Letter to the Editor

Rising burden of geriatric mental illness—Need for more specialized training

To the Editor,

With increasing life expectancy in developed and most developing countries, both the absolute number and the proportion of older adults (aged ≥65 years) are rising worldwide. It is estimated that the number of adults aged ≥65 years will rise from 300 million today to over 800 million by 2025—reaching 10% of the world population. The average life span is also expected to rise from 65 years in 1995 to 73 years in 2025. This will have widespread societal implications, as the number of older adults requiring support from adults of working age will increase from 12.3% in 1995 to 17.2% in 2025. A major contributor to the loss of independence of older adults will be dementia, as the number of such cases is estimated to double from 35.6 million to 65.7 million by 2030.

While this rising tide of dementia has garnered much international attention as governments scatter to divert more funding to research in the brain sciences, what is not as widely publicized is the high prevalence of depression and anxiety disorders among the elderly, particularly among those who are hospitalized or living in nursing homes. In fact, the prevalence of late-life depression is estimated to be 15–25.1% among those aged ≥65 years, compared to 5–8% in the overall population, and this is associated with reduced quality of life and increased mortality from both suicide and illness.

Causes of late-life mental illness are multifactorial and related to both biologic and social factors. With respect to biologic causes, many diseases of old age are associated with new-onset depression. For example, poststroke depression develops in nearly 30% of stroke survivors, while up to 38% of older adults living with cancer experience clinical depression. Regardless of the cause, hospitalized older adults with mental illness demonstrate high levels of functional dependency, psychological, and behavioral problems, which have implications for how they are cared for and their prognosis. Indeed, depression among inpatient older adults, if not well managed, is associated with poorer outcomes (e.g., slower recovery and more complications) and longer hospital stays.

Unfortunately, mental illness is often overlooked in medically unwell older adults, as its signs and symptoms are not readily apparent. Thus, these illnesses become difficult to diagnose, particularly when there is a substantial overlap in symptomatology. Managing mental illness in older adults is distinct from that in other age groups due to the high rate of comorbidity with other medical conditions, which complicates its management. When choosing to treat a disorder, a clinician must balance the potential benefits of treatment against an increased risk of adverse events or interactions with other prescribed medications, which can be fatal in older adults.

Mismanagement of mental illness in the elderly can partially be attributed to the scarcity of expertise among healthcare workers in the diagnosis and management of geriatric mental disorders. For example, reports by the Canadian Geriatric Society show that despite there being an estimated 300,000 Canadians over the age of 65 years with a confirmed mental health condition, there are only 230–242 practicing geriatricians and an even smaller number of geriatric psychiatrists practicing in Canada. This amounts to less than one geriatrician per 1300 older adults with a mental health disorder. The shortage has reached a crisis point in Canada; a recent workforce report on geriatric medicine confirmed that “there will never be enough specialists in geriatric medicine and more specifically geriatric psychiatry”. This situation, however, is not unique to Canada, and many other developed countries are also experiencing similar shortages in geriatric psychiatry.

One plausible solution to this issue would be to provide specialized training in the assessment and management of geriatric mental illness to existing primary care physicians, nurses, and allied health professionals through continuing education courses/workshops. Acquisition of these skills by family physicians has the potential to offset some of the physician shortages in senior care and allow for improved access to geriatric services for patients and their families. The feasibility of such a program has previously been discussed by Zweig et al. Additionally, medical schools should work toward increasing the amount of formal mandatory exposure to geriatric medicine that students receive through more seminars, geriatric site visits, and guidance from geriatricians. This may help dispel negative attitudes toward the field and promote greater interest even among those who ultimately practice family medicine.

Overall, we argue that there needs to be greater awareness of late-life mental disorders among health professionals and the general community, along with improvements in the accessibility of mental healthcare services for the elderly. Moreover, in light of the workforce shortages in geriatric psychiatry, we propose that programs should be developed for training primary care workers in the assessment and management of geriatric mental disorders.

Conflicts of interest

The authors declare no conflicts of interest of any nature.

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