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Editorial

Perspective: Social Determinants of Mental Health for the New Decade of Healthy Aging

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"If medicine is to fulfill her great task, then she must enter the political and social life. Do we not always find the diseases of the populace traceable to defects in society?"

— Rudolf Virchow, 1840 (https://www.momsmeals.com/blog/for-healthcare-professionals/a-brief-history-of-social-determinants-of-health

Awareness of the impact of social factors on health and illnesses is hardly new. It was, however, the 2008 Report of WHO Commission on social determinants of health (SDoHs) that represented a major milestone in medicine.[1] The SoDHs are non-medical factors that influence health outcomes and have a significant effect on health inequities. Initially, a limited set of SDoHs including nutrition, education, employment, and living environment was emphasized and applied to nearly all people. However, that list has since grown substantially to dozens of proposed SDoHs.[2] This is not

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surprising because SDoH is not a fixed, static, monolithic entity, and there are a number of additional SDoHs that relate to specific groups of people and to specific medical conditions. Importantly, some social determinants have beneficial rather than adverse effects on health.

The topic of SDoHs is particularly critical for older adults, and the COVID-19 pandemic has reaffirmed its importance. There are more than one billion people over age 60, with most living in low- and middle-income countries. Many do not have access to even the basic resources necessary for a life of meaning (https://www.who.int/initiatives/decade-of-healthy-ageing). It is heartening that the United Nations has declared 2021 to 2030 as the Decade of Healthy Aging, a global collaboration of governments, civil societies, international agencies, professionals, academia, the media, and the private sector, to improve the lives of older people and their families and communities (https://www.who.int/initiatives/decade-of-healthy-ageing).

Older adults with mental illnesses are impacted by several types of SDoHs:

1) general SDoHs that affect overall health,[3] 2) unique social determinants of mental health (SDoMH) such as stigma against mental illness, mental healthcare disparity, flawed criminal justice system, and homelessness,[4] and 3) aging-related SDoMHs listed below.

Ageism: The Global Report on Ageism defines ageism as stereotypes, prejudice, and discrimination directed toward people on the basis of their age.[5] Ageism, called "an insidious scourge on society", can be institutional, interpersonal, or self-directed. Ageism causes inequities and has detrimental effects on the individual, community, and society (https://dana.org/article/ageism-the-brain-strikes-back). In the October 2021 special issue of this journal, Rabheru and Gillis (2021)[6] show how the COVID-19 pandemic has led to a perfect storm combining ageism with prejudice against persons with mental symptoms (mentalism) and bias toward persons with disabilities (ableism).

Social Isolation and Loneliness: Because of losses of family members and friends, social isolation and loneliness are major problems for older adults, leading to increased morbidity and mortality.[4] Potentially modifiable factors associated with social isolation and loneliness in older adults include low quality of social relationships, poor mental health, low self-efficacy beliefs, unsafe neighborhoods, migration patterns, and inaccessible housing. This points out to a need to develop better solutions for public policy, city, and environmental planning as a public health priority.[7]

Geriatric Workforce Shortage: While most older Americans now have access to health care through Medicare, there is a growing gap between the need for and supply of geriatric experts. The number of physicians going into geriatric psychiatry and geriatric medicine has dropped in recent years due to poor reimbursement and unreasonable clinical case volume expectations.

Community-level Resilience, Compassion, and Wisdom: During the Covid-19 pandemic, older adults had a much higher risk of hospitalization and death than youth. Also, they were less able to handle social distancing because of problems with access to user-friendly technology. Yet, older adults had a significantly lower incidence of anxiety, depression, and stress compared to youth, likely due to greater resilience, compassion, and wisdom at individual and group levels.[8]

PUTATIVE MECHANISMS

SDoMH frameworks build upon the concept of "social gradient" – i.e., individuals with lower social status have greater health risks and lower life expectancy than those with higher status.[9] According to the cumulative inequality theory,[10] life course trajectories are influenced by early and accumulated inequalities. For example, lower level of education increases the likelihood of subsequent unemployment, low income, and poor access to healthcare, and is a risk factor for Alzheimer's disease. Social factors are linked to biology, epidemiology, and immunology. Genes, gestation, and childhood are critical to early and enduring inequalities, while the onset, duration, and magnitude of exposures affect longer-term health outcomes. The latter can be improved with appropriate use of available resources, perceived trajectories, and human agency. Epigenetic mechanisms may explain the gene–environment interactions in late-life depression.[11] These potentially reversible modifications influenced by the environment regulate gene activity in addition to structural changes in DNA. Those mechanisms may alter the process of coping with social stressors, thereby increasing that individual's psychological vulnerability versus resilience to future environmental stressors.

Prevention and Interventions

Prevention can occur at several levels:

1) Primordial (e.g., enhancing education to reduce longer-term risk of Alzheimer's disease), 2) Primary (e.g., starting counseling after stroke to prevent post-stroke depression), 3) Secondary (e.g., counseling after personal or community disasters to prevent PTSD), 4) Tertiary (e.g., reversing dementia caused by treatable factors like dietary deficiencies), and 5) Quaternary (e.g., preventing delirium by avoiding anticholinergics).

Some studies suggest that improving lifestyle can slow cognitive decline and potentially delay the onset of dementia. Recently an international network called the World-Wide FINGERS, which encompasses 25 countries, including some low- and middle-income countries, has been developed to provide evidence-base for prevention of dementia policies across communities.[12] Reducing barriers to and enhancing facilitators of early detection of dementia can help reduce bio-psycho-social morbidity associated with Alzheimer's disease and related dementias.[13].

A report by the National Academy of Medicine presented evidence that shows that a number of mental, emotional, and behavioral problems in young people are preventable.[14] Such preventive efforts could potentially save billions of dollars in costs associated with chronic mental illnesses in later life. Prevention is possible in older adults too. Reynolds and colleagues conducted a ground-breaking randomized controlled trial, labeled Depression in Later Life (DIL), in 181 older adults with subsyndromal depression at rural and urban primary care clinics in India.[15] Trained lay counselors provided problem-solving therapy, brief behavioral treatment for insomnia, education in self-care of common medical disorders like diabetes, and assistance in accessing medical and social programs. The DIL intervention was found effective in preventing episodes of major depression. In contrast, two very large studies of 18,353 older adults without clinically relevant depressive symptoms at baseline, treatment with vitamin D3 compared with placebo did not produce a significant difference in the incidence and recurrence of depression while omega-3 produced a slight but significant increase in the risk of depression over a median follow-up of 5 years.[16,17] Thus, the results did not support the use of vitamin D3 or omega-3 supplements in older adults to prevent depression.

In terms of interventions, the Global Report recommends three strategies found effective in reducing ageism: policy and law, education, and intergenerational contact interventions.[5] Lucyk and McLaren[18] divide SDoH-related intervention approaches into two categories: 1) Upstream interventions to diminish the 'causes-of-the-causes' of illness by acting on structural SDoHs at the policy level, and 2) Downstream interventions to reduce the 'effects of causes' of illness by attempting to meet the immediate needs of individuals and families by improving their access to health and social services. Below are two examples of hybrid interventions that help both communities and individuals.

Age-Friendly Communities: The WHO's global Age-Friendly Communities (AFC) Network and AARP's U.S. Network include hundreds of AFCs. In AFCs, older adults are actively involved, valued, and supported, with a focus on affordable housing, built environments conducive to active living, inexpensive and convenient transportation options, opportunities for social participation and leadership, intergenerational programs, and accessible health and wellness services.[19] There are also Dementia-Friendly Communities in European and other countries.

Compassionate Communities and Cities (CCCs): This movement promotes the motivation of communities to take greater responsibility for the care of people at the end of life. A systematic review of the studies of CCC programs found insufficient evidence of the implementation and evaluation models of CCCs.[20] A global model for the development and evaluation of CCCs in palliative care is warranted.

The use of technology in health care is going to increase rapidly in the coming years. Training in and easy access to technology including smart phones, telehealth, and social media can help keep older adults in communication with their peers and families, feel safe, reduce loneliness, and enhance well-being.

The UN Decade of Healthy Aging is expected to address four areas for action: age-friendly environments, combating ageism, integrated care, and long-term care (https://www.who.int/initiatives/decade-of-healthy-ageing). It suggests a need to build a movement to change the narrative around age and ageing. Older adults are a great resource of wisdom for youth. Considerable empirical evidence shows that intergenerational activities enhance health and well-being in both younger and older generations (https://dana.org/article/ageism-the-brain-strikes-

back). Let us hope that during the coming decade the world will become an age-friendly place without ageism and with integrated long-term care, resulting in healthy aging for everyone.

DATA STATEMENT

The data has not been previously presented orally or by poster at scientific meetings.

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