anxiety, and decreased well-being. A group at New York University (Mittelman et al., 2006; also see Resource Section) has developed a counseling and support program for caregivers and shown through their research that such support reduces depression in caregivers and delays nursing home placement. See the Resource section for other examples of empirically-supported caregiver programs that could be used as models for such services in any community.

Another innovative example of "aging in place" is occurring in states that are using state-run Medicaid programs to fund in-home health care services for older persons who would otherwise be forced to accept a nursing home placement due to care needs and financial limitations. For many years, Medicaid perpetuated an institutional bias in that federal law required these state-run Medicaid programs to fund nursing home residency for qualifying persons, but did not require reimbursement of community-based, in-home care services. This resulted in nursing home placement for many older adults who would have preferred to stay at home and could have remained there with additional care services. However, in 2007, Medicaid officials began piloting programs in several states to allow low-income or disabled elderly to receive funding for care services in their own homes.

Such innovative programs and shifts in funding priorities are not only important in maintaining factors that enhance well-being in older adults, they also represent a financially responsible approach to addressing the needs of our growing aging population. Local community groups might choose to lobby legislators to support policy changes that would facilitate state funding for in-home care for eligible seniors. Locally-based care programs may also be an option. Finally, adequate caregiver support services is key to helping spouses and adult children care for needy older adults at home, rather than opting for nursing home care. The development and strengthening of community-based care provisions needs to be high on the agenda of federal, state, and local government planning groups.

SUMMARY

Mental health problems are under-identified and under-treated in the elderly population. There continue to be barriers, stigma concerns, and lack of services that hinder older adults from getting help for mental health problems such as depression and anxiety. However, we hope that this guidebook has also shown that there is much in the way of research, governmental support, and empirically-supported model programs to effectively guide a community in making positive changes to improve the situation for their older citizens.

Perhaps most importantly, this guidebook has attempted to reveal the stereotypes and assumptions that continue to affect how communities think about and act on behalf of the elderly. At the present time, there are two prominent images or stereotypes of older adults in society at large, as presented in the media. One image is of frailty and limitation. This is an image that leads us to think of older adults as persons who are dependent, who must be cared for, and who are unable to make decisions on their own. This image also makes mental health problems seem inevitable, enduring, and "normal" in this population.

A second image is of vitality, wisdom and leadership based upon years of experience. This image may lead us to be ignorant of the need for societal changes and adaptations to accommodate the needs of many older adults. In fact, both images are true to some extent, and since older adults are as different from one another as are citizens at any other age group, they can be found anywhere along this continuum. This means that there is no one "right" approach to how older adults should be treated in society.

Perhaps the most important job of a community is to discard any assumptions and recognize this heterogeneity among older adults. This means caring for those who need help, while at the same time finding ways to utilize the resources of those who are capable of making continued societal contributions. We wish you well in these exciting and worthwhile endeavors.

RESOURCES

Primary Care (treatment guidelines, patient education materials, and more)

McArthur Foundation:
http://www.depression-primarycare.org/

IMPACT study and dissemination project:
http://impact-uw.org/

Schulberg, H. C., Bryce, C., & Chism, K. and the PROSPECT Group. (2001). Managing late life depression in primary care practice: A case study of the Health Specialist's role. *International Journal of Geriatric Psychiatry,* 16, 577-584.

Mental Health Issues

National Institute of Mental Health:
http://www.nimh.nih.gov/health/topics/older-adults-and-mental-health/index.shtml

Surgeon General's Report on Mental Health:
http://www.surgeongeneral.gov/library/mentalhealth/home.html

NAMI: www.nami.org

Substance Abuse in Older Adults

SAMHSA: http://ncadi.samhsa.gov/

Policy and Older Adults

Medicare/Medicaid:
http://www.cms.hhs.gov/healthinsreformforconsume/04_thementalhealthparityact.asp

Binstock, R. H. (2002). The politics of enacting reform. In S. H. Altman & D. I. Shactman (Eds.), *Policies for an aging society,* (pp. 346-377). Baltimore, MD: John Hopkins University Press.

Krain, M. A. (1995). Policy implications for a society aging well: Employment, retirement, education, and leisure policies for the 21st century. *American Behavioral Scientist,* 39, 131-151.

Greenfield, E. A., & Marks, N. F. (2004). Formal volunteering as a protective factor for older adults' psychological well-being. *Journal of Gerontology: Social Sciences*, 59B, S258-S264.

van Willigen, M. (2000). Differential benefits of volunteering across the life course. *Journal of Gerontology: Social Sciences*, 55B, S308-S318.

Dementia and Caregiving

Toolkit for supporting Caregivers:
http://www.aoa.gov/AoAroot/AoA_HCLTC/Programs/Alz_Grants/docs/Toolkit_8_Supporting_Family_Caregivers.pdf

The New York University Counseling and Support Intervention for Caregivers:
http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=122

Alzheimer's Association: www.alz.org

National Family Caregivers Association:
www.thefamilycaregiver.org

Older Adult and Family Center, Stanford University, *Coping with Caregiving* class manual:
http://oafc.stanford.edu/manuals.html

Coon, D.W. Gallagher-Thompson, D., & Thompson, L. (2003). I*nnovative interventions to reduce dementia caregiver distress: A clinical guide.* New York: Springer.

Oka, M. (2000). A special consumer cooperative association nursing home. In F. G.. Caro, R. Morris, & J. R. Norton (Eds.), *Advancing aging policy as the 21st century begins.* New York: Haworth Press.

Simon-Rusinowitz, L., Mahoney, K. J., Loughlin, D. M. & Sadler, M. D. (2005). Paying family caregivers: An effective policy option in the Arkansas Cash and Counseling Demonstration and Evaluation. In R. K. Caputo (Ed.) *Challenges of aging on U.S. families: Policy and practice implications.* (p.83-105). New York: Haworth Press. (Also published in Marriage and family review, 2005.)

Suicide

Prevention of Suicide in Older Adults:
http://www.samhsa.gov/OlderAdultsTAC/docs/Suicide_Booklet.pdf

Center for Mental Health Services (2009). *Report on the 2008 Summit on Opportunities for Mental Health Promotion and Suicide Prevention in Senior Living Communities*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
http://www.sprc.org/library/It_Takes_A_Community.pdf

The Older Americans Act (original and subsequent changes)

Administration on Aging website, information on act:
http://www.aoa.gov/AoARoot/AoA_Programs/OAA/introduction.aspx

O' Shaughnessy, C. V. (2008). *The aging services network: Broad mandate and increasing responsibility. Public policy and aging report, 18, #3*. National Academy on an Aging Society, Gerontological Society of America. Accessed at:
http://www.aoa.gov/AoAroot/Press_Room/News/2008/Policy_Report_on_the_AgingNetwork

[See these sections at above website:
Kunkel, S. R., & Lackmeyer, A. Evolution of the aging network: Modernization and long-term care initiatives; Browdie, R. & Castora, M. The aging network: State of the states; and Kahana, J. & Force, L. T. Toward inclusion: A public-centered approach to promote civic engagement by the elderly.]

Housing and Urban Design

Hulchanski, J. D. (1987). *Cooperative housing in Canada (CPI Bibliography No. 191)*. Chicago, IL: Council of Planning Librarians.

Parmelee, P. A., & Lawton, M. P. (1990). The design of special environments for the aged. In J. E. Birren & W. Schaie (Eds.), *Handbook of the psychology of aging* (3rd ed.) (pp. 465-489). San Diego, CA: Academic Press.

Tiny Tiger Intergenerational Center, Marshfield, WI. Co-located childcare, adult day services, and high school classrooms in one inter-actional center:
http://ci.marshfield.wi.us/planning/default.aspx?id=10216

Essential Ingredients of Community Based Programming

Stith, S., Pruitt, I., Dees, J., Fronce, M. Green, N., Som, A., & Linkh, D. (2006). Implementing community-based prevention programming: A review of the literature. Journal of Primary Prevention, 27, 599-617.

REFERENCES

Alexopoulos, G.S., Reynolds, C.F., Bruce, M.L., Katz, I.R., Raue, P.J., Mulsant, B.H....& Ten Have, T.; PROSPECT Group (2009). Reducing suicidal ideation and depression in older primary care patients: 24-month outcomes of the PROSPECT study. *American Journal of Psychiatry*, 166(8), 882-90.

Alvidrez, J., Areán, P., & Stewart, A. (2005). Psychoeducation to increase psychotherapy entry for older African Americans. *The American Journal of Geriatric Psychiatry,* 13(7), 554-561.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, DC: Author.

American Psychological Association (1998). What practitioners should know about working with older adults. *Professional Psychology: Research & Practice*, 29(5), 413-427.

Andresen, E.M., Malmgren, J.A., Carter, W.B., & Patrick, D.L. (1994). Screening for depression in well older adults: Evaluation of a short form of the CES-D. *American Journal of Preventive Medicine*, 10(2), 77-84.

Areán, P.A., Hegel, M.T., & Reynolds, C.F. (2001). Treating depression in older medical patients with psychotherapy. *Journal of Clinical Geropsychology,* 7(2), 93-104.

Bartels, S.J., Coakley, E.H., Zubritsky, C., Ware, J.H., Miles, K.M., Areán, P.A. & Levkoff, S.E. for the PRISM-E Investigators (2004). Improving access to geriatric mental health services: a randomized trial comparing treatment engagement with integrated versus enhanced referral care for depression, anxiety, and at-risk alcohol use. *American Journal of Psychiatry,* 161, 1455-62.

Chambless, D.L. & Hollon, S.D. (1998). Defining empirically supported therapies. *Journal of Consulting & Clinical Psychology*, 66(1), 7-18.

Cheng, S.T. & Heller, K. (2009). Global aging: Challenges for community psychology. *American Journal of Community Psychology,* 44, 161-173.

Cole, M. G. & Dendukuri, N. (2004). The feasibility and effectiveness of brief interventions to prevent depression in older subjects: A systematic review. *International Journal of Geriatric Psychiatry,* 19, 1019-1025.

France, D.G. & Dugo, J.M. (1985). Pretherapy orientation as preparation for open psychotherapy groups. *Psychotherapy: Theory, Research, Practice, Training*, 22(2), 256-261.

Freud, S (1924). *On Psychotherapy,* Vol 1. London: Hogarth Press.

Gatz, M., Fiske, A., Fox, L.S., Kasl-Godley, J.E., McCallum, T.J., & Wetherell, J.L. (1998). Empirically validated psychological treatments for older adults. *Journal of Mental Health and Aging*, 4, 9-46.

Gross, J. (2007). A grass-roots effort to grow old at home. *New York Times,* August 14, 2007.

Gum, A. & Areán, P.A. (2004). Recent advances in psychotherapy for older adults with psychiatric disorders. *Current Psychiatry Reports*, 6, 32-38.

Heller, K. (1993). Prevention activities for older adults: Social structures and personal competencies that maintain useful social roles. *Journal of Counseling and Development,* 72, 124-130.

Heller, K., Viken, R. J. & Swindle, R. W., Jr. (2010). Screening for depression in African-American and Caucasian older women. *Aging*

and Mental Health, 14, 339-346.

Hudson, R. B. (2005). The new political environment in aging: Challenges to policy and practice. Families in Society: *The Journal of Contemporary Social Services*, 86, 321-327.

Himmelfarb, S., & Murrell, S. (1984). The prevalence and correlates of anxiety symptoms in older adults. *Journal of Psychology: Interdisciplinary and Applied*, 116(2), 159-167.

Katz, I.R., Streim, J., Parmelee, P. (1994). Prevention of depression, recurrences, and complications in late life. *Preventive Medicine,* 23, 743-750.

Koenig, H.G. (2007). Physician attitudes toward treatment of depression in older medical inpatients. *Aging and Mental Health,* 11, 197-204.

Konnert, C., Gatz, M., & Hertzsprung, E. (1999). Preventive interventions for older adults. In M. Duffy (Ed.). *Handbook of counseling and psychotherapy with older adults*, (pp. 314-334). New York: Wiley.

Kroenke, K., Spitzer, R.L., & Williams, J.B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine,* 16, 606-613.

Krain, M. A. (1995). Policy implications for a society aging well: Employment, retirement, education, and leisure policies for the 21st century. *American Behavioral Scientist*, 39, 131-151.

Larsen, D.L., Nguyen, T.D., & Green R.S. (1983). Enhancing the utilization of outpatient mental health services. *Community Mental Heatlth Journal*, 19, 305-320.

Mittelman, M.S., Haley, W.E., Clay, O., & Roth, D.L (2006). Improving caregiver well-being delays nursing home placement of patients with Alzheimer disease. *Neurology,* 67, 1592-1599.

Oka, M. (2000). A special consumer cooperative association nursing home. In F. G.. Caro, R. Morris, & J. R. Norton (Eds.), *Advancing aging policy as the 21st century begins*. New York: Haworth Press.

Ory, M., Hoffman, M. K., Hawkins, M., Sanner, B., & Mockenhaupt, R. (2003). Challenging aging stereotypes: Strategies for creating a more active society. *American Journal of Preventive Medicine*, 25, 164-171.

The President's New Freedom Commission on Mental Health (2003). *Achieving the Promise: Transforming Mental Health Care in America.* http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf

Radloff, L.S. (1977). The CES-D Scale: A Self-Report Depression Scale for Research in the General Population. *Applied Psychological Measurement*, 1 (3), 385-401.

Rokke, P.D., Tomhave, J.A., & Jocic, Z. (1999). The role of client choice and target selection

in self-management therapy for depression in older adults. *Psychology & Aging,* 14(1), 155-169.

Rowe, J. W., & Kahn, R. L. (1997). Successful aging. *The Gerontologist*, 37, 433-440.

Schulberg, H.C., Katon, W., Simon, G.E., & Rush, A.J. (1998). Treating major depression in primary care practice: An update of the Agency for Health Care Policy and Research practice guidelines. *Archives of General Psychiatry*, 55, 121-1127.

Simon-Rusinowitz, L., Mahoney, K. J., Loughlin, D. M. & Sadler, M. D. (2005). Paying family caregivers: An effective policy option in the Arkansas Cash and Counseling Demonstration and Evaluation. In R. K. Caputo (Ed.) *Challenges of aging on U.S. families: Policy and practice implications*. (pp. 83-105). New York: Haworth Press. (Also published in *Marriage and Family Review,* 2005.)

Smith, G. C. (1999). Prevention and promotion models of intervention for strengthening aging families. In M. Duffy (Ed.). *Handbook of counseling and psychotherapy with older adults*, (pp. 378-394). New York: Wiley.

Thompson, D. & Borson, S. (2006). Major depression and related disorders in late life. In: M.E. Agronin & G. J. Maletta (Eds.), *Principles and practice of geriatric psychiatry* (pp. 349-368). Philadelphia: Lippincott, Williams & Wilkins.

Unützer J., Katon W., Callahan, C.M., Williams, J.W., Hunkeler, E., Harpole, L., & Langston, C. for the IMPACT Investigators (2002). Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. *Journal of the American Medical Association*, 288(22), 2836-2845.

U.S. Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General—Executive Summary.* Rockville, MD: U.S. Department of Health and

Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

U.S. Preventive Services Task Force (June 2003). *Screening for Dementia: Recommendations and Rationale*. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/clinic/3rduspstf/dementia/dementrr.htm

Wyman, M.F., Gum, A., & Areán, P.A. (2006). Psychotherapy with older adults. In: M.E. Agronin & G. J. Maletta (Eds.), *Principles and practice of geriatric psychiatry* (pp. 177-198). Philadelphia: Lippincott, Williams & Wilkins.

Yesavage, J.A., Brink, T.L., Rose, T.L., Lum, O., (1983). Development and validation of a geriatric depression screening scale: A preliminary report. *Journal of Psychiatric Research* 17, 37-49.

Yost, E.B., Beutler, L.E., Corbishley, M.A.,& Allender, J.R. (1986). *Group cognitive therapy: A treatment approach for depressed older adults*. New York: Pergamon Press Inc.

Zarit, S. H. (2009). A good old age: Theories of mental health and aging. In V.L. Bengtson, M. Silverstein, N.M. Putney, & D. Gans (Eds.). *Handbook of theories of aging*, 2nd edition. (pp. 675-691). New York: Springer.