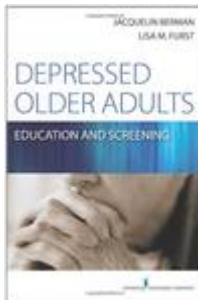


## The New Frontier of Depression and Aging: Outreach to Community-Residing Older Adults

A review of



### **Depressed Older Adults: Education and Screening**

by Jacquelin Berman and Lisa M. Furst

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In the 1980s a critical question for the aging and mental health field was whether existing psychotherapeutic treatments for depression in younger adults were useful for older adults. In the first decade of the 21st century, the salient issue is how psychotherapeutic and medication treatments for depressed older adults that have been found effective in clinical trials can reach the largest number of older adults. What a difference 25 years makes.

Underutilization of mental health services by older adults has been a recurrent theme in the geriatric mental health literature (Karlin & Norris, 2006). Oft-cited obstacles to use of mental health services include higher Medicare copays for mental health versus physical health services, reluctance of older people to use mental health services because of stigma, “therapeutic nihilism” exhibited by health care providers who assume depression is normative for older adults, poorly coordinated mental health and physical health services,

and the lack of an adequate network of mental health care providers trained in mental health and aging.

But Medicare copays for mental health services will slowly reach full parity with physical health services in the next few years; the baby boomer generation that will begin to enter later adulthood in 2011 has much more favorable attitudes about use of mental health services than did their parents' generation; and a decade-long campaign to educate primary care physicians about depression is paying dividends. On a recent primary care visit my physician casually remarked that he uses the Patient Health Questionnaire–9 to screen depression in his patients.

For those interested in reaching out to community-dwelling older adults who may be depressed, programs funded by the Administration on Aging, such as senior citizens' centers, seemed like a perfect venue through which to do outreach. But for most of the history of these well-established programs in which older adults congregate, there has been little emphasis on screening and referral for older adult mental health problems. A shining light in mental health outreach to older adults since the 1970s has been a program developed by Ray Raschko and his colleagues at the Elder Services Program of Spokane Mental Health. But mental health outreach to older adults has been very much the exception and not the rule.

However, the spirit of collaboration among providers of services to older adults has been in the wind for the last decade. Three collaborative, evidence-based programs that treat older adult depression stand out: The IMPACT program (Improving Mood–Promoting Access to Collaborative Treatment), the PEARLS program (Program to Encourage Active, Rewarding Lives for Seniors), and the Healthy IDEAS program (Identifying Depression, Empowering Activities for Seniors) all rely on collaborative efforts among different professionals to treat late-life depression.

A report from the American Psychological Association Task Force on Integrated Care, *Blueprint for Change: Achieving Integrated Health Care for an Aging Population* (American Psychological Association, 2008), underscores that integrated care is better care for older adults. Important evidence for this comes from the Department of Veterans Affairs health care facilities that routinely provide collaborative care to a large population of older veterans and for whom the quality consistently exceeds that of the private sector.

The timing of Jacquelin Berman and Lisa Furst's book *Depressed Older Adults: Education and Screening* couldn't be better. They provide an essential "how-to" manual for educating older adults and providers about depression, screening older adults for depression, and referring depressed older people for depression treatment. The manual is for the EASE–D model (Educating About and Screening Elders for Depression) developed in a collaboration among the Mental Health Association of New York City, the New York City Department for the Aging, and the New York City Department of Health and Mental Health.

Doing outreach is all about relationships. Berman and Furst are faithful guides on how to build and sustain those relationships. As in any relationship, understanding the other

party's perspective is critical, including what that party potentially gains or loses in that relationship. This book puts one in the shoes of the agency with which a collaboration is sought. It provides practical advice on how to engage older adults in education about and discussion of depression. It outlines the pathways and potential pitfalls in guiding a depressed older adult to a first appointment with a professional. What I really love about this book is that it forthrightly addresses the many places where a collaborative relationship with client, agency, or health professional might falter and then provides practical suggestions on how to avoid problems or address them when they arise.

There are so many things about this book that are excellent. It is clearly written, with an exceptional clarity of exposition. It reviews existing research literature on late-life depression in a way that does not get bogged down in details that are not of central interest to practitioners. At each stage of implementation of the EASE-D model Berman and Furst lay out the central tasks along with practical tools (e.g., recommended resources, checklists), common implementation questions, and, as noted above, wise advice on how to avoid pitfalls.

The book conveys enthusiasm about the importance of outreach to depressed older adults that is deepened by the authors' obvious expertise in implementing the EASE-D program in the complex cultural and social service environment of New York City. And the book is always mindful of how to address cultural and linguistic diversity among older adults in doing outreach.

However, as the authors of this book rightly note, there are larger forces that continue to militate against ready access to high-quality depression treatment for older adults, even when they are referred to health professionals. Despite the many advances in the science of the treatment of late-life depression and gradual improvement in reimbursement for late-life mental health services, the number of mental health providers is limited in many parts of the country, especially in rural areas. Relatively few mental health care providers have been formally trained in aging-specific issues.

Although the bulk of mental health care is provided by primary care physicians, they too often do a poor job in identification and treatment of mental health problems. A recent report from the Institute of Medicine (2008), *Retooling for an Aging America: Building the Health Care Workforce*, cautions that the health and mental health care workforce with aging expertise is woefully inadequate and that older adults chiefly rely on general practitioners, who often lack needed skills to optimally provide health services to older adults.

There are few substantive critiques that I can offer about this book. As I began to read the book I was eager to find a description of a study or studies that demonstrated the efficacy of EASE-D. Unfortunately, the model has not been formally studied. As a geropsychologist, I was struck that there were few references to psychologists as providers of psychotherapeutic services to depressed older adults. As a New York City resident, I wondered why I had not heard of the EASE-D project before I read this book.

This volume is one of the best practice-oriented books on mental health and aging that I have read. I hope that the coming years will see substantive developments in outreach to depressed older adults. This book lays a solid and credible foundation for these efforts.

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