Abstract
There are models which, integrating social determinants, outline the mental health/illness of the elderly. The number of homeless elderly people is growing, and they often suffer from mental illness. Assessment by a multidisciplinary team is indispensable, particularly at the onset of a psychiatric illness. What is needed is further empirical research, scientific surveys and studies on the subject of mental health of the elderly, focusing on mental health promotion, prevention, sustainable interventions, patient-centered services, and measuring options.

Introduction
What is mental health (MH)? On the website of the American National Institute of Mental Health (NIMH) we find mental health information subdivided by topics, such as generalized anxiety disorder. Another American website tells us that “it has always been easier to define mental illnesses than to define mental health” (about.com 2010). The WHO categorically states that “Mental health is an integral and essential component of health”, adding by way of explanation that “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. An important consequence of this definition is that mental health is described as more than the absence of mental disorders or disabilities” (WHO 2012). Further on, the WHO concludes that “Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of societies.”
of a community” (WHO 2012). This means that both objective and subjective factors are involved. Strauss similarly explains that “To have a complete human science in the mental health field it is essential to give adequate attention to both the objective and the subjective data related to people with psychiatric disorders” (Strauss 2010). At the same time he emphasizes that “subjective data are particularly neglected, sometimes considered (only) part of the “art” of medicine since the usual methodologies of the physical sciences in themselves are not adequate to reflect the nature, elusiveness, and complexity of human subjective experience” (Strauss 2010).

One question that emerges from all this is, can mental health be reliably measured both objectively and subjectively? Different scales exist for rating mental health (cf. Sajatovic & Ramirez 2001). Those frequently mentioned for rating quality of life include the WHO Bref (2004) of the WHOQOL Group (1998) and the SF-12. “The SF-12 Health Assessment Questionnaire items define two health status summary scales: a physical health scale and a mental health scale. SF-12 scores reflect quality of life or functioning as influenced by physical or mental health conditions.” (University of Cincinnati 2012; accessed 11/28/12).

The scales cited for rating mental health include the Mental Health Inventory (MHI) by Veit & Ware 1983, the psychiatric interview by Pridmore 2000 which examines the mental state, and the psychiatric mental status examination by Trzepacz & Baker 1993. The MHI is a self-rated questionnaire with 38 items on various symptoms which measures the last month before the survey. To obtain a more comprehensive picture of the mental health of a person, a many-faceted approach is needed. Diagnostic manuals without subjective, intersubjective and holistic sensitivity may not be suitable for adequately mapping the individuality of a person (cf. Kendel, 2012); this would require a holistic examination of individual cases. For such a purpose it is indispensable to repeatedly survey and observe individuals in their personal situation, giving consideration to various measuring options (cf. Bortz & Dörig 2006) as well as to the observer’s own function.

The model developed by Dahlgren et al. may be of assistance in the many-faceted context of the mental health of elderly people.

The model is useful since it illustrates how health influencing factors are embedded within broader aspects (cf. Dahlgren & Whitehead 1991). Social Determinants of Health (SDH) are helpful conceptual devices to identify the causal pathways which have differential impacts on health (cf. Exworthy 2008).

The medical model and the biopsychosocial model

Cultural and professional models of illness influence decisions, individual patients and the organization of health systems. The most dominant model in the last century was the biomedical model of illness, which cannot provide a comprehensive approach for many types of illness. The model attributes a key role to biological determinants and explains disease as a condition caused by external pathogens or disorders affecting the functions of organs and body systems.

The model postulates three major rules: all illness has a single underlying cause, disease is always the single cause and removal or mitigation of the disease will result in a return to health (Smith et al. 2013).

Such an approach has its historic justification and has proved effective in the control of massive infectious diseases. However, now that chronic non-infectious diseases prevail, its efficacy has not only become questionable; the issue of economic justification has been raised as well (Havelka et al. 2009).

The assumption that a specific disease underlies all illness has led to the medicalization of commonly experienced anomalous sensations and often to disbelief in patients who present with an illness without any demonstrable disease.

Traditional biomedical models of illness focus on discovering the pathology of an illness rather than on understanding it. Although these models have been associated with a huge improvement in medical care, they do not explain functional somatic syndromes and illnesses without a discernible disease.

An expanded illness model is proposed which emphasizes that disease is only one factor contributing to illness and illness-related behavior.

Therefore, it is imperative to develop a new model based on the concept of health proposed by the World Health Organization (WHO 2001; Wade et al. 2001).

In contrast, a biopsychosocial model has been proposed which, taking into account determinants of health and illness, supports the integration of biological, psychological and social factors in the assessment, prevention and treatment of diseases.

This model recognizes that psychological and social factors influence a patient’s perceptions and actions and thus the experience of what it feels like to be ill.

Particularly in mental health care, this biopsychosocial model is particularly important because of its holistic approach to health care. The core principles of mental health and the care of the elderly can be integrated in this model by a reciprocal relationship between old people and clinicians and a multidisciplinary perspective (Costa et al. 2011).

Mental Health of the Elderly

The influence of individual aging processes must be included in each analysis, particularly because old age and the process of aging can be an opportunity (cf. Motenko & Greenberg 1995) with limits and potentials (Baltes 1993).
Regarding the mental health of elderly people, the points to be covered include

- independence (cf. Koenig et al. 2011),
- the autonomy of the individual, including personal autonomy as prevention (cf. Bojorquez-Chapela et al. 2012),
- life challenges (cf. Chou & Chi 2001),
- psychosocial health (cf. Chong 2007),
- meanings in life (Low & Molzahn 2007),
- life course (Blane et al. 2004),
- dignity in later life,
- palliative and end-of-life care aspects (cf. NASW 2012),
- life quality (Laidmäe et al. 2012; cf. WHO 2004), and
- pain and health-related quality of life (Willman et al. 2012).

To determine the quality of life in old age in the context of health and illness, factors to be taken into account include self-reports and proxy measures (Moyle et al. 2012), models and perceptions of old age (cf. BMFSFJ 2010), cross-cultural understanding of QOL in older people and the influence of the socioecological context (Nilsson et al. 2012), to name but a few.

Further aspects to be covered include cultural backgrounds, modes of living (cf. al-Krenawi & Graham 2000), the political situation and urban and/or rural aspects relating to forms of residence (Apidechkul 2011).

Homelessness and Assessment

Homelessness and Mental Health of the Elderly

Gathering statistical data about homeless people is not without methodological problems; results differ worldwide (cf. Fichter et al. 2000; cf. Asienspiegel 2012) although there are common elements as well.

It is estimated that around 100 million persons worldwide experience homelessness (Burt & Aron 2001 in Badiaga et al. 2008) – estimated because we still lack sound statistics. Even in Germany politicians have been calling for the introduction of a nationwide statistic on housing emergencies in 2012 (Zeit 2012).

Increased homelessness among elderly persons may have many reasons; it can be a result of poverty or lack of residential accommodation. It is certain, however, that homelessness is one of the most important markers of social exclusion (cf. Department of Human Services Victoria, 2002). In her article on housing, homelessness and mental health, Bährer-Kohler (2012) emphasizes that housing conditions influence people’s health in positive and negative ways.

Yet individual is entitled to housing (The Universal Declaration of Human Rights United Nations 1948).

Studies indicate that around 4.2% of people over 62 in the United States were homeless in 2010. In the same year, the homeless percentage in the 54-61 age group was c. 22.3% (CSH 2011). In a metropolis like New York the number of elderly homeless people has shot up 55% in the last 10 years. In December 2011, 2,234 single adults over 55 years were in the shelter system, compared to 1,437 in 2002 (cf. New York Daily News 2012). In Australia, data from the 2011 census specify that 105,237 people were classified as being homeless (up from 89,728 in 2006); 60% of homeless people were aged under 35 years (Australian Bureau of Statistics, Summary of Findings 2011). In Germany, a total of c. 150.000 people were homeless in 2002, of which c. 21% were women (Diakonisches Werk 2004). In 2012, the chairman of the Protestant Homeless Relief put the estimated number of homeless people in Germany at 250.000 (Fokus-online.de 2012). A dedicated study of 941 people living
in the streets of Hamburg showed that 6.8% were between 60-70 and 1.9% between 70-80 years of age (Freie und Hansestadt Hamburg 2009).

Evans et al. impressively documented that research on housing and mental health is remarkably underdeveloped in general (Evans et al. 2003). In December 2012, Pubmed listed around 300 studies on the subject. Closer scrutiny shows that some studies did not focus on elderly people (cf. Hwang et al. 2012), and/or that certain clinical pictures (e.g. HIV-infected persons; cf. Riley et al. 2012) had priority in the context.

And yet, c. 25-30% of homeless people have some mental illness that requires psychiatric treatment (Nouvertné in Diakonisches Werk, 2004). In Japan, the NGO Tenohasi estimates that more than 60 per cent of the homeless suffer from depression or mental illness (Asienspiegel 2012). A German study of 102 homeless singles revealed a similarly high percentage of 68.6% mental disorders in need of immediate treatment (Salize et al. 2001). Another current study of a sample of 155 homeless people in Stockholm, which addressed quality of life, showed that "homeless persons had considerably worse HRQoL compared to the general population and reported most problems in the dimension anxiety/depression" (Sun et al. 2012). Furthermore, the results of Gordon et al. (2012) clearly show that elderly homeless people require special interventions to address their unique pathways to homelessness.

Yet another current study by Brown et al. (2012) addressing geriatric syndromes in older homeless adults (of which 19.8% were women) found that 39.8% had a major depression, hearing and visual impairment was present among 29.7% and 30.0% of subjects, respectively, urinary incontinence was reported by 49.8% of all subjects. The authors conclude that homeless adults were more likely to have functional impairment, frailty, depression, visual impairment and urinary incontinence compared to population-based cohorts of older persons. A meta-analysis in which Stergiopoulos & Herrmann searched through the Medline, AgeLine, and PsycINFO databases in 2003 for information about elderly homeless people emphasizes that although seniors only represent a small percentage of the homeless population, their numbers are growing steadily. Documenting the high prevalence of psychiatric disorders and cognitive impairment in this population, the authors conclude that "geriatric psychiatrists could play a significant role in evaluating and treating this population more comprehensively".

Conclusion: the data available suggest that people who are homeless, elderly people included, tend to be male, and that a high percentage of these is affected by mental illnesses (cf. Hwang et al. 2012: 69%; cf. O'Connell et al. 2004: around 73% ranging in age from 60-82 years; Brown et al. 2012: around 80% in the 50-69 age group; Lovisi et al. 2003: around 76% in those aged around 45). Nevertheless, the data need to be analyzed exactly, not only because different survey methods were employed. Thus, for example, the social report of North Rhine-Westphalia (NRW) of March 2012 found that more women (percentage) than men were homeless among elderly people aged 65 years and over (Ministerium für Arbeit, Integration und Soziales NRW 2012, p.4).

**Assessment and Mental Health of the Elderly**

In practice, a neuropsychiatric assessment approach deals with neurological or psychiatric paradigms with particular emphasis on geriatric patients in whom the interplay between biology and psychology is complex. Only a comprehensive neuropsychiatric examination can reconcile this dichotomy and lead to an integrated treatment plan (Cummings 1985; Ovsiew 2007; Schiffer et al. 2003; Strub et al. 2000; Weintraub 2000).

Assessment of mental health in the elderly must have as its main focus the subjective cognitive complaints that are frequent not only in patients with gradually progressive dementia but also in old people in the general population, in hospitals and in general practice.

The presence of cognitive complaints is a sign of dementia, but also for numerous other disorders, including a wide range of neurological, psychiatric and metabolic disorders causing fluctuation, persistent or progressive cognitive symptoms.
A basic study should include patients and carers interviews, physical, social and neurological examination, cognitive tests, evaluation of psychiatric symptoms and activities of daily living, a battery of laboratory tests and a CT (or MRI) of the brain and, more recently, with PET (or SPECT) and biomarkers, mainly for the diagnosis of mild cognitive impairment (Waldemar et al. 2007).

As for all other conditions, a specific diagnosis must be established for the psychiatrist and neurologist to plan appropriate treatment and care. In any case, this evaluation programme requires a multidisciplinary team and should be individually tailored according to the clinical presentation of the patient.

Early stage diagnosis is becoming very important, leading to therapeutic and remedial measures in order to prolong the independent functioning of patients, improvement in the quality of life, and diminishing the significant expense of caring for elderly persons unable to function autonomously (Campbell 2011).

Aims for the future in the context of mental health of the elderly, homelessness, and assessment

To improve the support for and preserve the mental health of elderly people, what is needed first of all is a competent examination of their individual situation. The focus should be on health promotion, prevention, and sustainable intervention, always related to the individual.

Each affected individual must be involved, and the same holds true for social networks, communities, political structures etc. We need participation and inclusion, adequate low-threshold access, visiting services, delivery of community services (cf. Lovisi et al. 2003) and new and creative and – most importantly – fundable housing options (O’Connell et al. 2004), to name a few relevant aspects.

Among other things, this calls for

1. Decision-makers who are well informed, e.g. about the social determinant of housing/homelessness and its relation to mental health components
2. Additional scientific surveys and studies on the subject
3. Decision-makers who are well informed, e.g. about multidisciplinary teams and neuropsychiatric assessment approaches.

F.e. the increase of dementia all over the world has been associated with growing social problems, disability and physical illness. In this context, an accurate assessment of patients’ social functioning should encompass full needs assessment, in determining an effective implementation of community-guided policies (Fernandes et al. 2009).

Specifically some assessment tools like the Camberwell Assessment of Needs for the Elderly/CANE (Reynolds et al. 2000), a comprehensive and person-centered instrument, can measure the multiple needs of individuals over the age of 65 and define which of these needs are not being met. It allows views of the professional, user and carer to be recorded and compared, identifying a need as a problem plus an appropriate intervention, which will help or alleviate the need.

Much research has shown that basing resources allocation and individual care plans on diagnosis or measures of disability does not necessarily result in appropriate interventions for many individuals (Slade et al. 1996). Instead, research has shown that the relationships between treatment and outcome, especially in mental health are more complicated than simply adding up the severity of symptoms and that the process is intricately linked to each individual’s’ needs. Thus, outcome for mental health services should be guided by an individual’s evaluation of their unmet needs (Boardman et al. 1999). This type of model is based on vulnerability and risk, not on legal status or diagnosis, and concludes that modern health care should always integrate a whole system approach in order to match services with need. There has also been pressure for services to become patient-centered rather than service-
centered and this has led to increased emphasis on individual’s’ needs, as well as a shift towards looking for cost-effective evidence for health care services with particular importance in mental health (Philp 1997; Orrell et al. 2007).

References


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Sabine Bährer-Kohler Mental Health of the Elderly-multidimensional aspects


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