Working with older adults experiencing mental health concerns

A practice toolkit for mental health practitioners working in regional or rural areas

Who is this resource for?

The following resource is designed for mental health practitioners working in rural or regional NSW who have not completed specific training in working with older adults but may be treatment providers for this population.

What does this resource include?

This is an introduction to working with older adults and is not exhaustive nor designed as a treatment manual. It is not designed to replace clinical decision making or specific training. We encourage all practitioners who are working with older adults to seek training in evidence-based treatments and engage in professional supervision and reflective practice.

A snapshot of older adults in Australia[1]

- Older adults are generally considered those over age 65
- In 2018, one in six people were 65 years or older, and Australia has an ageing population
- 86.5% of older people experience at least one long-term condition
- Most older people live in households (private or self-care retirement). 4.6% of older adults live in cared-accommodation (residential aged care, hospitals)

Useful resources

- Older people's mental health services
- Community Older People's Mental Health Services: A guide for older people with mental health problems, and their families, carers and friends
- Older Person's Advocacy Network (OPAN)

Is poor mental health a normal outcome of ageing?

It is a myth that depression, anxiety or dementia is a natural outcome of ageing. In fact, older people generally report better emotional wellbeing, with a higher proportion of "positive" emotions compared to the general adult population, and more emotional stability[2].

There are some groups of older people who have higher rates of mental health disorders, including those with chronic health conditions, individuals in residential aged care facilities and people with refugee backgrounds[3].

Mental health of older people living in rural areas

For people living in rural areas, the prevalence of mental health disorders is similar to metropolitan areas in Australia, however the suicide rate is higher in rural areas[4].

This is likely the result of many factors, including unique stressors associated with living in rural or remote areas, availability of more lethal means, less employment opportunities, lower mental health service availability and utilisation, and potentially lower levels of mental health literacy.

THE PEREGRINE CENTRE

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What makes an older person vulnerable to worsening mental health?

There are several factors which can increase risk of deterioration in an older person's mental health

Risk factors for deteriorating mental health [5,6]
Having a partner die in the last two years
Being a carer
Living alone with limited social opportunities
Separation or divorce
Being recently retired or unemployed
Low income
Health concerns and disability
Having to give up driving

How do we make sense of this?

Older people may be at higher risk for poor mental health when they experience a sense of loss – whether that is loss of a loved one, loss of connection, loss of independence, loss of purpose, loss of income, or deterioration of physical health.

These factors are important to be aware of and target in mental health treatment.

What are normal memory changes as we grow older?

Many older people, and the people that care for them, may worry about memory changes. Most older adults will notice changes in how quickly they can process or recall information as they grow older, though their level of learnt knowledge will often reduce the impact of this.

This is generally a normal change, but other memory or recall changes should be investigated to understand if these are related to mental health concerns, physical health concerns or neurodegenerative disorders.

What about dementia?

- Dementia refers to symptoms caused by a range of different neurodegenerative diseases, including symptoms related to cognition and behaviour.
- In Australia, 1 in 12 people 65 and over will experience dementia [7], with the proportion of people with dementia increasing with age[1]

Early signs of dementia

Early symptoms of dementia can include **trouble recalling recent events, confusion, withdrawal, or reduced function.**

You can find helpful information on dementia here:

- Agency for Clinical Innovation Allies in Dementia Health Care
- Dementia Australia

Acting early

If you suspect a client you are seeing has early signs of dementia, refer them to their GP or your local Older People's Mental Health Service for further assessment.

How can I screen for mental health concerns and dementia in older adults?

Kessler Psychological Distress Scale (K10)

The K10 is 10-item a self-report questionnaire assessing levels of emotional distress in the past four weeks. This can be a helpful short questionnaire for older adults without cognitive impairment.

The Geriatric Depression Scale 15-item (GDS 15)

The GDS 15 is a self-report questionnaire that is highly useful for detecting subthreshold depression and major depression in older adults[8]

Cornell Scale for Depression in Dementia (CSDD)

The CSDD is a 19-item clinician-administered questionnaire that assesses depression in older adults with dementia or cognitive impairment. It may have better reliability for people with cognitive decline as it includes information from both client and caregiver[9]

Rowland Universal Dementia Assessment Scale (RUDAS)

The RUDAS is a 6-item cognitive screening tool that takes approximately ten minutes to complete. It was designed to lessen the impact of gender, education level and language [10,11]. This means that it can be used with clients from non-English speaking backgrounds or different cultural backgrounds.

The Modified Mini-Mental State Exam (3MS)

The 3MS is a clinician-administered extended version of the Mini-Mental State Examination that takes approximately ten minutes to complete.

Informant Questionnaire on Cognitive Decline in the Elderly (Short IQCODE)

The Short IQCODE is a screening tool completed by an older person's family or friend to assess cognitive decline over time. This can be useful if an older adult is unable to complete a screening questionnaire. The Short IQCODE is available in several languages here.

If scores on these screening measures are indicative of a mental health or potential neurodegenerative disorder, you should:

- Refer your client to their GP
- Contact your local Older People's Mental Health Service

Remember, becoming familiar with one instrument that works in your setting is more important than trying to find the perfect questionnaire. More information and options for screening and assessment for older adults can be found here:

- ACI Screening and assessment tools for older people
- Dementia Outcomes Measurement Suite

Modifying treatment

For some older adults, treatment will need to be modified to increase effectiveness. These factors should be discussed collaboratively with your client, valuing their expertise and choices.

Factors to consider include:

- Scheduling appointments when the client is most alert
- Slowing the pace of intervention
- Increasing number of sessions
- Focus on behavioural interventions and problem solving
- Including carers or support people in treatment
- Lowering background noise
- Reducing glare in treatment rooms
- Printing written materials in larger font size
- Speaking more slowly and clearly enunciating

What interventions should I focus on when working with older adults?

Many older adults may present with mental health concerns similar to other age groups, and **general mental health assessment and intervention skills will be useful** for this population.

There are also unique challenges that become more common with age. These can include comorbid physical illnesses, bereavement, cognitive decline or impairment, transition to retirement or to assisted living arrangements, and end of life planning.

For older adults experiencing depression, they may be more likely to have beliefs relating to ageing that maintain depression, such as thoughts about being too old to change, being "a burden" to society or believing there is no further meaning or joy left in life. They are also more likely to report somatic symptoms or symptoms of anhedonia (loss of pleasure), apathy or irritability rather than depressed mood [12].

Generally, older adults respond just as well as younger adults to mental health interventions

Treatment planning should be undertaken collaboratively, respecting a person's dignity, agency and choices. Other carers or family members should be included where possible. Older people often have a range of professionals involved in their care, for instance they are more likely to be on medication(s). Treatment planning should understand the roles and responsibilities of all parts of the care team and should inform all parties of any changes to the treatment plan.

Plans should take into account the person's presentation, goals, the best evidence practice and your skills as a mental health practitioner. There are some therapeutic interventions that might be particularly helpful for older adults, which are detailed later in this toolkit.

Being aware of ageism

Ageism refers to discrimination based on age and might be present in ideas about older people not deserving or warranting treatment, or beliefs about older people being incapacitated without evidence, not respecting rights or dignity of older people or dismissing their ongoing contributions to society. Just like working with other age groups, there is a need to balance autonomy and safety when working with older people.

When engaging in mental health treatment for older people, be particularly aware of **therapeutic nihilism**, where you might doubt the effectiveness of treatment or have lowered expectations for treatment gains for older people compared to younger populations. Research has found that health providers can think depressive disorders are understandable and justifiable in older adults, and this prevents appropriate care [13].

Engage in **reflective practice and supervision** to explore your own reactions and ensure you can manage them effectively.

Being aware of stigma

Research has found that older adults living in rural areas have higher levels of stigma towards experiencing a mental health concern themselves, and have a greater preference to manage psychological problems in private [14, 15]. This may be related to attitudes about remaining stoic and experiencing mental health problems being perceived as a personal failing.

For older adults who hold these beliefs, it may be necessary to facilitate an indirect entry into mental health services, through non-clinical services or discussion of mental health related topics such as sleep, exercise, movement or nutrition.

Who should be included in treatment?

- The role of family or carers is important when working with older adults. Discuss with your client who their support network is, and if they consent, involve them in treatment. Make sure you continue to check in that the older person feels involvement from others is on their terms.
- It is important to consider that a caring role can be demanding and challenging. Research with carers of older people with mental health disorders found that the **caring role is physically and emotionally draining**, with many carers experiencing elevated stress which can also lead to impacts on lifestyle and social activities. Carers also describe a sense of grief and loss, and a change in their role within the family.
- When speaking with carers, explore how they can reach out for their own support or how support for the older adult can be shared by multiple support people.
- If your client has a conflictual relationship with their family or does not feel supported by family members, discuss who they would like involved in their care and in what capacity, and help to facilitate these conversations if needed.

Older First Nations adults

First Nations people in Australia have a lower life expectancy due to multiple factors including the effects of dispossession, social determinants, ongoing systemic challenges and access to care.

When working with First Nations people, consider their connection to local communities and Country, and their role within their families and communities. Consider a focus on maintaining these connections as they grow older, and link them in with an Aboriginal health worker if the person is interested.

How is recovery from mental health difficulties different for older people?

Some factors related to recovery are unique for older adults.

Research has found that when considering the experience of mental health recovery, older adults speak about **'continuing to be me'** or **'getting back to being me'**[16].

Older adults tend to have a strong sense of self and clear identity, and connect their recovery from mental health concerns to regaining this sense of identity.

Another element of recovery for older adults is the **development of coping strategies** which includes focusing on maintaining long term relationships, social networks and meaningful activities.

Older people's recovery is also impacted by coexisting physical illnesses, primarily in that it can interfere with their capacity to continue meaningful roles or activities. Older people speak about needing to develop coping strategies to manage these conditions.

Some older people will need ongoing support, and there should be a focus on that makes a meaningful and fulfilling life for them, working together to achieve this.

Suicide in older adults

While numbers of completed suicides are lower in adults over 85 years compared to younger age groups, **males over 85 years have the highest rate of completed suicide within any age group**. Older people are also much more likely to die from a suicide attempt compared to adults[17].

This means that the **threshold** for referral to specialist older people's mental health services or aftercare services when an older person is presenting with suicidality needs to be **lower** than the threshold for younger populations.

Suicide in rural areas

While the absolute *number* of suicide deaths is highest in metropolitan areas, age-adjusted suicide *rates* increase with the level of remoteness[18]. In 2020, the rate of suicide for people in very remote areas of Australia was **2.3 times** the rate of people living in major cities[18].

How can I understand suicidality for older adults?

When working with older people at risk of harm to themselves, there are suggestions that considering the "5 D's" might be a practical way to explore risk factors that are common for older adults[19]:

- Deadly means
- Depression
- Disease
- Disability
- Disconnectedness

It is important to remember, however, **risk formulation needs to take an individualised approach** to your client and should consider more than just risk factors.

Using the SafeSide model can help you conceptualise risk in a broader manner and plan treatment.

Safety planning

Safety plans should be developed with an individual when they are not in crisis. Safety planning should be completed collaboratively with a client, paying attention to their specific circumstances and what works for them, rather than being imposed on a client.

Safety plans should be reviewed regularly and, with permission, shared with support people and other members of the treating team.

The grey-area of suicidality with older adults

One challenge when working as a mental health practitioner with older people is the so-called "grey area" of suicide-related concepts and behaviours[20].

Research has found there are different behaviours that older people might present with that may be mistakenly perceived as a normal reaction to ageing, but may be suicide-related expressions. This includes a **sense of disconnection from life – feeling unable or not wanting to connect with life, feeling that life is completed, feeling tired and exhausted of life, and existential loneliness.** This is thought to lead to death wishes and thoughts, which may lead to both behaviour that hastens death (e.g., voluntarily stopping eating or drinking), and self-destructive behaviour (e.g., neglect of self).

Mental health practitioners should take these behaviours or expressions seriously and assess risk of harm to self for all older adults. Older people may have difficulty finding the right words to explain how they are feeling, and may be confused, doubt or dismiss the feelings they experience.

Specific therapeutic interventions for older adults

Older people may benefit from the same interventions as other adults, with adaptations as described above. However, the following interventions have been developed with older people specifically in mind.

Reminiscence Therapy

Reminiscence Therapy involves talking about past experiences and memories in individual or group settings to improve wellbeing and stimulate mental activity[21, 22]. It takes an unstructured approach discussing themes and pleasant memories, and often uses photos, videos, music or other objects to facilitate discussion[22,23].

It can be helpful to use the senses to prompt reminiscence:

Listen to the older person's favourite songs

Look at photos of family and friends, or photos or pictures of hobbies

Use tactile objects like fabrics, paintbrushes, chalk, or pens to discuss memories

Eat a favourite meal together

Identify smells that evoke pleasant memories using essential oils or candles

For people experiencing dementia or other neurocognitive disorders who generally lose short-term memory but can recall longer-term memories, there is evidence that reminiscence therapy might have a small positive effect on quality of life, cognition, memory, depressive symptoms and communication [24, 25, 22]

Life review therapy

Life review therapy is similar to Reminiscence Therapy, but it evaluates experiences that are considered both positive and negative by the older person[26]. Life review therapy is designed to help an individual resolve, accept and make meaning of their experiences. There is a moderate effect of life review therapy for older adults with depressive symptoms [26, 27], and it can be used in individual or small group settings.

Question prompts can include:

Tell me about a day, when you were an adolescent, and you did something out of the ordinary

Did someone close to you or someone you knew recuperate from a grave illness?

Tell me a time that you remember experiencing pride at work

What do you consider to be the most important thing that you have done in your life? [27]

More example questions can be found here

Intervention tools: Timelines

The use of timelines in treatment with a focus on past challenging experiences and reflection on how the client was able to cope with these experiences may be helpful to increase motivation and belief in their ability to change.

Specific therapeutic interventions for older adults

Behavioural activation

Behavioural activation – working on replacing avoidant behaviours with previously enjoyed pleasant or valued-based activities – has been shown to be effective for older adults[28]. Research has shown no difference between behavioural activation and cognitive behavioural therapy for adults, and this is replicated for older adults[29]. Here is a guide on using behavioural activation with individuals.

Intervention tools: Exercise and movement

There is strong evidence that exercise is important for older adults with mental health concerns, particularly for management of depression. There is a large antidepressant effect for moderate intensity exercise for depressed older adults [30].

In particular, aerobic exercise and resistance training have been shown to reduce symptoms of depression and anxiety amongst older adults [31]. It is likely there is also a benefit from the social interactions when engaging in group exercise. Speak about the usefulness of exercise with your client and problem solve any barriers.

Intervention tools: Prioritising health

Talking with older adults about their health is very important. Talking about these topics might also increase the level of comfort an older person experiences, and can be an indirect way to start a conversation about their mental health.

Sleep

There are bidirectional links between insomnia and depression for older adults, meaning that individuals experiencing depression are more likely to suffer from insomnia, and individuals experiencing insomnia or difficulty sleeping are at increased risk of developing depressive symptoms[32]. Insomnia is also associated with poorer quality of life for older people. Ask about sleep patterns when working with older people, and focus on sleep hygiene – you can find a guide on sleep and sleep hygiene here. For older adults who may be reluctant to talk about mental health symptoms, discussing sleep can be a helpful 'indirect entry' into discussing mental health services.

Nutrition

A balanced diet is linked to lower psychological distress in older adults. Check in regarding older adults' diet, and refer to relevant health professionals such as dietitians as appropriate. Australian dietary guidelines can be found here, as well as tips for healthy eating for older adults. Appetite is often altered when experiencing a mental health concern, and starting a conversation about food habits first relating to mental health might help an older person feel comfortable. Taste can also change as adults grow older, and may impact on the experience of eating.

Medications

Remember that many older adults take medication, and may need assistance with adhering to treatment or medication regimes. Problem solve with the older adult and other professionals involved in their care if there are concerns about medication. Routine, reminders and support from carers can be helpful in addressing forgetfulness related to medication.

Specific therapeutic interventions for older adults

Pets as therapy

There is increasing evidence of the benefits of interactions with animals for older adults in relation to mood, social connection and physical activity[33]. Studies with older pet-owners have found that pets provided a sense of comfort, safety and companionship, increased socialisation and helped connect them with other people, assisted with routine and physical activity, and provided a sense of purpose, meaning and commitment[34, 35].

Recently, robotic pets have also been used with older people. Socially assistive robots have the appearance and behaviours of pets, and their use with older adults with dementia has found positive effects on wellbeing, including improved mood and anxiety, improvement in agitation, socialisation, communication and decreased loneliness[36, 37].

Consider talking with the older adults you are working with about their access to pets or other animals, and explore possibilities to help them with animal interactions.

Self-compassion

Self-compassion is the practice of being kind and supportive to oneself, and research suggests older adults practising self-compassion may have improved wellbeing. Self-compassion is linked to life satisfaction and wellbeing, and negatively associated with depressed mood[38]. Self-compassion might also buffer the psychological impact of health issues in later life or protect against life stressors [38, 39]. You can find out more about self compassion here. For some older adults, this may initially be a challenging concept as they may have been raised to be stoic, and so may take some time to implement.

Intervention tools: Language

Older people may not seek help due to feeling that their concerns are not severe enough for professional help or may feel that others are more deserving of assistance.

Try using less clinical language to describe concerns if you notice this, such as “feeling low”, “down”, “stressed”, “tense”, “feeling nervous” or “on edge”.

Values

Values are what you want your life to be about and what is meaningful to you. Values can act as a compass to help you make choices about where you want to go in life and how you want to act. Using values can be helpful for older adults both as a tool to guide future behaviour and as a reflection tool. Thinking about values and how they can inform behaviour can be particularly helpful when people are in difficult or uncomfortable situations that are not easily solvable. Follow these links to find an introductory video on values and a video on choice points. You can find more resources based on Acceptance and Commitment Therapy here.

What about the end of life?

Meaning-making and spirituality

Talking about death has often been described by older adults as a positive experience, particularly as it alleviates fears about the dying process and helps people feel supported [40]. Older people who engage with religious or spiritual activities experience less emotional distress[41]. Exploring spirituality and meaning by talking about **uncertainties about death, emotions about death and existential questions can be helpful for older adults** as it can strengthen sense of self and purpose in life, and it can decrease worries about death [40, 42, 43].

In a study of older people in hospice care, participants described thoughts and feelings about death including an awareness of the presence of death, a sense of grief about leaving life and anxiety relating to both death and the dying process [43]. The same participants spoke about managing death by avoiding the topic, considering ideas about what may occur after death, planning practical aspects of their death, and focusing on the joy of living.

Bereavement and grief

Grief is a normal reaction to loss, which can include loss of a significant loved one, loss of physical function or independence, loss of relationship and many other types of losses.

Visit the National Association for Loss and Grief for more information and resources.

Intervention tools: Dual Process Model of Bereavement

Consider using the Dual Process Model of coping with bereavement with the older people you are working with, which values both loss-oriented and restoration-oriented coping actions and acknowledges that individuals will oscillate between loss- and restoration-oriented activities[44, 45].

Loss-oriented coping [44, 45]

- Grief work
- Intrusion of grief
- Relinquishing-continuing-relocating bonds/ties
- Denial/avoidance of restoration changes

Restoration-oriented coping [44, 45].

- Attending to life changes
- Doing new things
- Distraction from grief
- Denial/avoidance of grief
- New roles/identities/relationships

Look out for any symptoms of **complicated grief**, including prolonged acute grief, excessive avoidance, and a loss of purpose or meaning[46].

For Complicated Grief, treatment focused on the Dual Process Model of Grief, facilitating both types of coping processes, and Complicated Grief Treatment, based on the Dual Process Model and using Cognitive-Behavioural Therapy approaches, have also been shown to be helpful[47]. More information on complicated grief and evidence based treatment can be found in this article.

Managing the transition out of work for older farmers in rural areas

For many people working in agriculture in rural and remote areas, the transition to reduced work or retirement as they grow older can be challenging.

- Farmers may have worked on the land their whole life and often have a sense of identity or belonging that is strongly connected to their work.
- Stepping away from work can feel overwhelming and may increase thoughts that they are "useless" or no longer contributing.
- As farming often takes up such significant time and energy, people may have few interests outside of farming, which can strengthen a desire to remain in the industry and a fear of reducing work and losing a sense of self and belonging.
- Farmers often find social connection with other farmers, and a loss of occupation may increase fears that social circles will be lost.
- Family farm transfer can bring up fears around family and the future

Intervention tools: Farmers and agricultural workers

For farmers or individuals in similar industries who have reduced work, focus on:

- Maintaining and extending social relationships through groups like Men's Shed Australia
- Encouraging activities that give back to the next generation such as passing knowledge onto or mentoring younger farmers
- Exploring ideas about identity and values
- Challenging beliefs about usefulness

Social isolation and loneliness in rural areas

While social isolation (objective absence of social relationships) and loneliness (subjective experience of relational quality and quantity) are problems for many Australians, they may be particularly difficult for older people living in rural areas. Loneliness and social isolation have similar health effects to smoking, physical inactivity and high blood pressure[48]. Loneliness is also associated with mental health concerns and cognitive decline.

Older people are at higher risk of loneliness and social isolation if they:

- Have decreased mobility and poor physical health
- Are not living close to family members
- Have experienced death of a close connection

Loneliness and social isolation for older adults is impacted both by their circumstances, including frailty, disability and difficulty getting out and about, and their subjective responses, such as thinking of oneself as useless or a burden[12].

Social and mental wellbeing for older adults

Intergenerational engagement

Intergenerational engagement brings together members of different age groups – often older and younger populations – for the benefit of both groups [49]. The interventions employed are wide-ranging, and can include discussion groups, helping with academic activities, computer training, sharing stories, craftwork, games or excursions. Intergenerational engagement helps with anxiety and might help with depressive symptoms, quality of life and self-esteem[49]. This intervention seems to also provide a sense of meaningfulness and a feeling of being able to 'manage' for older people[50].

Social prescribing

There is emerging research that supports a health provider referring an individual to non-clinical community services or resources to benefit their mental and social health. This might include social activities, art or music activities, exercise groups, lunch clubs, nature-based activities and others[51]. Healthcare workers might provide information on community programs, make a referral, or connect a client to a link worker to help with referral[52]. Social prescribing is an emerging area, and there are some early indications that there may be beneficial physical and psychosocial outcomes for older adults[52].

Intervention tools: Addressing loneliness and sense of belonging

Understand loneliness and social connections

- Create a map of your client's social connections
- Explore quality and quantity of current relationships
- Identify client values and explore if relationships are aligned with values.

Address unhelpful thoughts and behaviours

- Explore fears of negative evaluation when creating new connections or maintaining existing connections
- Challenge unhelpful thoughts relating to loneliness or belonging
- Explore avoidance of social interaction if present and how this may maintain loneliness

Keeping engaged

- Work towards maintaining and strengthening current relationships with family and friends – have planned check-ins with family, friends, neighbours, community members.
- Sometimes, it can be helpful to consider the easiest step towards making a connection and use SMART goals to determine how to go about this.
- Use values to identify new activities to try
- Encourage reminiscence with close others
- Leverage the community strengths and resources available to increase connection – get involved in important town matters and engage in local social groups