



# **Mental Disorders and Aging An Emerging Public Health Crisis in the New Millennium?**

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# Mental Disorders and Aging

- Impact of Problem:
  - 4 Facts to Guide Public Policy
- Examples of Model Programs
- Vision and Values for Improving Services
- Suggested Directions

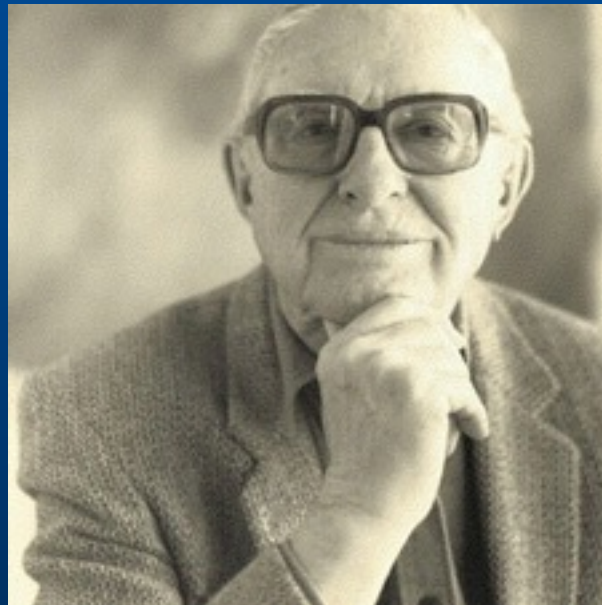


# Mental Disorders of Aging: 4 Facts To Guide Public Policy



- 1) Dramatic recent and projected growth
- 2) Major direct and indirect impact on health outcomes, service use and costs
- 3) We know treatment works, but effective services are not reaching those in need
- 4) An alarming under-investment in knowledge dissemination, service development, and research to meet future need

# Impact of the Problem



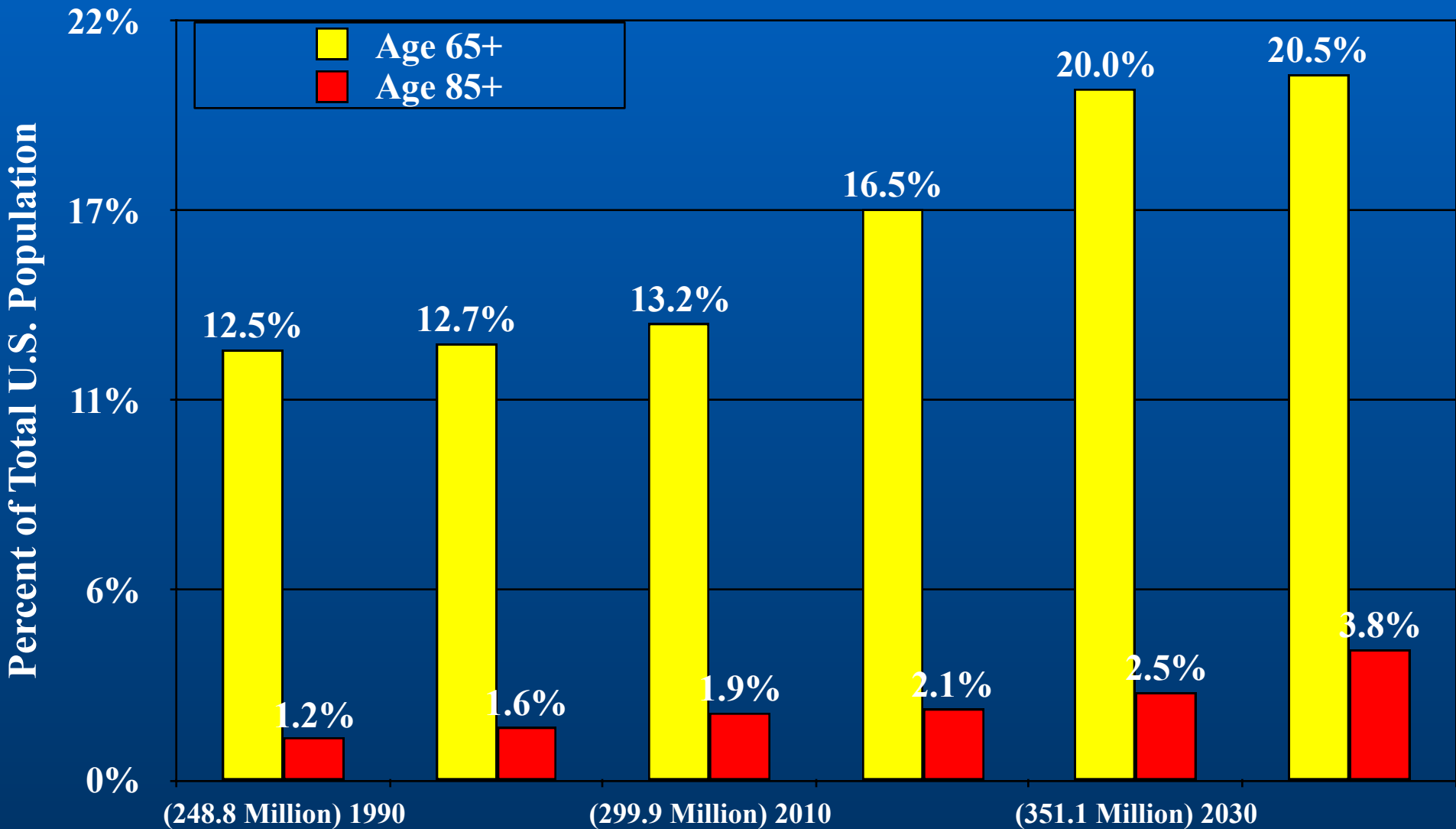


# Projected Growth In Older Adults With Mental Illness

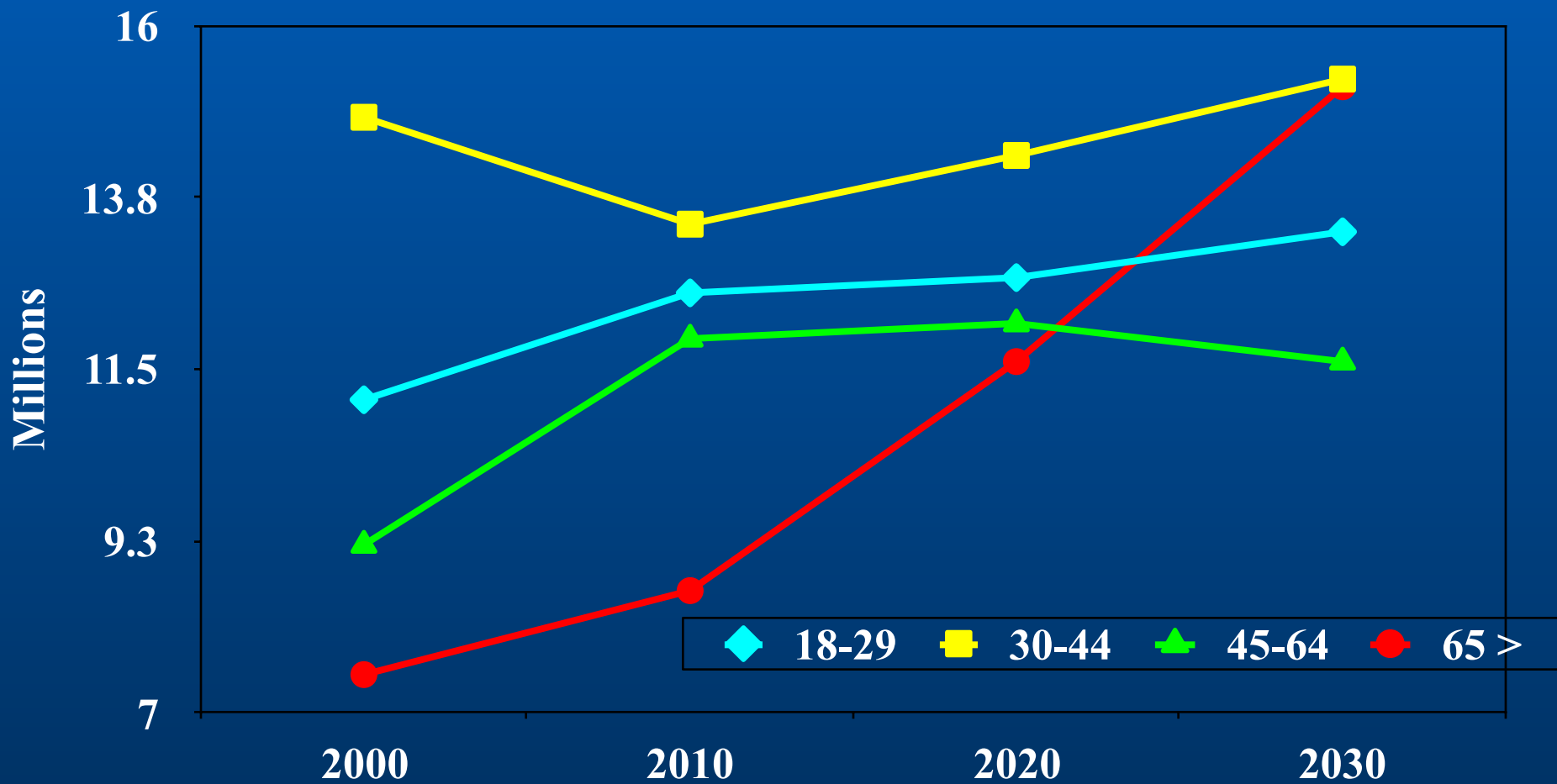
- Population aged 65 and older will increase from 20 million in 1970 to 69.4 million in 2030.
- Older adults with mental illness will increase from 4 million in 1970 to 15 million in 2030.

(Jeste, et al., 1999; [www.census.gov](http://www.census.gov))

# Aging In America



# Estimated Prevalence of Major Psychiatric Disorders by Age Group





# Prevalence of Mental Disorders Age 65+

- Psychiatric 16.3%
- Dementia 10%
- **Mental disorders:** 26.3%  
(including dementia)
- **Psychiatric disorders** 19.8% based  
on prevalence of 30-40% of dementia complicated by  
depression, psychosis, or agitation.





# Mental Disorders in Older Adults: The Silent Epidemic

- Alzheimer's and other memory disorders (30-40% complicated by depression or psychosis)
- Depression, anxiety disorders, severe mental illness, alcohol abuse
- Suicide: highest rate: age 75+

# Psychiatric Illness in Older Persons as a Public Health Problem: Impact on Health Outcomes





# Depression Associated with Worse Health Outcomes

- **Worse outcomes**
  - Hip fractures
  - Myocardial infarction
  - **Cancer** (Mossey 1990; Penninx et al. 2001; Evans 1999)
- **Increased mortality rates**
  - **Myocardial Infarction** (Frasure-Smith 1993, 1995)
  - **Long term Care Residents** (Katz 1989, Rovner 1991, Parmelee 1992; Ashby 1991; Shah 1993, Samuels 1997)

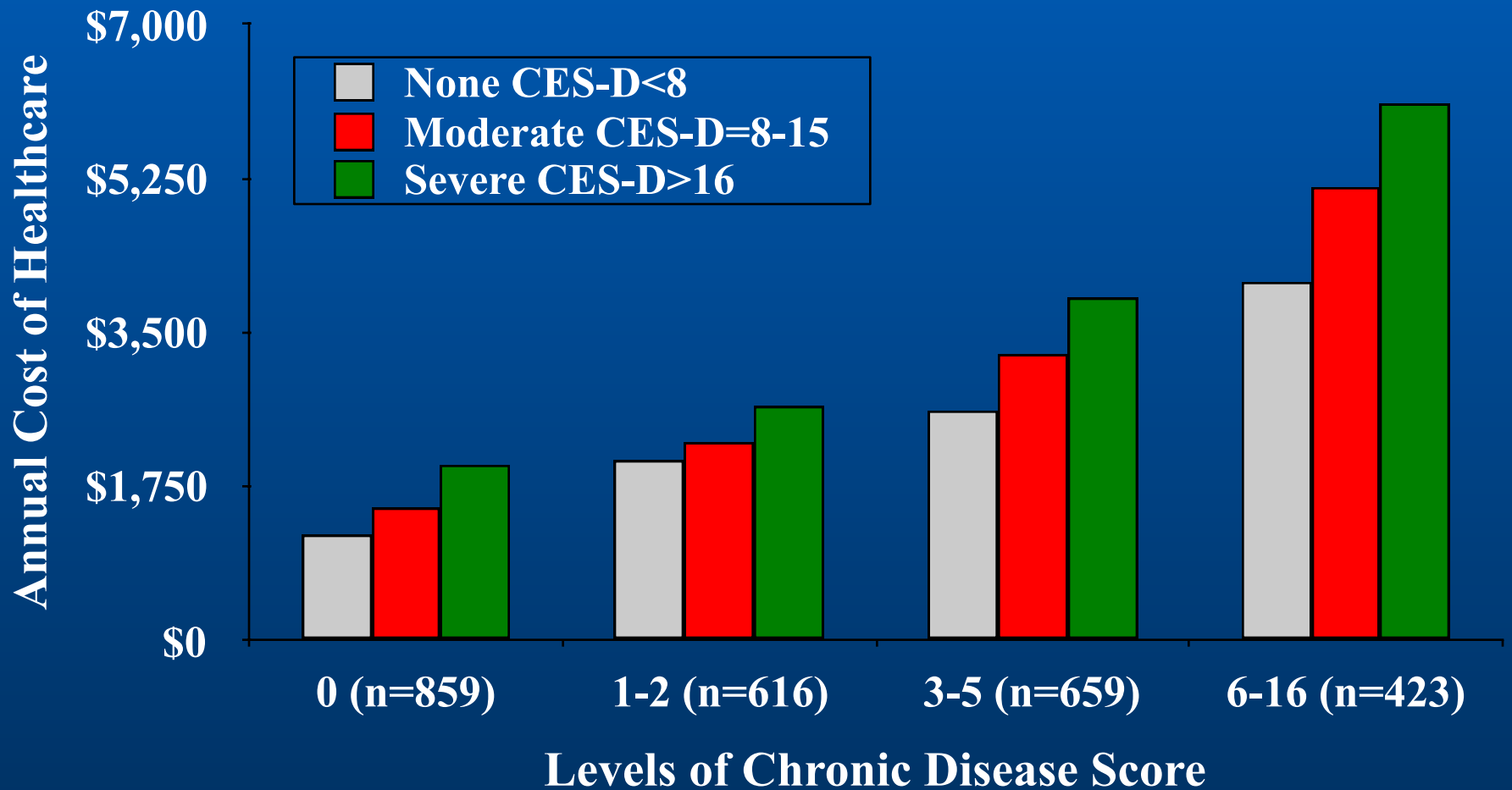


# Depression in Cancer

- Increased Hospitalization
- Poorer physical function
- Poorer quality life
- Worse pain control

(Evans 1999)

## Depression in Older Adults and Health Care Costs

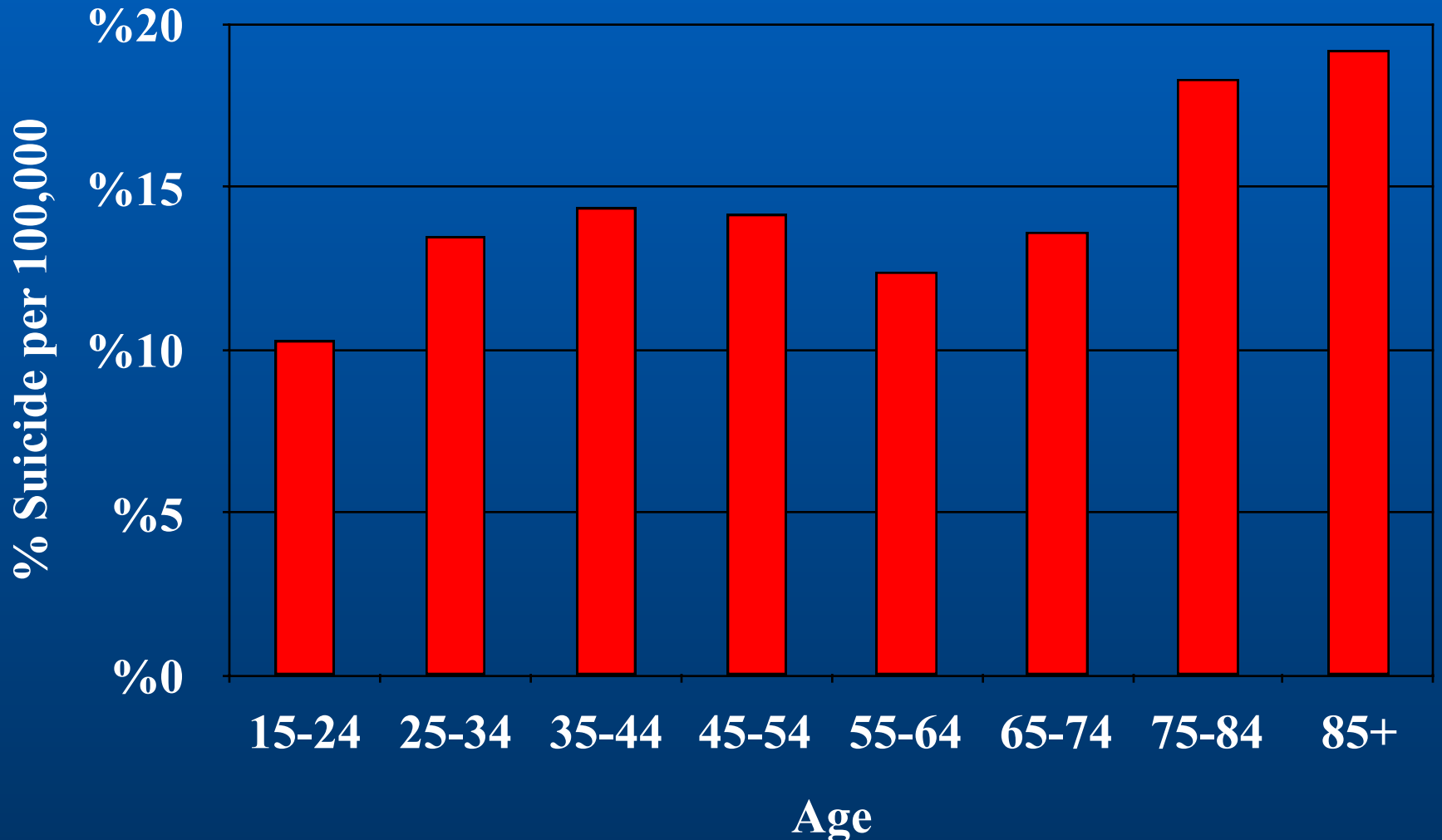




# Suicide in Older Adults

- **65+:** highest suicide rate of any age group
- **85+:** 2X the national average (CDC 1999)
- **Peak suicide rates:**
  - Suicide rate goes up continuously for men
  - Peaks at midlife for women, then declines
- **1/3 of older men saw their primary care physician in the week before completing suicide; 70% within the prior month**

# Suicide Rate by Age Per 100,000



Older people: 12.7% of 1999 population, but 18.8% of suicides.

(Hoyert, 1999)



# Summary of Findings

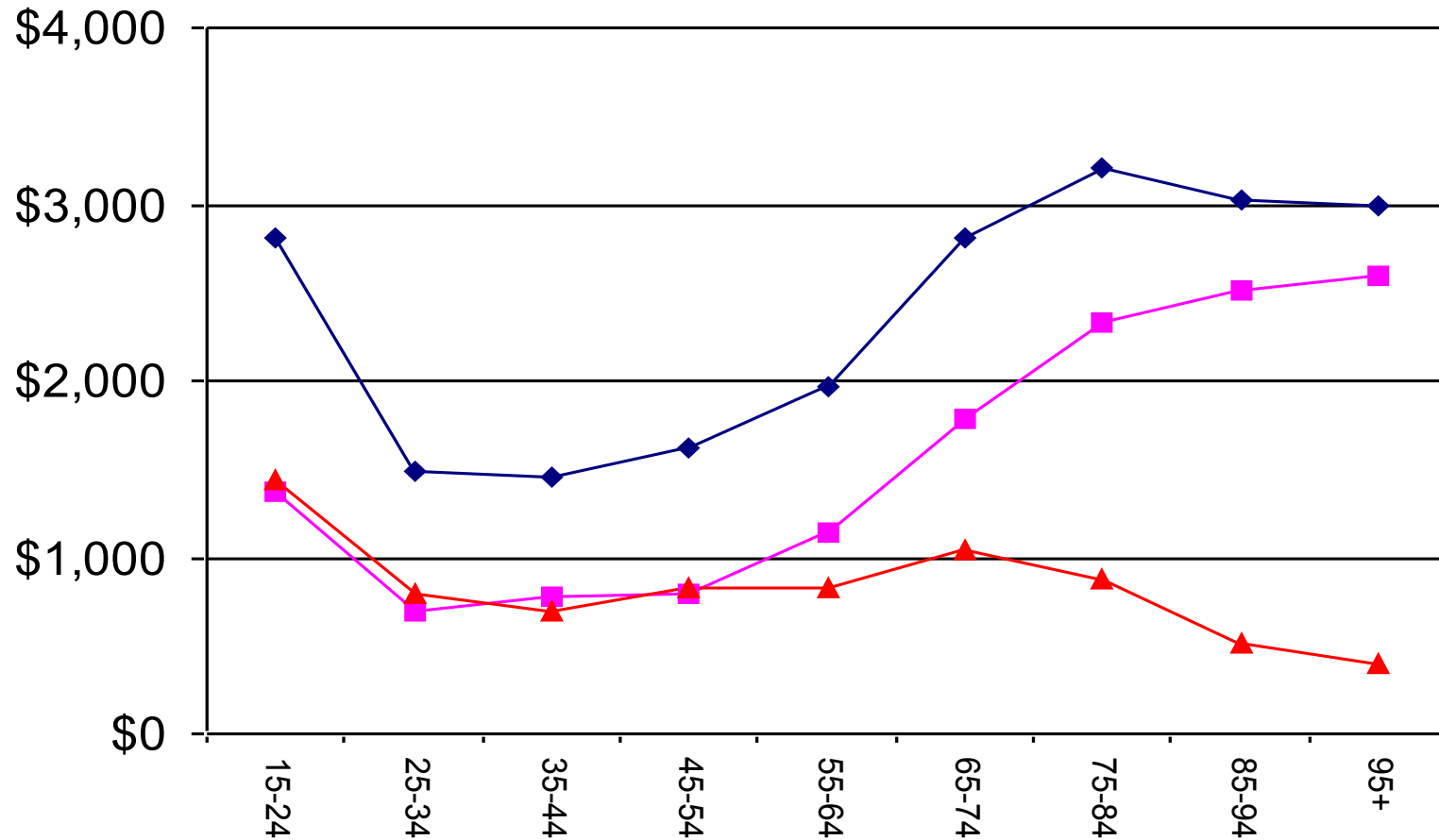
- Depression is common in medical disorders among older patients
- Associated with worse health outcomes
- Greater use and costs of medications
- Greater use of health services
  - medical outpatient visits, emergency visits, and hospitalizations



# Older Adults with Severe Mental Illness

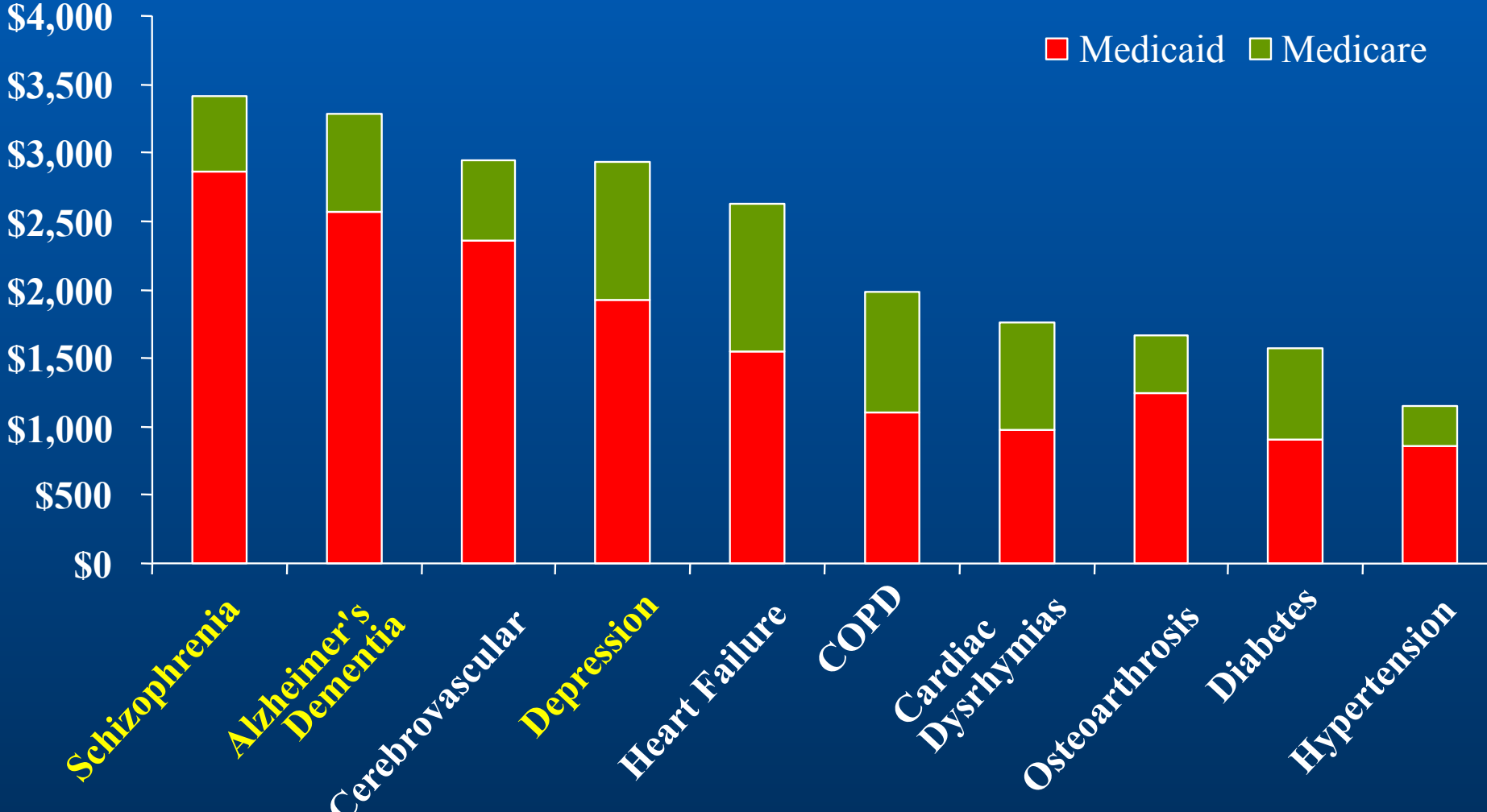


# Monthly Per Person Costs by Age: Severe Mental Illness



◆ Medicaid+Medicare    ■ Medicaid    ▲ Medicare

# New Hampshire Total Monthly Costs Per Person Over Age 65





# Severe Mental Illness in Older Adults

- **Rapid growth projected** (Jeste, et al., 1999)
- **Lack of community living skills associated with nursing home and high cost services**  
(Bartels et al., 1997, 1999)
- **Lack of Rehabilitative Interventions**
- **High Medical Comorbidity**  
(Vieweg, 1995; Goldman, 1999)
- **Poor Health Care and Increased Mortality**  
(Druss, 2001)



# Falling Through the Cracks

- **Community Mental Health Services**
  - Under-serve older persons
  - Lack staff trained to address medical needs
  - Often lack age-appropriate services
- **Principal Providers:**
  - Primary Care and Long-term Care**
- **Medicare**
  - No general outpatient prescription drug coverage & lack of mental health parity



# Unmet Need for Community Treatment

- **Less than 3% of older adults receive outpatient mental health treatment by specialty mental health providers**
  - (Olfson et al, 1996).
- **Only 1/3 of older persons who live in the community and who need mental health services receive them**
  - (Shapiro et al, 1986).



# **Nursing Homes: The Primary Provider of Institution-Based Care for Older Persons with Mental Disorders**

- **65-80% of Nursing Home Residents- A Diagnosable Mental Disorder**
- **Among the Most Common Disorders**
  - **Dementia**
  - **Depression**
  - **Anxiety Disorders and Psychotic Disorders**

**(Burns & Taube, 1990, 1991, Rovner et al., 1990)**



## Unmet Need for Mental Health Services in Nursing Homes

- Over one month: 4.5% of mentally ill nursing home residents received mental health services (Burns et al., 1993)
- Over one year: 19% in need of mental health services receive them.
  - Least likely: Oldest and most physically impaired (Shea et al., Smyer et al., 1994)





## Fragmentation of the Service Delivery System for Older Persons

- Primary care
- Specialty mental health
- Aging network services
- Home care
- Nursing Homes
- Assisted Living
- Family caregivers

***“The advantages of a decisive shift away from mental hospitals and nursing homes to treatment in community-based settings today are in jeopardy of being undermined by fragmentation and insufficient availability of services.”***

**(Admin. on Aging, 2000)**



## Poor Quality of Care for Older Persons with Mental Disorders

- **Increased risk for inappropriate medication treatment** (Bartels, et al., 1997, 2002)
  - > 1 in 5 older persons given an inappropriate prescription (Zhan, 2001)
- **Less likely to be treated with psychotherapy** (Bartels, et al., 1997)
- **Lower quality of general health care and associated increased mortality** (Druss, 2001)



# Inadequate Workforce of Trained Geriatric Mental Health Providers

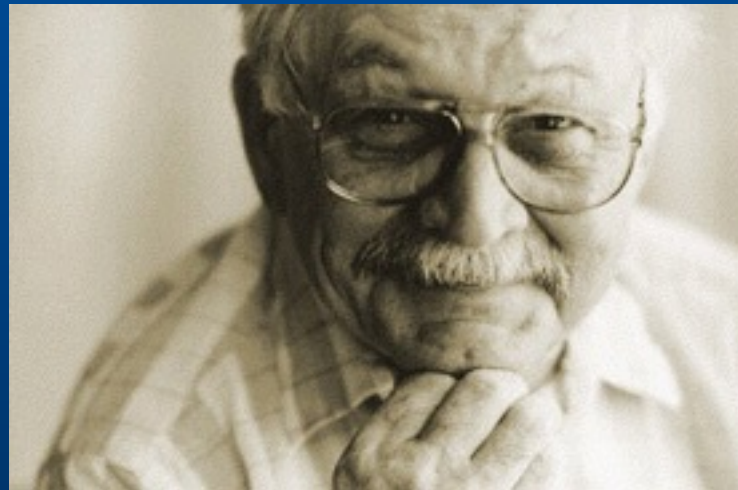
- Current Workforce:
  - 2,425 Geriatric Psychiatrists
  - 200-700 Geriatric Psychologists
- Estimated Current Need:
  - 5,000 + of each specialty
- Severe Nursing and Allied Health Care Provider Shortage



# The Public Health Crisis

- **Dramatic growth in aging population**
  - Major direct and indirect impact on health service use and costs
- **Under-investment in Knowledge Dissemination, Service Development, & Research to Meet the Future Need**

# **An Underinvestment in the Service Infrastructure for Older Adults Mental Health Services**

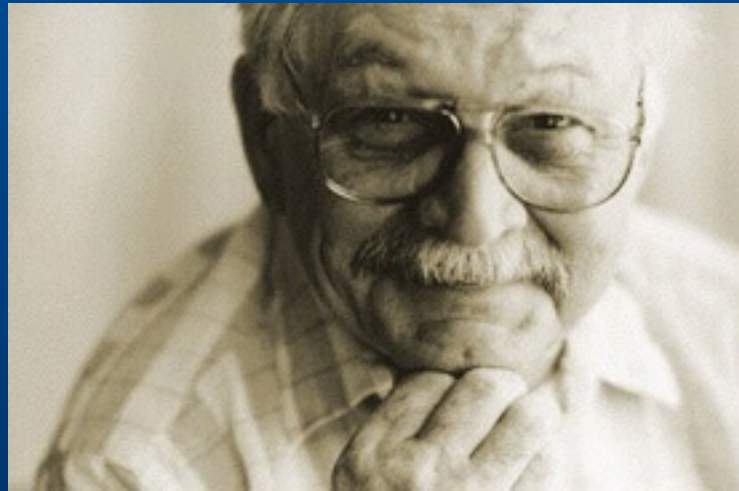


# Medicare Expenditures for Mental Health Services

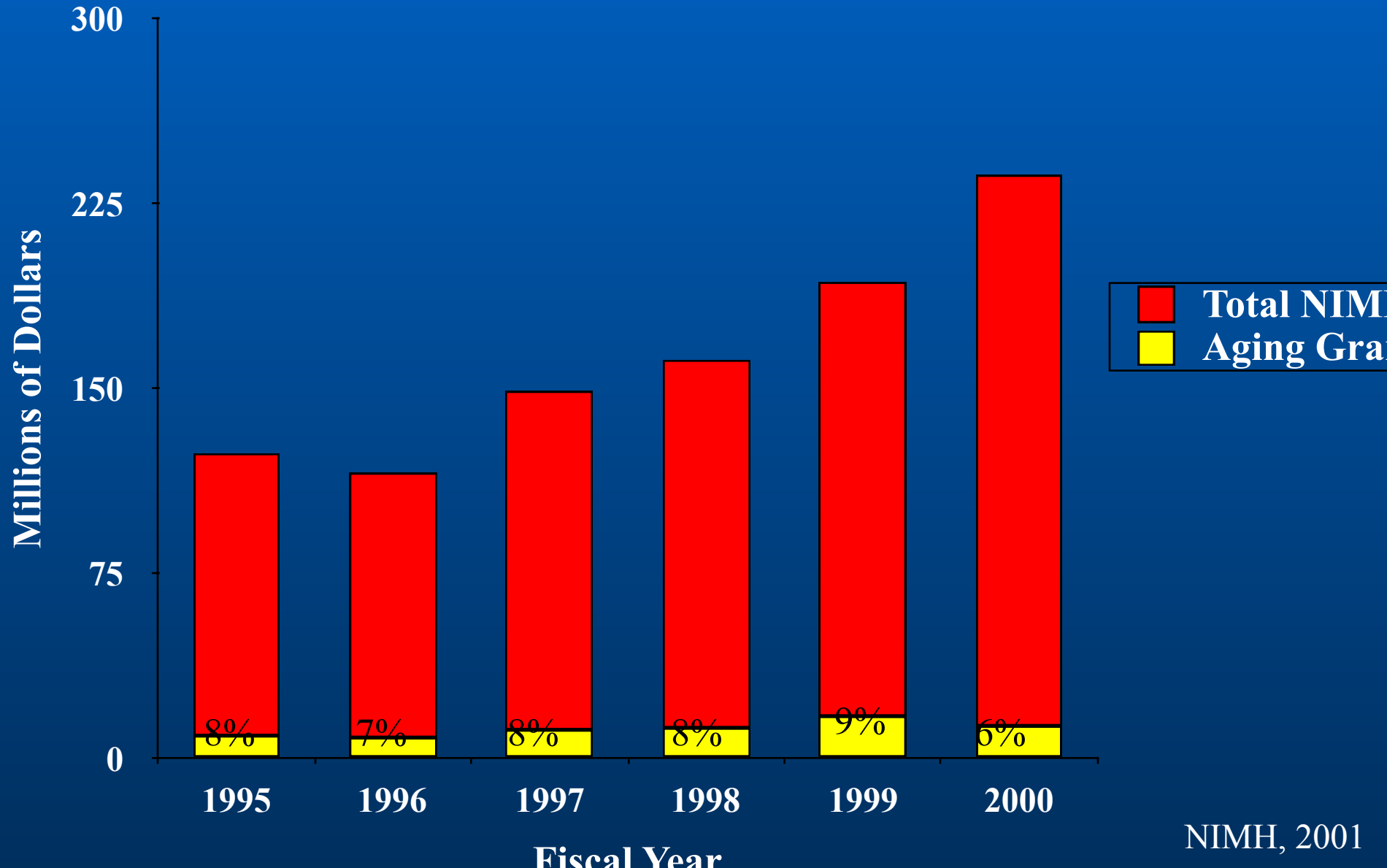
- Total 1998 Medicare Health care Expenditures: 211.4 Billion
- Total Mental Health Expenditures: 1.2 Billion (0.57%)
- Outpatient Mental Health Expenditures: 718 Million (0.34%)

CMS, 2001

# An Underinvestment in the Research Infrastructure Devoted to Mental Health and Aging

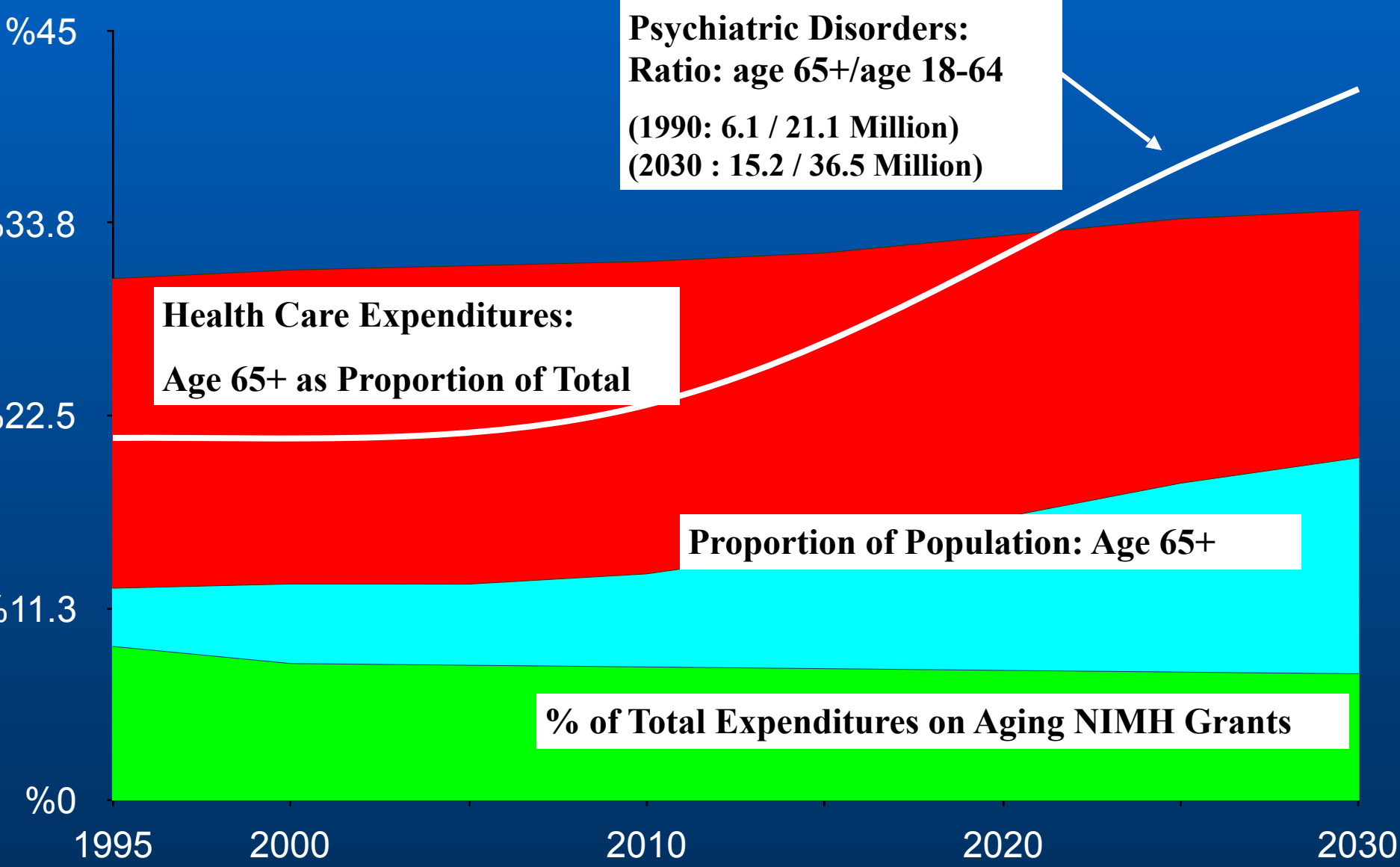


# Expenditures on NIMH Newly Funded Grants





# Projected Prevalence & Research Funding



# Recognition of the problem

**We know treatment works.....**

**But effective treatments are not getting to those in need**

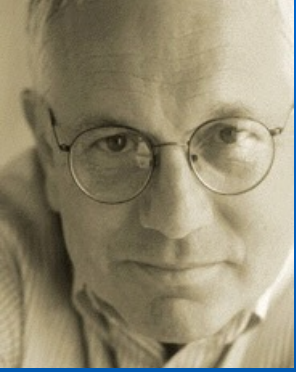


# **We Are Failing to Provide Effective Treatments and Services to Those in Need**

- **System Barriers:** Fragmentation: A Need for Integrated Mental Health Services in Primary and Long-term Care
- **Training Barriers:** The Limits of Traditional Educational Approaches in Changing Provider Behavior and Ageism
- **Financial Barriers:** Including a Mismatch Between Covered Services and a Changing System of Long-term and Community-based Care
- **Consumer Barriers:** Stigma and education

# What Can Be Done to Improve Access and the Quality of Care? Examples of Promising Models





# We Know Treatment Works

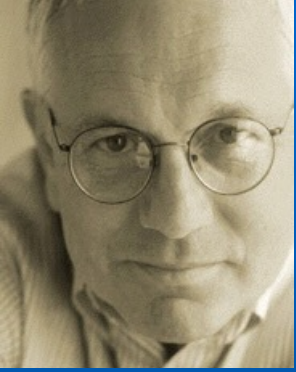
## Systematic Reviews of the Highest Levels of Evidence for Geriatric Mental Health Interventions and Services:

- 26 Meta-analyses
- 8 Systematic evidence-based reviews
- 12 Expert consensus statements

“Evidence-based practices in geriatric mental health care”

Bartels SJ, Dums AR, Oxman TE, Schneider LS, Areán PA,

Alexopoulos GS, Jeste DV. Psychiatric Services, 53, 53:1419-1431, 2002



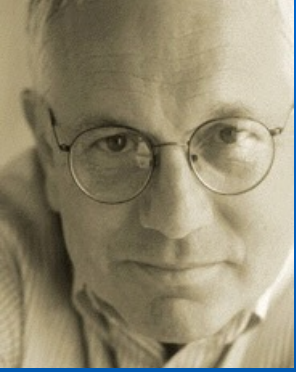
# Evidence-based Practices

- **Mental health outreach services**
- **Integrated service delivery in primary care**
- **Mental health consultation and treatment teams in long-term care**
- **Family/caregiver support interventions**
- **Psychological and pharmacological treatments**
  
- **Strategy: Implementation Toolkits**



# **Integrated mental health in primary care**

- **PRISMe (SAMHSA)**
- **PROSPECT (NIMH)**
- **IMPACT (Hartford Foundation)**
  - **Current studies which will inform researchers, clinicians, and policy makers on optimal models for integrating mental health in primary care for older persons.**

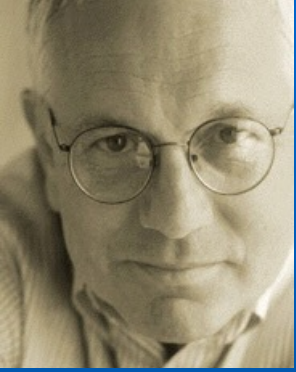


# Outreach programs

- “Gatekeeper” Model
  - Trains community members to identify and refer community-dwelling older adults who may need mental health services
  - Effective at identifying isolated elderly, who received no formal mental health services

Florio & Raschko, 1998





# Outreach programs

- **Psychogeriatric Assessment and Treatment in City Housing (PATCH) program.**
  - **Serving Older Persons in Baltimore Public Housing**
- **3 elements**
  - **Train indigenous building workers (i.e., managers, janitors,) to identify those at risk**
  - **Identification and referral to a psychiatric nurse**
  - **Psychiatric evaluation/treatment in the residents home**
- **Effective in reducing psychiatric symptoms**

Rabins, et al., 2000



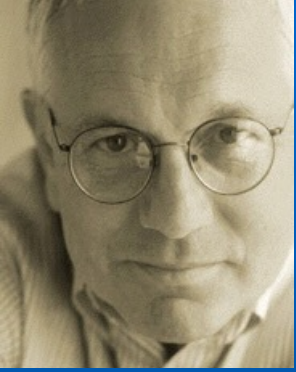
# Caregiver Support Interventions

- Delays placement in nursing homes for persons with dementia from 166 days to 19.9 months

(Mittleman et al., 1995; Moniz-Cook et al., 1998;  
Riordan & Bennett, 1998; Roberts et al., 1999)

- **Improved Caregiver Mental Health**
  - Decreased incidence and severity of depression -
  - Improved health (e.g., lowered blood pressure)
  - Improved stress management

Sorensen, Pinquart, Duberstein, 2002



## Peer Support and Faith-based Services

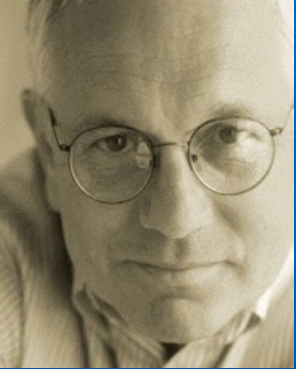
- Peer support groups for older persons with losses improve mental health outcomes  
(Lieberman & Videka-Sherman 1986)
- Peer support groups may be more acceptable to older persons and allow participants to be recipients and providers of assistance  
(Schneider & Kropf, 1992)



# The HOPES Study: Helping Older People with Severe Mental Illness Experience Success

- **Rehabilitation:**
  - Skills training groups on community living skills, social skills, and health maintenance skills
- **Health Care Management:**
  - Nurse case manager monitoring, facilitation, and coordination of primary/preventative health care, health education

Bartels et al., Supported by NIMH



# A Sourcebook Describing Locally Developed Model Programs

## *“Promoting Older Adult Health through Aging Network Partnerships”*

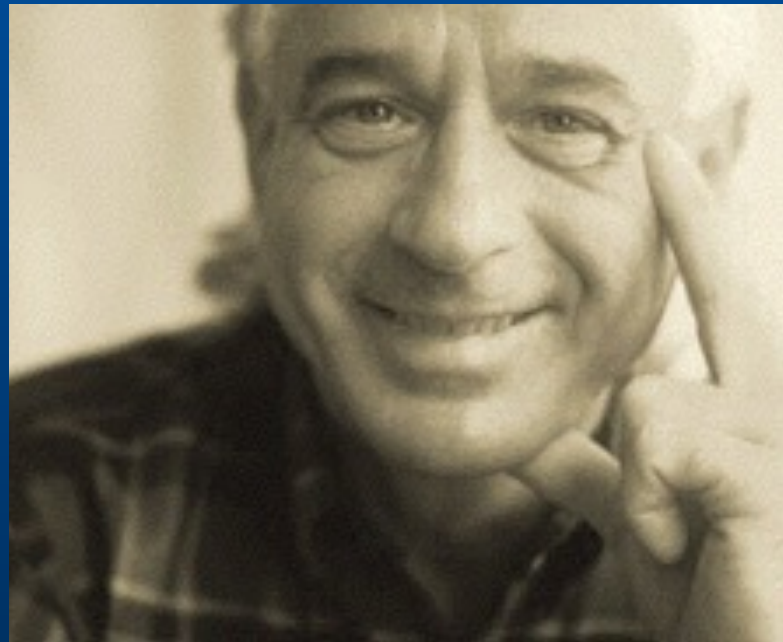
- Education and prevention
- Outreach
- Screening, referral, intervention, and treatment
- Service improvement through coalitions and teams



# Vision and Values for Improving Services

- Enhance independent functioning
- Aging in place
- Quality of life
- Home and community-based alternatives
- Integrated care
- Quality medical care
- Rehabilitation
- Recovery
- Access to mental health services (parity) and needed medications (drug benefit)
- Aging with dignity
- Support of meaningful activities
- Community integration
- The "right" to evidence-based treatments

# Improving Mental Health Services for Older Americans



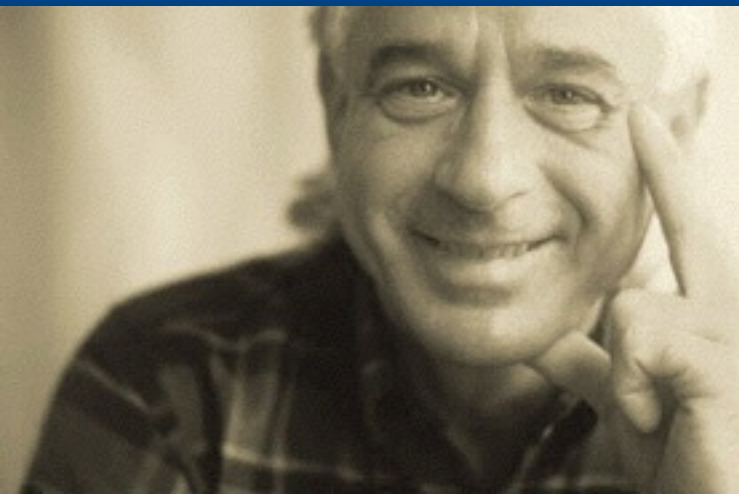


# **Priority Policy Areas for Mental Health and Aging**



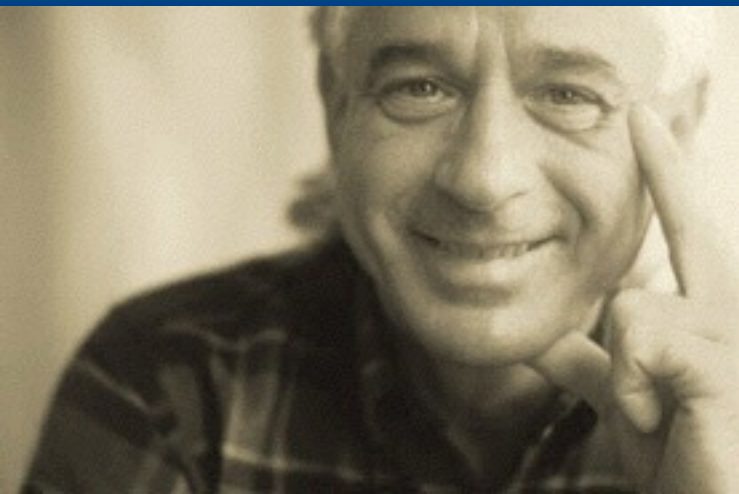
# Medicare Mental Health Parity and Prescription Drug Benefit

Urge federal legislative action on Medicare mental health parity and a Medicare Pharmacy benefit



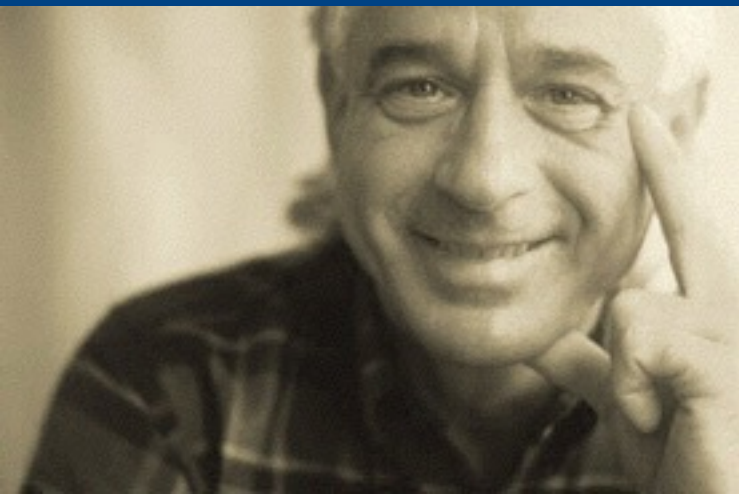
# Integrated Mental Health Services in Primary and Long-term Care

- Waivers supporting integrated mental health in primary and long-term care
- Extend Medicare-covered care planing and case management to community settings



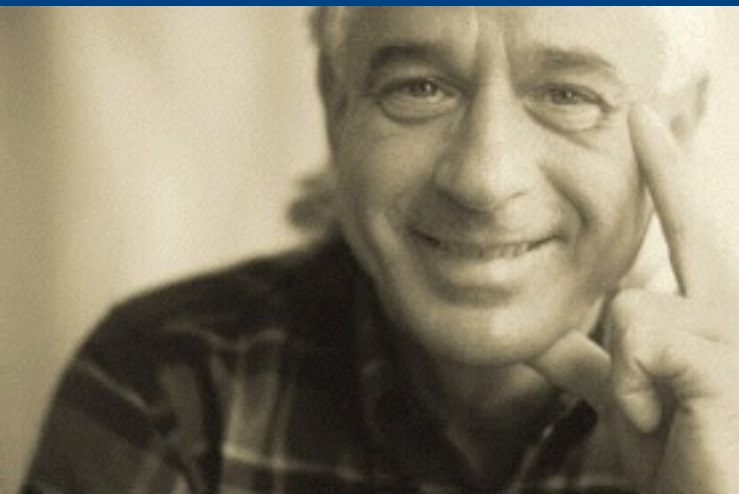
# Multidisciplinary Outreach and Wraparound Services

- Waivers supporting multidisciplinary community outreach and wrap-around service teams to prevent nursing home placement



# Implementation of Evidence-based Mental Health Practices

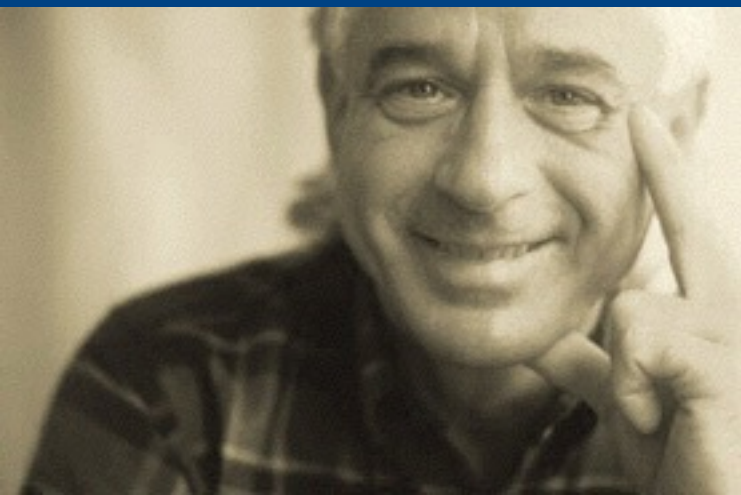
- A National Initiative to Disseminate and Implement Evidence-based Mental Health Practices for Older Persons (SAMHSA, NIMH, AHRQ)



# Reduce Stigma and Other Barriers to Mental Health Care

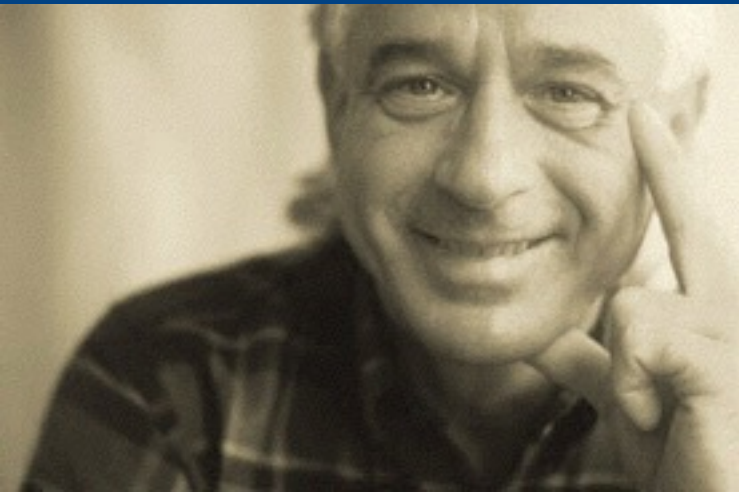
- HHS Public Education Campaign:  
Reduce Stigma, Prevent Suicide, Identify and Treat Late Life Depression

- Develop Culturally Competent Services



# Increase workforce with training in treatment of older persons

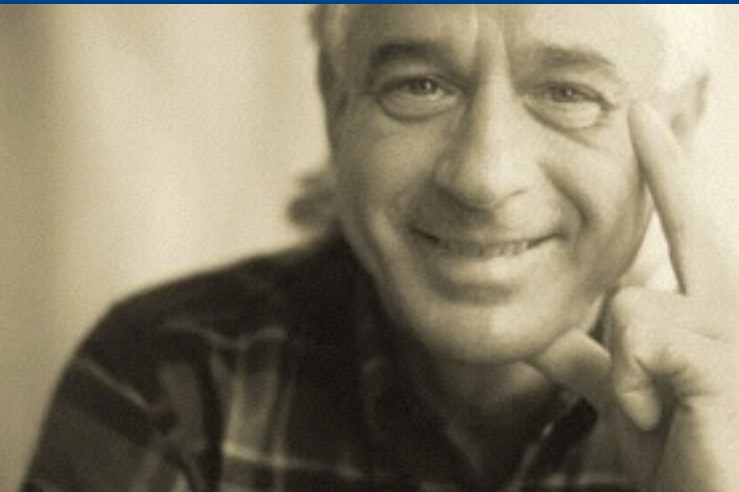
- Federal Study of Geriatric Health Workforce Needs
- Nurse Training Programs
- Loan repayment and Limit Exemption for Geriatric Residency Training Programs



# Enhanced Caregiver Mental Health and Support

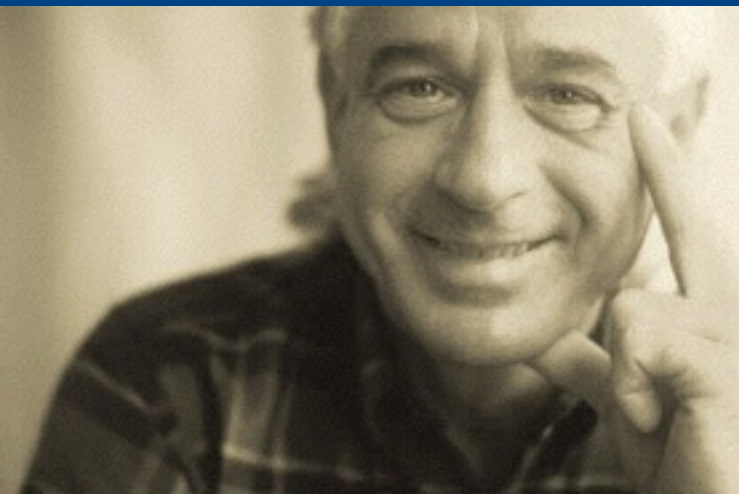
- AOA-funded caregiver support services to include screening for depression and other mental disorders

- Include mental health services as a priority for caregiver support services



# Prevention

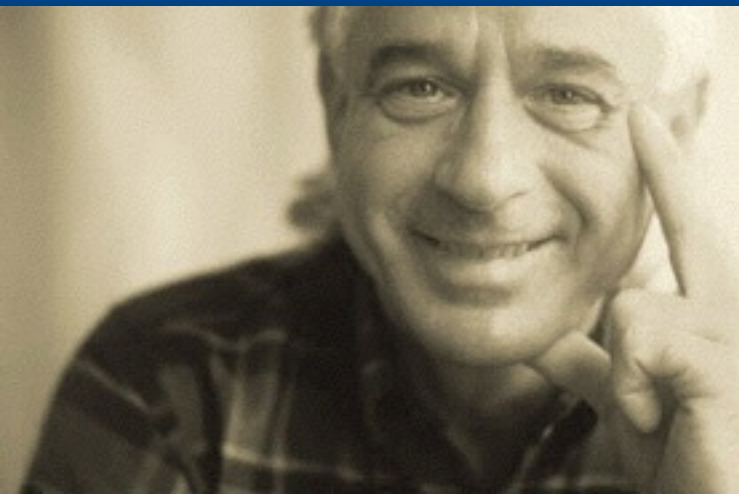
**Prevention of late life depression, suicide, and alcohol and medication misuse as a priority for HHS and CDC prevention programs**





# Enhance Research on Mental Health and Aging

- Designate mental disorders of aging as a priority at NIMH, CMHS, CSAT, CSAP, AHRQ
- Designate an office for oversight of mental disorders of aging research
- Require federally funded grants to address inclusion of persons age 65 and older





# The Calling and the Opportunity

**“ The opportunity to address these critical challenges is before us. If we hesitate, our service delivery systems will be strained even further by the influx of aging baby boomers and by the needs of underserved older Americans.”**

Administration on Aging, 2000



**“Above all, now is the time to alleviate the suffering of older people with mental disorders and to prepare for the growing numbers of elders who may need mental health services.”**

**Administration on Aging, 2000**



**“The capacity of an individual with mental or behavioral problems to respond to mental health interventions knows no end-point in the life cycle.**

**Even serious mental disorders in later life can respond to clinical interventions and rehabilitation strategies aimed at preventing excess disability in affected individuals.”**

**C Everett Koop, Surgeon General’s Workshop Health Promotion and Aging, 1988**