



Generations

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Paradox of Scarcity in a Land of Plenty: Meeting the Needs of Older Adults with Mental Health and Substance Abuse Disorders

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The approaching demographic wave of aging Baby Boomers will bring unprecedented growth in the number of Americans with mental health or substance use disorders, all of whom will need services over the coming decades. There are approximately 5.6 to 8 million Americans ages 65 and older who have a mental health or substance use disorder (Institute of Medicine [IOM], 2012). By the year 2030, this number is projected to reach 10.1 to 14.4 million older Americans (IOM, 2012).

Growing life expectancies also are changing the face of mental health and aging by contributing to high rates of physical health comorbidities; and we are witnessing an extraordinary increase in older adults afflicted with Alzheimer's dementia. In the absence of a major research breakthrough, the future magnitude and related impact of this condition is breathtaking. The number of individuals with Alzheimer's Disease (5.2 million currently) is predicted to more than double by the year 2040 to 8.4 million, resulting in an estimated cost of \$1.2 to \$1.6 trillion (Bynum, 2014). To put this into perspective, the total U.S. budget in 2014 is \$3.6 trillion.

Despite an urgent need for a trained professional workforce with expertise in treating geriatric mental disorders, there are fewer than 1,800 geriatric psychiatrists in the United States, and this number will decrease to 1,650 by the year 2030, amounting to fewer than one geriatric psychiatrist for every 6,000 older adults with mental health and substance use disorders (Bartels and Naslund, 2013). Similar shortfalls are likely to extend to other providers with specialty training in geriatric mental health, including nurses, psychologists, and social workers. Projections indicate we have passed the "tipping point" of an inevitable shortfall in specialty providers with geriatric expertise in the future (IOM, 2012).

The facts are clear: The current system of geriatric mental care is unsustainable and will not begin to meet future needs. Yet we live in a country with the highest per capita healthcare expenditures in the world for older adults; the largest long-term investment in research developing evidence-based geriatric mental health interventions; and, a rapidly growing population of older retired Americans who represent an untapped volunteer peer workforce. Tragically, this is only one of many examples in our healthcare delivery system of "the paradox of scarcity in a land of plenty" (Muir, 2011).

Where do we begin if we are to engage in a serious strategy to address the gap between "what we know" and "what we do"? The following article provides a perspective on these important questions and suggests future directions for program development and applied research aimed at addressing these critical challenges in healthcare today.

Current and Projected Prevalence and Impacts

The IOM estimates that 14 percent to 20 percent of older adults have a mental health disorder or experience clinically significant psychiatric symptoms that affect functioning (IOM, 2012). Within this group, approximately 3 percent to 4.8

percent of the older population was estimated to have a serious mental illness (i.e., schizophrenia, bipolar disorder, or chronic depression with long-term functional impairment), amounting to between 600,000 and 1.9 million older adults in the United States (IOM, 2012). By 2020, there will be at least 7.7 million to 11 million older adults with one or more mental health or substance use disorders (IOM, 2012). In the absence of adequate treatment, these conditions result in a substantial negative effect on emotional well-being, functioning, and self-care activities, as well as decreased quality of life.

Impacts on people and society

Mental health disorders in older adults are associated with poor outcomes, including increased disability, poor quality of life, poor health outcomes, and increased mortality. Older adults with depression have higher rates of mortality following hip fractures, heart attacks, and stroke (Penninx et al., 1999). Older white males (ages 85 and older) have the highest rate of suicide of any subgroup (Conwell, 2014). Middle-aged and older adults with serious mental illness represent a particularly high-risk group, as evidenced by a decreased life expectancy of thirteen to thirty years (Colton and Manderscheid, 2006). This dramatic health disparity largely is associated with greater mortality from cardiovascular disease (Colton and Manderscheid, 2006). Similarly, mental illness is more prevalent in patients with common chronic conditions (Katon, 2003). If untreated, mental disorders are associated with greater disability, poor treatment adherence, and increased healthcare costs (DiMatteo, Lepper, and Croghan, 2000; Scott et al., 2009; IOM, 2012). Finally, in addition to the financial costs to family members, caregivers of older adults with mental disorders have higher rates of depression and poorer health status (Karlawish, 2014).

The presence of mental health conditions in older adults also dramatically increases overall healthcare costs (Unützer et al., 1997). The 2009 Medical Expenditure Panel Survey found that 7.4 million older adults received services for mental health conditions costing \$17.1 billion, making mental illness among the most costly of eight health conditions for adults ages 65 and older in the United States (IOM, 2012). Among those who are dually eligible (Medicare and Medicaid beneficiaries), mental health conditions increase overall costs by two to three times (Bartels et al., 2003).

Treatment Should Be Tailored to Older Adults

An extensive evidence base supports the effectiveness of psychosocial and pharmacological interventions for treatment in older adults as comparable to that of younger adults (Bartels and Drake, 2005). Despite this evidence base demonstrating the effectiveness of treatment for older adults, age-related changes present additional challenges and require tailored interventions. Tailoring psychopharmacological interventions includes accommodating biological changes associated with age-altered sensitivity to medications, and the rate of metabolism of medications, as well as managing the multiple prescribed medications that increase the likelihood of adverse side effects and complications from negative drug interactions (Mangoni and Jackson, 2004; Mallet, Spinewine, and Huang, 2007). Tailoring psychosocial interventions includes accommodating the co-occurrence of medical conditions, sensory impairments, and mobility decline that can affect functioning, behavior, mood, and cognition, and complicate diagnosis and outcomes. Mental health treatment for older adults also often involves behavioral health interventions targeting medical adherence, sleep disturbance, and functional changes associated with age.

Regardless of modality, addressing mental health conditions in older adults often requires coordinating with the patient's medical team and social service providers, and making efforts to engage caregivers and family members. Access to treatment can be especially challenging when there are economic limitations, transportation challenges, and the perceived stigma associated with mental health treatment. In summary, conventional approaches to delivering mental health services are inadequate for older adults (IOM, 2012).

Transforming Mental Health Services to Meet the Need

The greatest current challenge to providing appropriate mental health services is not a knowledge gap, but an implementation gap. The approaching unprecedented demographic wave will overwhelm an inadequate mental health workforce in the absence of major reforms. There will never be enough specialty mental health providers to address the needs of the geriatric population (IOM, 2012). So what can be done?

Solutions for addressing this clear and pressing future need can be found in other countries challenged by a long-standing scarcity of trained healthcare providers. Locally trained community health outreach workers have provided general primary care services to those in need. This approach has been shown to be effective for mental health care in countries where mental health providers are scarce or entirely absent. Lessons learned from these under-resourced countries can be directly applied to the future shortfall of geriatric mental health providers in America.

Known as “reverse innovation,” this approach illustrates that the creative innovation of developing countries can directly inform solutions in Western cultures that are economically wealthy, but paradoxically experience significant healthcare workforce scarcities. (Govindarajan, Trimble, and Nooyi, 2012). Examples include novel approaches to rural health service delivery, use of indigenous community health workers, mobile phone telehealth, and social entrepreneurship.

How might this work for American older adults? Consider the existing workforce of almost 30,000 aging network service providers who reach more than 10 million older adults each year in senior centers, senior housing, and through home-delivered meals programs. This group of social service providers could be trained to provide mental health screening and brief interventions to the individuals they interact with every day. Also consider the untapped potential of retired older adults who represent a growing natural resource that could be employed in part-time paid or volunteer work as peer counselors. This group, many of whom have had prior experience in social service and health professions, can forge a mental health outreach workforce in their communities. As well, the extensive community college system in America could be employed to train a new type of health outreach worker specifically dedicated to addressing the needs of complex frail elders in their communities. This new type of outreach worker also could be an entrée into a career development ladder in underserved health professions in communities (Bartels and Naslund, 2013).

Technology also represents a major resource that is only beginning to be tapped to help address unmet mental health care needs. Smartphone and sensor technology use are skyrocketing as a means to augment, supplement, and support home- and community-based treatment for a host of healthcare conditions, including depression and other mental disorders. While many older adults may not have extensive computer skills, older adults are the fastest growing group of computer users (Hart, Chaparro, and Halcomb, 2008). Older adults readily use such interactive computer-based healthcare programs as Project Re-Engineered Discharge (RED) (Berkowitz et al., 2013). Project RED has been shown to be highly effective compared to routine discharge procedures. It includes a nurse avatar who delivers detailed bedside instructions at discharge, allowing patients to take as much time as necessary to fully understand and review their personal care plan. Unfortunately, these programs do not provide mental health treatment and are not designed for community use.

Other potential solutions should capitalize on the emerging role of Web-based and mobile health technologies. There is a ready opportunity to provide screening and treatment that is otherwise inaccessible for a variety of reasons. Smartphone applications can support detection, monitoring, and self-management. Telehealth and automated computer-based programs have been developed with the capacity to deliver cognitive behavioral and problem-solving therapy. Social media may be leveraged to engage peer support to prevent depression by overcoming social isolation. Computer-based psychotherapy programs and mobile health technologies should be tailored to older adults to optimize their usability and increase access to needed services.

The ACA Holds Opportunities for Advancing Geriatric Mental Health Care

The Patient Protection and Affordable Care Act (ACA) makes little explicit mention of mental health care, yet many of its provisions have significant implications for improving access and quality of care to older adults with complex conditions ((Bartels, Gill, and Naslund, in press). (See also the article in this issue by Golden and Vail.)

The ACA provides the opportunity to deliver services through accountable care organizations (ACO)—providers and hospitals accountable for quality of care and costs to a given population of patients. Although the first generation of ACOs largely focused on chronic health conditions, mental health care will increasingly become a focus for integrated delivery, given the significant, substantial cost of these disorders on overall health. In addition, ACOs are actively promoting “patient-centered medical homes” that specifically incorporate access to integrate mental health services as a component.

Within the ACA, a core strategy for meeting the goals of improving care and lowering costs is the development of these “patient-centered medical homes” (Rittenhouse, Shortell, and Fisher, 2009). There are five key attributes of a patient-centered medical home—it is comprehensive, patient-centered, coordinated, accessible, and ranks high in value and safety. Integrated mental health in primary care is intrinsically related to all of the goals of the patient-centered medical home, and should be a core component (Croghan and Brown, 2010).

A large body of evidence supports the effectiveness of integrated collaborative care models in primary care specifically focused on older adults. Three independent randomized trials of integrated collaborative care for older adults in primary care have shown that this approach improves engagement and care, results in greater direct reduction in depressive symptoms, decreases suicidal ideation, and is associated with a cost offset with respect to

overall healthcare costs (Unützer et al., 2008). Also, under the ACA, patient-centered medical homes receive increasing degrees of reimbursement for greater use of integrated care management, coordination, and health information technology. These built-in incentives provide an extraordinary opportunity for geriatric mental health to become a core component of innovative models of integrated care.

Also through the ACA, Medicaid “health homes” provide the opportunity to develop and support primary healthcare delivered directly into mental health care settings to address the needs of people with serious mental illness and medical comorbidity. There also are opportunities to incorporate psychosocial interventions for older adults with serious mental illness, which are likely to be more feasible and accessible through discussed healthcare reforms. Group interventions have been developed and proven effective specifically for older adults with serious mental illness, including skills training in independent community living and preventive health (HOPES, or Helping Older Persons Experience Success) and integrated physical and mental health self-management for co-occurring chronic health conditions (I-MR, Integrated Illness Management and Recovery) (Bartels et al., 2014a; Bartels et al., 2014b).

Numerous other ACA provisions have the potential to improve access to geriatric mental health services. The hospital readmission and healthcare transition program supports and promotes using evidence-based healthcare transition models of care shown to be effective through a series of randomized trials (Naylor, 1990; Berkowitz et al., 2013). As mental health conditions are likely to complicate transitions and increase the likelihood of readmission to hospitals, mental health services are likely to be increasingly incorporated into these care models. As hospitals are directly accountable for hospital readmissions within sixty days of discharge, there is a clear incentive for achieving successful transitions to communities and to reduce readmissions. Additional opportunities include the Medicare Annual Wellness Visit, which includes a mandated depression screening. Because screening is likely to raise the number of detected cases of depression, referral and integrated forms of treatment for geriatric depression will increasingly be a necessary component of care.

Other opportunities are afforded by the Independence at Home and 1915(i) state plan community-based services programs. These demonstration programs aim to provide comprehensive and timely care to improve health, reduce hospitalizations, and to lower costs. Through the 1915(i) state plan, states have the option to offer community-based services for complex patients who might benefit from psychosocial rehabilitation, behavioral supports, health promotion, health coaching, and health monitoring. The ACA also provides support for increasing use of health information technology, as well as automated remote technology and telehealth for complex high-risk patients. There is growing evidence showing these technologies can reduce emergency room visits and hospitalizations, specifically in high-risk patients with concurrent mental illnesses and chronic health conditions (Godleski et al., 2012).

Conclusion

With the approaching demographic wave, we will witness an unprecedented increase in the number of older adults with mental health or substance use disorders over the coming two decades. At the same time, the decreasing capacity of the specialty workforce in geriatrics will result in an inevitable shortfall in the healthcare workforce, with geriatric expertise needed to address this public health challenge, with potentially devastating consequences. Federal leadership is needed to embrace this challenge going forward. Unfortunately, we need vigorous advocacy to engage leadership in embracing this critical concern for the nation’s healthcare delivery system and aging population.

As noted in the 2012 IOM report, federal agencies such as SAMHSA have discontinued their Older Adult Targeted Capacity Expansion Grant program that successfully implemented evidence-based geriatric mental health services in numerous sites and states across the nation. Despite the IOM’s recommendation to restore this program and to embrace geriatric mental health within the mission, the recently released 2015–2018 SAMHSA strategic plan makes no mention of older adults or geriatric mental health. Instead, the strategic plan for workforce training and education specifically limits SAMHSA’s measure of success in disseminating evidence-based core competences, training, and technical assistance to “increase the number of behavioral health providers (professional, paraprofessional, and peers) addressing children, adolescents, and transitional-age youth” (SAMHSA, 2014).

A possible silver lining in this cloud is an increasing public awareness of the importance of mental health as intrinsic to physical health as we age, in conjunction with new mechanisms under the ACA for adopting innovative models of care. By combining evidence-based practices with innovative strategies to create a new type of workforce, assisted by technology, we have a fighting chance to redesign healthcare to address the needs of the both the physical and mental health of the “whole person” as we age (Bartels, 2004).

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