MENTAL HEALTH IN NEW ZEALAND FROM A PUBLIC HEALTH PERSPECTIVE

Edited by

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The views expressed in this report are those of the authors and they do not necessarily represent the views of the Ministry of Health.
New Zealand’s elderly population is steadily increasing. In 1996, 11.5 percent of the population was over 65. By the time the baby boom generation reach late life in the year 2025, elderly people will represent 18–19.5 percent of the total population; that is, an estimated 540,000 persons based on 1991 data, medium fertility, medium mortality and migration (Richmond et al 1995). The effects of these changes on New Zealand society in general have been reviewed elsewhere (Koopman-Boyden 1993). More specifically, this rise in the elderly population means that absolute numbers of elderly people with mental disorders presenting to services will also increase. This has major implications for the provision of health care for the aged in New Zealand over the next 25 years.

While the major mental health issue of old age is still dementia (see Chapter 22), all the mental disorders that appear in adult populations are also represented in late life, to a greater or lesser extent. Among the most common (non-dementing) mental health disorders are depression, anxiety, adjustment and psychotic disorders. Others, such as alcohol or substance abuse and somatisation disorders, also occur frequently. These functional disorders cause a considerable amount of distress and loss of quality of life in old age. In old age there are specific developmental ‘crises’ to be faced, including retirement and bereavement. Those elderly with mental illness must suffer the double stigma of being older, and of having mental illness (Byrne 1995).

PREVALENCE OF MENTAL DISORDERS IN LATE LIFE

The over-65 age group can present specific problems for epidemiological researchers. Low response rates, institutionalisation of those most at risk, respondent shielding from interviews by caregivers (Tweed 1994) and cognitive impairment jeopardising data collection contribute to the pitfalls of conducting research in this age group. As a result, many large population studies of mental disorders in the general community, including the Christchurch epidemiological studies, have not included the older age groups in their surveys, with the consequence that reliable New Zealand data are lacking.

The increasing population of older people, particularly in the northern hemisphere, and the demand for extra services have prompted a number of studies on the prevalence of mental health and illness in late life. Those using brief screening instruments are notoriously non-specific and overstate ‘caseness’, but there is considerable agreement on prevalence rates between studies using structured or semi-structured interviews (eg, the Geriatric Mental State, the Cambridge Mental Disorders of the Elderly Examination, the Canberra Interview for the Elderly).
Comorbidity is common in older people and they often have mixed syndromes rather than categorical diagnoses. It is common for patients to have complicating physical illnesses as well as depressive, cognitive and anxiety symptoms. Estimates of the prevalence of specific disorders in a population usually fail to capture these complexities (Gallo 1995). This is an important omission as comorbidity has major effects on service delivery, can undermine therapeutic programmes and prolong hospitalisations. Services, particularly in-patient services, need to be capable of responding to the needs of patients with mixed physical and mental pathology.

**COMMON MENTAL HEALTH DISORDERS IN OLDER ADULTS**

Table 6.1 presents the one-month prevalence rates for various mental health disorders in older adults.

**Table 6.1: Community-based (non-institutional) world epidemiological surveys of one-month prevalence of common mental health disorders in people aged over 65 years**

<table>
<thead>
<tr>
<th>Mental illness</th>
<th>Study</th>
<th>Year and place</th>
<th>Instrument</th>
<th>Prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Copeland et al 1987b</td>
<td>1987 Liverpool UK</td>
<td>GMS-AGECAT</td>
<td>2.9 MDE 8.9 Dep neurosis</td>
</tr>
<tr>
<td></td>
<td>Blazer</td>
<td>1980 USA</td>
<td>DIS</td>
<td>0.8 MDE 2 Dysthymia</td>
</tr>
<tr>
<td></td>
<td>Ben-Arie et al 1987 South Africa</td>
<td>PSE</td>
<td>13 Depression</td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>Neugebauer 1980 Europe</td>
<td>DIS</td>
<td>0.32</td>
<td></td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>NIMH study (Regier et al 1984)</td>
<td>1984 USA DIS</td>
<td>0.1F 0.9M</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blazer</td>
<td>1980 USA DIS</td>
<td>1–2.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ECA (Regier et al 1988)</td>
<td>1988 USA DIS</td>
<td>5.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Copeland et al 1987b</td>
<td>1987 UK GMS-AGECAT</td>
<td>2.4</td>
<td></td>
</tr>
</tbody>
</table>

GMS-AGECAT Geriatric Mental State 1995 (Copeland 1995)  
MDE Major depressive episode  
DIS Diagnostic Interview Schedule  
PSE Present State Examination (Wing et al 1974)  
ECA Epidemiologic Catchment Area

The Epidemiologic Catchment Area (ECA) studies used the Diagnostic Interview Schedule (DIS), which has been criticised as understating the prevalence of some disorders in older adults. The Geriatric Mental State (GMS-AGECAT) (Copeland 1995) is a modification of the Present State Examination (PSE), made more specific to older people’s mental health problems.
New Zealand lacks epidemiological data on its elderly population and therefore estimates for current and future prevalences of major mental disorders have been extrapolated from the widely used GMS-AGECAT surveys. These are shown in Table 6.2. While these represent community prevalence rates (and do not include the elderly resident in institutions), the latter represent only 5–6 percent of the population and will not seriously bias the estimates.

Table 6.2: Estimated monthly prevalence of major mental disorders (number of cases of people affected) in New Zealand for 1996 and projected for 2025, based on overseas GMS-AGECAT data (Copeland et al 1987b) for people aged over 65 years

<table>
<thead>
<tr>
<th>Disorder</th>
<th>1996</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major depression</td>
<td>11 673</td>
<td>18 271</td>
</tr>
<tr>
<td>Minor depression</td>
<td>35 823</td>
<td>56 070</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>1 288</td>
<td>2 016</td>
</tr>
<tr>
<td>Other psychosis</td>
<td>10 063</td>
<td>15 571</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>9 660</td>
<td>15 120</td>
</tr>
</tbody>
</table>

**DEPRESSION**

One of the most important disorders in old age is depression. Major depression is a serious disorder and can be of such a degree that it leads to malnutrition or dehydration and becomes seriously life threatening. The disorder is very distressing, contributes to a very poor quality of life, increases mortality from other illnesses and suicide, and can have a tendency to chronicity, particularly if missed in the early stages. Depression, even of this severity, is treatable by giving appropriate medication or electroconvulsive therapy. Lesser degrees of depression are even more common.

The ECA studies (Regier et al 1984) gave a prevalence for depression in people aged over 65 years of less than 1 percent, but this probably underestimates true prevalence. The GMS-AGECAT studies give prevalence figures for depression of the order of 2.9 percent, higher than ECA findings and more in keeping with clinical impressions.

Old age can be a time of adversity for many older people. Among the major stresses are multiple bereavements, including loss of partners and friends, changing occupational and family status and physical illness in themselves and partners. On the other hand, the retired, leading quieter lives, may have considerably less minor stressors or hassles than younger adults. Henderson and colleagues (1972) suggested that old age brought the advantage of resilience to adversity, possibly as the result of a ‘psychological immunisation’ through exposure to stress and hassles in earlier life. Such ‘immunisation’ perhaps alters the older person’s perception of the severity of any incumbent stress, lowers expectations of what is considered a satisfactory resolution and provides greater satisfaction with their circumstances. Certainly, many older people do show a pragmatic resilience to stressors and this may be a factor in findings of a lowered incidence of depression in elderly people living in the community.

However, older people’s resilience should not be a reason to be either complacent or dismissive of the very real problems that depression can cause for older people. The healthy elderly population may be remarkably free of depression despite the major losses of old age but this does not apply to the institutionalised, the physically sick and the cognitively compromised.
DEPRESSION IN THE INSTITUTIONALISED

A major review of the prevalence of depression among those in supervised care found a prevalence of 6–15 percent for major depression and 20–30 percent for minor depressive syndromes using standard criteria (Ames 1993). Comparative community studies in New York and London (Copeland, Gurland et al 1987b) gave an overall prevalence of 4.6 percent for major depression and 8.5 percent for dysthymia and bereavement with some variance in the rates for the different cities. These figures are considerably higher than those from community samples. Table 6.3 gives a summary of prevalence rates for depression from various studies.

Table 6.3: Depression studies in institutionalised patients using similar case-finding methods in people aged over 65 years

<table>
<thead>
<tr>
<th>Study</th>
<th>Instrument</th>
<th>Year and place</th>
<th>Diagnostic criteria</th>
<th>Prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ames</td>
<td>GMS and chart</td>
<td>1990 London</td>
<td>DSM-III</td>
<td>9.2 MDE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7.4 other</td>
</tr>
<tr>
<td>Rovner et al</td>
<td>GMS</td>
<td>1986 USA</td>
<td>DSM-III</td>
<td>6 MDE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>18-mixed dementia/depression</td>
</tr>
<tr>
<td>Rovner et al</td>
<td>Modified PSE</td>
<td>1990 USA</td>
<td>DSM-III-R</td>
<td>15 MDE</td>
</tr>
<tr>
<td>Phillips,</td>
<td>CIE, MMSE</td>
<td>1991 Australia</td>
<td>DSM-III-R</td>
<td>10 MDE</td>
</tr>
<tr>
<td>Henderson</td>
<td></td>
<td></td>
<td>ICD-10</td>
<td>19 ICD-10</td>
</tr>
</tbody>
</table>

MDE: Major depressive episode
GMS-AGECAT: Geriatric Mental Status Examination (Copeland et al 1986)
PSE: Present State Examination
CIE: Canberra Interview for the Elderly (Henderson et al 1972)
MMSE: Mini Mental State Examination

The incidence of depression of elderly in supervised care settings and in the medically unwell appears to be about three to six times higher than the general elderly population. The reasons for this higher rate are unclear. Some studies comment that many patients have incipient depression at admission to the facilities and suggest that this factor accounts for most of the variance. However, institutionalisation as an event in a person’s life is highly significant. It usually means a degree of dependency, physical illness or increased perception of ill health, loss of autonomy and loss of usual relationships – all of which are substantial risk factors for depression in themselves.

DEPRESSION AND PRIMARY CARE

Depression in older people is often missed at a primary care level or misidentified as ‘loneliness’ (Green et al 1992), ageing (NIMH Consensus Panel on Depression in Late Life 1992), or sometimes even dementia. One Swedish study found only 39 percent of those with a diagnosis of major depressive disorder were accurately diagnosed and treated (Forsell et al 1994) and a London study found that
only 39 percent of those elderly who had revealed symptoms of their depression to their general practitioner received antidepressants (Blanchard et al 1994). The reasons for this low rate of recognition are not clear, but depressed elderly with serious physical illnesses are identified as depressed at only a fifth the rate of those without physical illness (Tylee et al 1993).

Although depression is a treatable illness and individual episodes usually respond well to treatment, the long-term prognosis of severe depression in older people is generally considered to be poor and recurs, even after treatment, in about two-thirds of patients (Murphy 1983). Although these opinions are based on patients treated in hospital, the outcome was also poor in one, admittedly relatively small, community sample (Forsell et al 1994). If, indeed, prognosis really is poor for this disorder, even in community samples, then even more effort needs to be directed into primary prevention of depression.

**DEPRESSION AND PHYSICAL HEALTH STATUS**

Depression is common in the physically ill, with reported rates varying between 30 and 70 percent (Sadavoy et al 1990; Fenton et al 1994). One community study found that 70 percent of depressed people reported one or more physical illnesses (Lindesay 1990). Depression was more marked where the illness causes dependency or restricted activity (Arling 1987; Lindesay 1990).

**SUICIDE IN LATE LIFE**

Suicide, a tragic complication of depression, is common in the elderly. See also Chapter 23. Of all suicides, 11.7 percent occur among those over the age of 65, and the rate of 33.4 per 100 000 for elderly males is not much less than that for male adolescents, and yet far more public attention focuses towards the latter. Perhaps this is because the adolescent suicide rate has risen dramatically in recent years whereas the elderly suicide rate has been constant over this period. Even the high official suicide figures may underestimate the true state of affairs. There are a number of possible suicides that have been wrongly classified as natural causes, and these include people who deliberately do not comply with nutritional requirements or medical interventions in an effort to hasten their deaths (Glass and Reed 1993).

The World Health Organization databank on elderly suicide demonstrates a consistent worldwide trend for elderly males to have the highest rate of successful suicide of any age group in most countries that supply data (Catell 1994). These males use more violent methods of ending their lives and New Zealand is no exception to this trend. New Zealand figures for 1993 show that 80 percent of elderly females who committed suicide tended to use drowning or poisoning as preferred methods but 58 percent of the males used the more violent methods of hanging, shooting or stabbing.

Many elderly people who have committed suicide will have had undiagnosed depression or other mental illness and even fewer will have received treatment. Catell (1994) found of 104 successful suicides in elderly people in London, only 12 were taking antidepressants and fewer than 20 percent had specialist care. The risk factors are well known and are the same as those for depressive illness in general (Blazer et al 1986; Green et al 1992; Gallo 1995). They include those who have been widowed in the last year, are socially isolated, living alone, have physical illness particularly if painful, depressive illness, alcoholism, and mild dementia. Particular emphasis needs to be placed on identifying those with these risk factors to reduce morbidity and mortality.
The lack of interest in the phenomenon of elderly suicide might reflect some societal attitudes about older people. For example, attitudes may be held that older people have lived their lives and are therefore expendable, or that older people have a moral right to end their lives, which will not last much longer anyway. Another is the notion that suicide in an elder is likely to be thought out and rational. The implication of this is that the consequence of such a death is less of a burden to society and therefore morally justifiable (Kerkof et al 1991). Although controversial and ageist, these attitudes unfortunately do prevail. An alternative view could be that elderly self-harm is an important public health issue and that death by suicide is always premature, whatever the age of the individual (McIntosh 1995).

Family attitudes are important in recognising suicidal and depressive ideation in older people. Many older people have been resilient at handling stressors in their adult lives and adult children expect their parents to cope as competently as previously. They often consider sadness to be a normal reaction to a stress in old age and they fail to recognise the despair. Older people often ‘do not want to be a burden’ and do not readily reveal their depressive or suicidal thoughts to their children (Kerkof et al 1991). All these factors can add up to suicidal intentions being missed or ignored by friends and families. Even worse is the very rare murder-suicide by the despairing depressed elderly person.

**PSYCHOSES**

Descriptions of psychotic syndromes occurring for the first time in late life have provoked much (as yet unresolved) debate as to whether these syndromes are distinct disorders or lie on a continuum with a neurocognitive degenerative process. Psychoses can arise in late life without cognitive impairment and meet all criteria for schizophrenia. There is usually less personality disintegration and thought disorder in late-onset schizophrenia than when it presents earlier. To confuse matters further, psychotic phenomena can also occur as part of a dementing process (Burns et al 1990) with minimal or no cognitive impairment in the initial stages. Some late-onset psychoses seem to have distinctive schizophrenia-like characteristics but are qualitatively different to early-onset schizophrenia and are referred to as paraphrenia. This syndrome occurs more in women, is associated with visual and hearing impairments and, for as yet unknown reasons, is associated with remaining single and low fertility. The psychotic phenomena are often paranoid in nature but personality and thinking remain intact. The patient’s social and personal functioning is much higher than in those suffering schizophrenia (Almeida et al 1995) or those with psychosis complicating cognitive impairment.

Distinctions between the various psychotic disorders are not made in most epidemiological studies. The prevalence of schizophrenia, schizophreniform or paranoid psychosis in the over-65 age group is 1–2.5 percent (Blazer 1980), which is not too dissimilar to that in other adult age groups. People with early-onset schizophrenia also grow old and have the potential for developing comorbid ageing pathologies. Several workers have noted brain changes of increased ventricular size and hypofrontality with dilated sulci in patients with schizophrenia, changes very similar to those that can also occur with ageing and dementia. Whether schizophrenia increases the risk for dementia has not been empirically studied. The confounding effects of long-term neuroleptic medication, hospitalisation, cigarette smoking and inactivity are difficult to control for and all of these may be risk factors for neurodegeneration (Harvey et al 1995).
CHRONIC MENTAL ILLNESS AND AGEING

Little work exists on the course of chronic psychotic illnesses in late life or the interaction of mental illness with the pathophysiological changes of ageing, although there seems to be an attenuation of the more florid symptoms of schizophrenia with advancing age. For about half to two-thirds of patients, episodes are less distressing or the illness seems to attenuate (Pugh 1994). This, of course, still leaves a sizeable number of patients disabled by illness, side-effects of long-term medication and chronic institutionalisation. In New Zealand during the 1980s, many people with chronic mental illness who had been in hospital for many years were re-institutionalised in rest homes, often with inadequate psychiatric follow-up. While some patients adapted well to rest homes, the more severely ill did not and continued to require repeated admissions. This group of patients falls into a gap in service provision. While their needs for aged care are well met, current rest home or private hospital facilities do not meet their additional special needs for high-level psychiatric expertise.

TARDIVE DYSKINESIA: AN IATROGENIC COMPLICATION OF CHRONIC MENTAL ILLNESS

Older patients with a long history of chronic mental illness treated with antipsychotic medication are at risk from developing tardive dyskinesia (TD). This is a devastating side-effect of the older antipsychotic drugs that until very recently were the only ones available. Recently introduced drugs such as Clozapine or Respiridone may lack or have a substantially reduced propensity to cause this disorder, but are in limited use in New Zealand because of high cost. Tardive dyskinesia (abnormal rhythmic mouth movements) is unpleasant for elderly patients and caregivers and can cause severe problems with the mouth and dentition and interfere with nutrition. Similarly induced tardive dystonia (rhythmic abnormal body movements) can interfere with mobility, lead to disturbances in activities of daily living, and cause gait disturbances and falls. While there is a strong correlation between lifelong use of antipsychotic medication and tardive dyskinesia (Sweet et al 1995), age is a risk factor itself. One study of patients over age 77 found 31 percent of subjects had developed this condition within 43 weeks of commencing antipsychotics (Salz et al 1991). Other risk factors include cognitive impairment and female sex with a 1.69:1 female:male ratio (Barnes 1994).

ANXIETY AND ADJUSTMENT DISORDERS

Ageing, with increasing frailty, produces some increase in mild anxiety as older people feel more vulnerable. While they often have exaggerated fears of being assaulted, mugged, or their homes violated, these fears do not generally interfere with people’s functioning. Older people may also be at risk for adjustment disorders when they find themselves with unaccustomed leisure and reduced income after retirement. Marital relationships that may have endured previously can come under some strain as couples spend more time with each other. Anxiety may increase in response to multiple losses of old age such as decline in health and physical status, decreased mobility and loss of independence. In European cultures ageing usually brings a decline in social responsibility. In contrast, in Māori and Pacific cultures late life may bring added responsibility that can cause a frail older person some stress (see also Chapters 3 and 4). These changes, both positive and negative, can increase tension and anxiety for elderly people. Despite the pressures, the one-month prevalence of diagnosable anxiety disorders was only 0.7–5.5 percent in a number of major epidemiological surveys (Flint 1994) (see Table 6.4 on the following page).
The variation in these figures reflects differing thresholds for diagnosis. Anxiety may often exist together with depression, but be the more obvious condition when the older person seeks treatment, resulting in the depression being overlooked and left untreated (Flint 1994).

Table 6.4: One-month prevalence for anxiety disorders in (non-institutionalised) people aged over 65 years

<table>
<thead>
<tr>
<th>Study</th>
<th>All anxiety</th>
<th>Panic</th>
<th>Phobic</th>
<th>Generalised anxiety disorder</th>
<th>Obsessive-compulsive disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECA (Schatzberg 1991)</td>
<td>5.5</td>
<td>0.1</td>
<td>4.8</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>Copeland et al</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liverpool (Copeland, Gurland et al 1987a; Copeland, Dewey et al 1987; Larkin et al 1992)</td>
<td>1.9</td>
<td>0.7</td>
<td>1.1</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>London</td>
<td>1.7</td>
<td>0</td>
<td>1.1</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td>New York</td>
<td>0.7</td>
<td>0</td>
<td>0.7</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Guy's/Age Concern (Lindesay et al 1989)</td>
<td>0</td>
<td>10.0</td>
<td>3.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edmonton</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Bland et al 1988)</td>
<td>3.5</td>
<td>3.8</td>
<td>0.3</td>
<td>1.5</td>
<td></td>
</tr>
</tbody>
</table>

**DRUGS AND ALCOHOL**

While there is no good evidence for a significant substance abuse problem among elders, substance overuse is common with a considerable number of people having ‘accidental addiction’ as a result of long-term prescribing of benzodiazepines as hypnotics or anti-anxiety agents. Benzodiazepines are of particular concern as there is considerable morbidity attached to their chronic use. Falls, delirium (confusional states), memory impairment, neuropsychological deficits (Starr and Whalley 1994) and incontinence are just a few of the problems associated with psychotropic use in older people (Sullivan 1994). Most studies group all psychoactive drugs together, and it is often difficult to ascertain if there is a specific problem with prescribed benzodiazepines in older people as opposed to other sedative psychotropic agents. In general, the use of sedative drugs appears to be less in older people than in younger adults, but over half of older people will become habitual users (Sullivan et al 1988; Hohagen et al 1995). In the latter study, many of these people started on hypnotics while in hospital. Clearly there is an important education issue on the dangers of over-prescribing benzodiazepines, perhaps especially in institutional settings. It is likely that similar problems exist in New Zealand but these have not been documented.
Older people tend to drink less alcohol than younger people and are more moderate in their habits. Sullivan and colleagues (1988) in the Liverpool longitudinal epidemiological study demonstrated that the most marked decline in drinking occurs in heavy drinkers. Nevertheless, alcohol-related problems are not uncommon in older people, occurring in 3 percent of men over 65 years and are the third most common diagnosis in elderly men in the community (Ticehurst 1990). Alcohol problems are more common in elderly men than elderly women although alcohol may be used by both sexes as a way of coping with loss, depression or loneliness (Brennan and Moos 1990). The ageing brain is more vulnerable to the effects of alcohol and even small amounts can produce problems. A lifetime habit of a couple of sherries in the evening can produce delirious symptoms or ‘sundowning’ (fluctuating levels of confusion occurring when the patient tires or at night-time) in susceptible older people with early cognitive impairment.

**SOCIAL NETWORKS**

Social contact and good social networks can be very supportive for older people but these can break down in the face of mental disorders because of high demands and dependency needs. Of the types of social network described by Wenger (1994), two are particularly vulnerable in such situations. Family-dependent networks (close family members who are committed to looking after their aged relative) are at risk from caregiver stress. Private restricted networks, characterised by social isolation, absence of kin, neighbours or friends are common among independent-minded or isolated individuals and couples. In both family-dependent and private restricted networks, the mental health needs of all are often unmet because of the restricted nature of the network.

In contrast, some networks are predictive of fewer problems. Wenger identified a ‘wider community-focused support network’ as a lifestyle for some outward-looking older people, based on a low level of kin involvement and a high level of involvement in friendship and voluntary organisations. This type of network is associated with retirement migration and is mostly, but not exclusively, a middle-class adaptation. It is the type of network associated with the retirement village concept that is becoming increasingly common in New Zealand. This is associated with high morale and a low incidence of loneliness. However, the older person needs better health, higher income and to be less physically or emotionally dependent to establish this type of network and so it is not clear whether it is the network itself, or the ability to establish it, which promotes better mental health.

Identifying the type of social network for each individual is a valuable part of an assessment and may allow some prediction of likely problems and highlight the resources needed for optimal functioning. Clare Wenger’s (1994) detailed analysis of social networks for older people is a valuable resource in this.

**CAREGIVER STRESS**

The ageing of society is putting an increasing strain on health services. Health policy in New Zealand, as in many parts of the Western world, indicates that there will be an increased emphasis on provision of care for the aged by the family and a consequent trend towards community care. Fewer long-stay hospital beds are available than in recent years and community places are limited.

Carers of the elderly can be elderly spouses or late-middle-aged adult children who sometimes are near retirement themselves. Most of these caregivers are women (Barnes et al 1992; Jones and Peters 1992). As with new parents, these informal caregivers receive no training for this, often unexpected,
role. Networks can break down when caregivers become overburdened. For many families, mental illness still carries great stigma, particularly when the patient has not been mentally unwell previously. Denial is also common and caregivers may delay seeking help in early stages. Guilt is a common emotion for caregivers if a person needs a higher level of care and psychological symptoms of guilt and depression can arise in caregivers, both in response to caregiving and when relieved of caregiving. Irrespective of whether the identified patient has a mental, organic or physical problem, the caregiver’s mental health and coping capacities come under considerable strain. According to Wenger (1994), family-dependent networks are particularly at risk for caregiver stress as these systems have a higher number of dependent older people, are highly committed to looking after their aged relatives and are less likely to seek outside support.

The effects of providing care on caregivers have been examined in a number of studies. Both anxiety and depression are more common than in the general population, with anxiety associated with older dependents and the degree of caregiver disability and depression commoner when the elderly dependents were themselves depressed. Loneliness in the caregiver was significantly associated with both depression and anxiety (Jones and Peters 1992; Livingstone et al 1996). Other effects included a reduced social life, effects on family life, a lack of holidays and limited employment opportunities (Livingstone et al 1996). Adult children caregivers have a range of feelings about providing care, including feelings of abandonment by the rest of the family and negative feelings about caregiving, while spouses generally felt they had a greater obligation to provide care. However, spouses were physically less capable of coping with the demands, which had a greater effect on their own physical health (Barnes et al 1992). A New Zealand study found 55 percent of caregivers who were unable to continue care had significant health problems and this was frequently why institutionalisation was necessary (Koopman-Boyden 1979).

ELDER ABUSE

While child abuse is well known, the phenomenon of elder abuse has received less attention despite a reported incidence of about 3.2 percent (Lachs and Pillemer 1995). Abuse can take many forms. Probably the most common form of abuse in New Zealand is financial (Age Concern 1992) and the perpetrators are the adult children or close relatives who misappropriate the elder’s funds for their own use. Physical violence and psychological or emotional abuse are not uncommon, and neglect can also be a form of maltreatment. Perkins (1995), in a recent address to a New Zealand seminar on ethical issues in old age, considered inadequate or poorly managed services to be a form of institutional abuse of the negligent kind. Institutional abuse can take several forms. These include unreasonable chemical (with psychotropic medications) or physical restraint, isolation from other residents, and failure to respect the privacy or wishes of an elderly person regarding medical or other interventions (Lachs and Pillemer 1995). With education, support and adequate training these forms of abuse are highly preventable.

There are several identified risk factors in both the abused and perpetrators. For elderly persons themselves, the risk factors are physical, mental, cognitive or functional impairment, social isolation, excessive dependency on, or shared living with, the abuser. In perpetrators, the main characteristics are substance abuse, mental illness, a history of violence, and dependency upon an elderly person for financial support. In a United States community-based prospective study of the elderly, functional disability, minority status, older age, and poor social networks correlated with a greater chance of an ombudsman investigation for elder mistreatment (Lachs et al 1994).
The issue of elder abuse is often complicated by family dynamics and dependency of the elder on the abuser for care. Carer stress can be an important aetiological factor in elder abuse and for some older people, abusive care is preferable to no care. Physicians and health workers are much more likely to identify physical abuse than any other forms. However, psychiatric symptoms such as anxiety or depression may be the only indicators of psychological abuse.

THE ELDERLY PERSON AT RISK FROM MENTAL ILLNESS

There are no data on how New Zealanders age or the problems that need to be specifically addressed from a national policy perspective. While overseas studies give some useful information, there is an urgent need to have data on our own unique multicultural society and our needs. In particular, we need to identify which people in our communities are at risk and target services appropriately.

Unsurprisingly, physical health problems, poorer psychological wellbeing, higher levels of unpleasant stress events and perceived deficits in social support are predictive of increased need for contact with mental and general health services (Phillips and Murrell 1994). The British Medical Research Council longitudinal study on adjustment in later life (Taylor 1994) found that the recently discharged from hospital were clearly at more risk for physical and psychological ill health. The recently widowed, those living alone, the poor and the socially disadvantaged were next most at risk, while the childless, the isolated and the never married did not show any greater risk than the sample as a whole.

ROBUST AGEING

Identifying people at risk is but one aspect of public health. Identifying factors that are productive of good or robust health can also be useful in primary prevention. Little has been written on this aspect but one study found that successful ageing seems to depend upon ability to continue to be productive, have social contact, and having better health, eyesight and fewer significant life events (Garfein and Herzog 1995).

SUMMARY OF EPIDEMIOLOGICAL DATA AND IMPLICATIONS FOR NEW ZEALAND

- Mental disorders are common in older people.
- The number of mentally ill elderly will increase as the population ages.
- All mental illnesses are represented in late life with depression, suicide, anxiety, psychosis, alcohol and drug overuse being the most prominent.
- Major risk factors for mental disorders in late life are: comorbid physical illness, poorer eyesight, hearing or mobility, living alone or in private restricted networks, poor social contact, previous mental illness, recent bereavement or widowhood, poverty and social disadvantage.
• Risk factors for depression and suicide are: recent widowhood, being male, social isolation, living alone, with physical illness (particularly if painful), depressive illness, alcoholism, or mild dementia.

• Considerable morbidity and loss of quality of life for both patients and caregivers are the result of inadequately treated mental disorders in late life.

• Premature institutionalisation is a consequence of inadequate treatment of mental disorders in late life.

• Recognition of depression in the community is poor and consequently many patients are undertreated and have a poorer prognosis as a result.

• The institutionalised elder is particularly at risk for depression and other mental disorders.

Major public health issues are:

• undertreatment of serious depression and other disorders

• prevention of suicide risk with particular attention to elderly males

• over-prescribing or inappropriate prescribing of psychotropic and sedative drugs

• prevention of iatrogenic-induced dependency on benzodiazepines

• limiting iatrogenic-induced tardive disorders

• prevention of iatrogenic delirium

• prevention of caregiver morbidity.

It is obviously important to identify programmes that have potential to reduce risk or prevent mental illness or mental morbidity in older people in New Zealand as the elderly population increases in future years. The number of older people with mental health problems is already considerable. Services are not meeting current needs and are inadequate for a future increase in the elderly population. Prevention strategies may operate at four levels: within national policy, through health promotion campaigns, in primary care, and at a community level.

First, people at risk and service requirements need identifying from a New Zealand perspective. Cross-sectional studies will only give a snapshot at a point in time and tell us little about how mental disorders progress or the effect of interventions. Extrapolation from overseas studies is also inadequate for New Zealand needs. While these may provide indicators, they are still second-hand studies whose subjects are usually other Caucasian races. Many other countries have supported major longitudinal research studies into ageing and New Zealand needs to follow suit and institute its own study on ageing and include in this data about mental health. Despite our multicultural society, we have no data on ageing and late-life mental health in Māori, Pacific and Asian New Zealanders. Each of these has unique sociocultural influences on their mental health and ageing process. We urgently need to know what unique New Zealand factors influence mental health in late life in our people.
STUDIES NEEDED IN NEW ZEALAND

- A major study on prevalence and incidence of mental disorders in late life in both community and residential settings in a similar manner to the GMS-AGECAT studies, with particular emphasis on including New Zealand’s different ethnic groups.
- A study on the prevalence of comorbidity and treatment patterns of medical and mental illness. Does physical illness get treated at the expense of mental health?
- A study to look at the factors that influence mental health for older people living in the community in New Zealand and to examine factors such as social contact, transport, lifestyle, physical health, mobility, exercise and nutrition that may influence quality of life.
- A study on the use of benzodiazepine and psychotropic drug prescriptions in community and residential settings with an emphasis on identifying the relationship between these drugs and complications such as falls, iatrogenic delirium, cognitive impairment et cetera.
- A study on alcohol use in hospital, community and residential populations and its relationship to physical and mental health and suicide.
- A study to look at the environmental factors in residential care and to identify those that might contribute to the high incidence of depression in these institutions. These would include physical environmental factors, patient autonomy and choice, the effect of a mix of demented and non-demented clientele in the same care setting, institutional abuse, medication use, the influence of provided activities, and social contacts outside the residential setting.
- A longitudinal study to look at caregiver stress for New Zealanders, to identify resources needed to support families to care for their older people and to look at the effect of interventions aimed at caregivers from both mental health and cost-effectiveness perspectives.

HEALTH PROMOTION

Health promotion campaigns can be very useful. We know from overseas work that mental health is improved in older people who have a purpose in life, better health, have good eyesight and hearing and social contact. Exercise is beneficial not only to mental health but also to cognition. Policies that encourage appropriate health care assessments, advocate educational pursuits and support older people to have social contact by enabling access to cheaper forms of transport and communications, could have benefits in reduced hospitalisation or pharmaceutical bills. Healthier older people with a good quality of life can delay or defer institutionalisation.

Retirement can cause a huge gap in a person’s life that many do not anticipate in advance. Women may retire from the workforce several times in a working life and seem to adjust better than men to final retirement. This of course may change with future generations as both sexes have experience of more mini-retirements earlier in life for child care or necessitated by unemployment. One useful health promotion intervention could be working with employers to prepare those about to retire to maintain their physical and mental health. We already have medical examinations on entering school, and employers often insist on this on entry to certain jobs. It is perhaps even more important to have a medical examination on exit from the workforce and for the individual to be given advice on health maintenance thereafter.
Several studies have highlighted the need for older people to feel socially useful or have a purpose in life. The fitter older person often does find an altruistic purpose in assisting society by delivering meals on wheels, hospital volunteer work, and in extended family structures, or child-minding to help out parents who both work. As mentioned earlier in this chapter, Māori society relies on kaumātua and kuia for guidance, wisdom and cultural stability. While these senior positions can be stressful, they also provide an important and satisfactory role both for the elders and for the benefiting tribe or iwi. However, a fine line sometimes exists between society accepting the altruistic help of an elderly volunteer and exploitation of elders by failing to acknowledge the social and cost-saving benefits of such volunteer work. Public institutions such as health service providers could be invited to have a policy encouraging elderly volunteers in various helping areas on health promotion grounds, providing they also acknowledge the value of such work by providing – at the very least – out-of-pocket expenses.

Another potential target for health promotion is the retirement village concept. These have proven to be very attractive to middle- and upper-income older people in New Zealand. These people are those attracted to Wenger’s (1994) wider community-focused network, and are the ‘doers and fixers’. They are often their own care managers, are usually articulate and very much interested in ‘self-help’. They are also the least at risk for mental health problems but the most likely to listen to health messages. Because of their low reliance on kin, high reliance on friendship and the value they put on autonomy, they are actually more likely to seek institutionalisation at an earlier stage than their peers in some of the more at-risk networks. There could be some value in public health initiatives to maintain their wellness through health promotion and education, but this should not be at the expense of more at-risk populations.

The media, particularly television, are little used but potentially useful channels for community education and health promotion. ‘Home-grown soaps’ could provide a unique opportunity to get health messages across to the public by using storylines that highlight the problem issues.

**PRIMARY PREVENTION**

There are several potential gatekeepers who can benefit the elderly population when suitably educated. These include police, community care workers, people delivering meals on wheels and home care agencies, all of whom are in a unique position to recognise and refer older people at risk to appropriate help (McIntosh 1995). These workers could be educated to recognise signs of illness and poor functioning in elders. Pharmacists, who are said to be the health care professionals most often consulted by the public, are also valuable resources as community gatekeepers and repositories of information on mental health problems. Pamphlets and fact-sheets on depression, anxiety, early cognitive impairment and directories of mental health services could be effectively distributed through these community gatekeepers.

General practitioners could benefit from more education about mental health problems in their older patients. This should include recognising people at risk such as the ‘old-old’, the newly discharged and the isolated together with more information on the indicators for elderly suicide. They need to be especially alert to spouse survivors of suicide, as risk for them also increases in the time following the death of the spouse. Psychogeriatric community teams in New Zealand can work very closely with primary care physicians to assist with these aims but not all areas of the country have the benefit of such teams. In the UK the establishment of fundholding practices meant that all elderly patients listed in a practice had to be reviewed regularly to continue their capitation funding. New Zealand health
policies could utilise a similar strategy by supporting annual check-ups in elderly people and link these to education programmes enabling general practitioners to improve their recognition of the sometimes very subtle signs of mental illness.

Specific disorders lend themselves to primary prevention. In disorders such as depression where outcomes may be poor, it is important to concentrate on prevention as well as secondary prevention by screening and early intervention (Murphy 1983). In particular, there needs to be education about the high incidence of depression associated with physical illness as the former tends to be undertreated or missed when comorbidity is present.

There is considerable scope at the primary care level to target groups. The recently discharged, moved, socially disadvantaged, the physically disabled or immobile, those living alone and with restricted social support are all at high risk for mental illness. People who fall into these groups could receive special scrutiny at primary or community care level. This would need special resourcing as a specific policy, as these people are unlikely to seek primary care assistance because of physical and financial considerations or isolative natures.

Many cases of delirium are iatrogenically induced and education about psychotropic medications and their effects is needed for health providers, although it is hoped that New Zealand does not need to follow the US example in legislating against the use of psychotropic drugs in institutionalised care.

A major risk factor for mental health problems in elders, elder abuse and caregiver stress, lies in lack of community, social or network support. Again education is important at a primary care level to help general practitioners and community gatekeepers to identify people at risk. Programmes that target the mental health of older people need to include and support caregivers as part of the process. This will have benefits in the prevention of potential mental illness in these vulnerable caregivers. Examples of potentially useful interventions are provision of respite care, respite centres, day care, in-home respite, alternative living arrangements on a temporary or permanent basis, and support groups.

A variety of strategies are available for the prevention of elder abuse. Age Concern in New Zealand has a comprehensive resource kit (Age Concern 1992) available for health workers in geriatric settings but this needs wider dissemination to reduce elder abuse significantly. Elder abuse teams are increasingly being set up, but mainly in the major centres. Reporting laws could be considered, perhaps on a mandatory basis. This would assist in identifying the scale of the problem in New Zealand.

SECONDARY PREVENTION

Older people are often much more compliant with health care than younger adults, as health is usually a major concern for them. Comprehensive geriatric assessment on an annual basis has the potential to identify those with mental illnesses and refer them for appropriate treatment at an early stage. There are some simple case-finding instruments for use in general practice settings such as the Geriatric
Depression Scale (GDS), and the Even Briefer Assessment Scale for Depression (EBAS Dep) that could assist general practitioners to identify these conditions and help avoid problems such as undertreating depression and overuse of benzodiazepines.

Suicide is a major preventable disorder. Once again the risk factors are well known. To prevent suicide in elders these risk factors need to be identified and depression or other mental illness treated aggressively. Removing the means for self-harm may have some merit. Prescriptions can be limited or less toxic antidepressants used in those at risk. Firearms could be restricted or require more stringent requirements for licensing such as medical and cognitive examinations for those aged over 65 years.

Alcohol use also needs to be identified in primary care and hospital settings. Many older people are quite shocked to learn that what they consider the moderate habit of a lifetime becomes hazardous drinking in old age with consequences for their physical and mental health.

**TERTIARY PREVENTION**

A major issue for New Zealand mental health services is that of the old chronically mentally ill patient whose disorder may increase with the complications of ageing and who may require permanent supervised care. This group is the ‘forgotten’ in the health restructuring. They are often people who require specialised psychiatric treatment on a 24-hour basis that was previously provided by state psychiatric institutions. With the closure of the psychiatric hospitals and a lack of specialised hostels for these patients, they are often inappropriately placed in rest homes and private hospitals that cannot meet their specialised needs, with the consequence that recurrent acute hospital admissions are necessary. This is unsettling for patients and relatives. Rehabilitation services and specialised units for these graduates of adult psychiatric services are needed to ensure ongoing stability of their mental condition and give them some quality of life.

Many mental disorders in late life are chronic or recurrent and to prevent further problems assertive follow-up is indicated. As older people have problems with transport and mobility, community case management and provision of care is the optimal method of assertive follow-up. This model not only allows oversight of patient problems but provides a conduit for services for caregivers under stress. This model has been described as beneficial in several areas in the UK and Auckland (Melding et al in press).

There is also considerable scope to influence attitudes about the mental health needs of older people. The community has a network of organisations, such as Age Concern, Senior Citizens, Civilian Maimed Association and the Alzheimer Society, that can influence community attitudes and encourage health programmes. Awareness of these problems must increase if the health services are to meet older people’s mental health needs.
REFERENCES


