

MEETING THE MENTAL HEALTH CHALLENGES OF THE ELDER BOOM

By

Michael B. Friedman

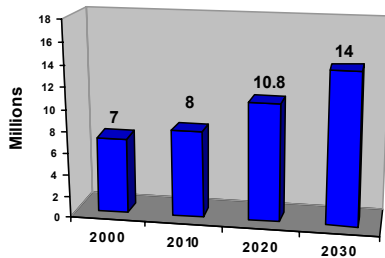
Chairperson, the Geriatric Mental Health Alliance of New York

ALLIANCE FORMED IN RESPONSE TO URGENT NEED

The Center for Policy and Advocacy of the Mental Health Associations of New York City and Westchester formed the Geriatric Mental Health Alliance of New York in January 2004 after a series of discussion groups with over 100 providers from the fields of mental health, health, and aging services as well as researchers, academic leaders, advocates, consumers, and public officials. These meetings revealed vast inadequacies in current geriatric mental health practice and policy and a widespread sense of alarm about lack of readiness to meet the mental health challenges of the coming elder boom.

A POPULATION BOOM

Projected Growth of 65 and Over Population with Mental Disorders: 2000 to 2030

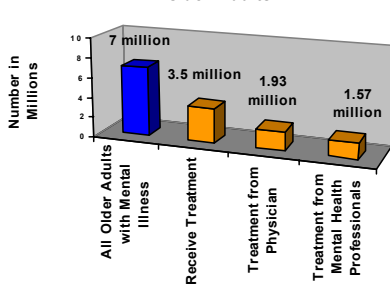


The massive growth of the population of older adults that will take place over the next quarter century has fueled great concern about the future solvency of the Social Security system and of Medicare. Less noticed is the fact that approximately 20% of older adults have

diagnosable mental disorders in any given year and that, accordingly, as the population of adults 65 and older grows from 35 million to 70 million, the number of older adults with mental disorders will grow from 7 million to 14 million. Will services be available to meet their mental health needs?

REASONS FOR CONCERN

Treatment for Mental Illness Among Older Adults



There are reasons for concern. The current system does not do enough to help older adults with mental disorders to remain in the community. It does not provide adequate access to services. Generally services are not designed to respond to the unique needs of older

adults. Mental health, health, and aging services are excessively fragmented. There is limited capacity to serve cultural minorities, who will grow from roughly 15% of the elderly population to over 25%.

In addition, fewer than 25% of older adults with mental disorders get treatment from mental health professionals. An additional 25% get treatment from primary care physicians, many of whom do not provide adequate care. The rest may get help from family, friends, clergy, and community organizations, but they do not get treatment. What will happen as the population doubles?

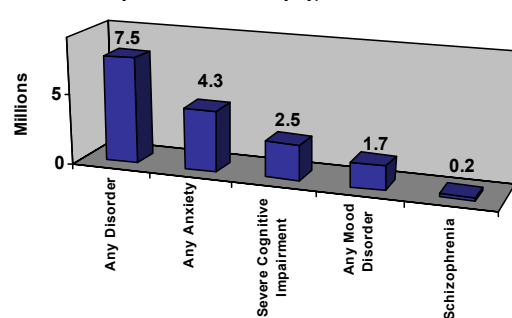
Were the size of the helping professions increasing at the same pace, things might not get worse. But in fact, as the proportion of Americans who are older increases, from 13% to 20%, the proportion of working age adults will decrease by 5%, creating a shortage of those who can help older adults in need.

Of course, the majority of older adults are between the ages of 65 and 75. Most are healthy and have abilities that they can use to help other people. With creative planning, they can become part of the solution rather than part of the problem.

A HETEROGENEOUS POPULATION

When most people think about mental disorders among the elderly they think of either depression or dementia. While these are common disorders of old age, the sorts of mental disorders that affect older adults are much more diverse. It is particularly important to distinguish among (1) people with severe long-term psychiatric disabilities that began when they were young, and who are now aging, (2) people with mental disorders that began or were exacerbated in old age, and (3) people who have difficulty meeting the developmental challenges of old age, such as retirement and losses of family and friends.

Estimated Number of Adults 65 and Over in the United States Affected by Mental Disorders by Type of Disorder - 2005



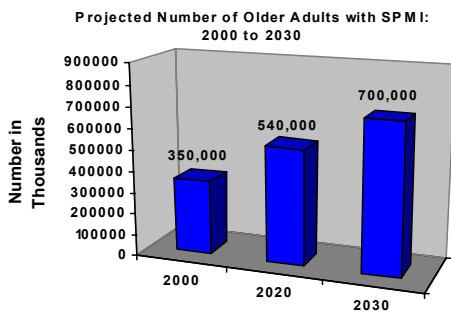
LONG-TERM PSYCHIATRIC DISABILITIES

People with severe long-term psychiatric disabilities have been the primary responsibility of the public mental health system for the past two centuries. Until about 50 years ago, our nation met this responsibility by putting people into institutions. Towards the middle of the 20th century, the United States adopted a policy of serving people with severe psychiatric disabilities in the community and using institutions only as a last resort.

During the first phase of the community mental health movement—"deinstitutionalization"—a few people who would have been in institutions, did well. But most were dumped in the community without adequate services or were taken in by their families, who were not provided with supports to help them manage.

In the late 1970s the nation shifted to a policy of community support and began to make housing, rehabilitation, and case management available while also expanding outpatient treatment services and shifting towards the use of psychiatry units in general hospitals instead of state psychiatric hospitals.

Although still incomplete, the community support movement has made a decent quality of life possible for hundreds of thousands of people with long-term psychiatric disabilities. However, the vast majority of its services are designed for working age adults, and they will need to be redesigned as this population becomes old.



Actually, the first concern needs to be assuring that people with serious mental illnesses live long enough to become old. The life expectancy of people with serious mental illnesses is 10 years less than the general population. The reasons for this appear to be their

increased risks of (1) poor health—especially obesity, high blood pressure, diabetes, and cardiac and respiratory diseases, (2) accidents, and (3) suicide. It is therefore critical to improve medical care for people with serious mental illness and to develop approaches to prevent accidents and suicide.

Even without an increase in life expectancy, the population of older adults with long-term psychiatric disabilities will probably grow from about 350,000 people nationwide to 700,000 (150,000 more than the total population in state hospitals in the United States at their peak use in the mid-1950s.)

To avoid unnecessary institutionalization of older adults with long-term psychiatric disabilities, the current community support systems will need to be adapted to take into account changes due to aging. For example, people with long-term psychiatric illnesses are also prone to the physical illnesses common in old age. Therefore, linking health and mental health services will be increasingly important as this population ages. In addition housing programs will need to provide more assistance with medication management and with activities of daily living than they do for younger adults. And rehabilitation programs, which are now heavily oriented towards work, may need to be more oriented towards "retirement" in order to respond to the developmental needs of older people.

LATE LIFE MENTAL DISORDERS

Mental disorders that develop or are exacerbated in later life range from the profoundly disabling to the merely distressing.

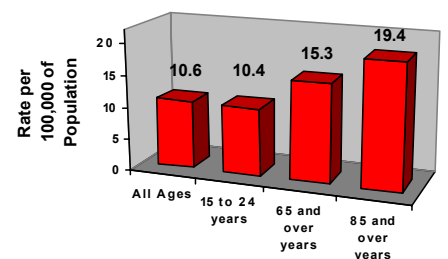
At the more severe end of the spectrum are the dementias—which affect 6-7% of people over the age of 65, but which increase dramatically as people age. The prevalence of dementias doubles every five years beginning at age 60. Many people with dementia also develop anxiety and/or depressive disorders; sometimes treating these disorders reduces cognitive impairment.

In addition there are psychotic conditions that develop in late life, including late-onset schizophrenia and paranoid conditions. Many of the behavioral problems which can make older adults difficult to serve such as distrust, refusal to adhere to treatment, belligerence, and social isolation may reflect undiagnosed and untreated paranoid conditions. Such behavioral problems are major contributing factors to placement in nursing homes. Mental health services will, therefore, be key to current efforts to reduce the use of nursing homes and to provide home and community-based care instead.

The most common mental disorders of old age are anxiety and depression. Approximately 15% of older adults develop anxiety and/or major depressive disorders, which often contribute to severe social isolation and inactivity. These symptoms in turn often cause deepening anxiety and depression—a vicious cycle that is difficult to break.

Depressive disorders contribute to the high rate of suicide among older adults. Overall adults 65 and older are 50% more likely to commit suicide; this rises to 600% in white men 85 and older.

Suicide Rates of Specific Age Cohorts per 100,000 of population in the year 2000



Many people with anxiety and depressive disorders do not go to mental health professionals for help because of a sense of shame and embarrassment, because of ignorance about mental illness and effective treatment, and because they often cannot, or will not, leave their homes. For this population it is critical (1) that the mental health system be more mobile—that mental health professionals go to people in their homes and community settings where they are comfortable rather than waiting for them to come into the office and (2) that there be better linkages between mental health and both primary health care and home health care providers.

Substance and alcohol abuse also frequently develop late in life. The percentage of heavy drinkers among older adults has been estimated at as high as 16%. Moreover, certain physical changes associated with aging (increased blood-brain barrier permeability, decreased capacity for homeostatic regulation) tend to exacerbate the impact of alcohol use. The misuse of prescription drugs is also a significant concern. Older adults use prescription drugs nearly three times as often as the general population and studies suggest that misuse is extremely common. The most frequently abused prescription drugs include opioids, benzodiazepines and sedative hypnotics. Currently very few older adults use illegal drugs, but that number could increase as the generation of “drugs, sex, and rock and roll” becomes elderly. Substance abuse among older adults typically occurs in a unique psychosocial context, which requires targeted intervention and treatment.

DEVELOPMENTAL CHANGES LATE IN LIFE

Becoming old involves many changes in social roles, abilities, and relationships including retirement, loss of status and respect, caregiving responsibilities for very old parents or for grandchildren, decline of physical and/or mental abilities, increasingly frequent deaths of family and friends, and preparing for one’s death.

Although the developmental challenges of old age do not usually result in a diagnosable mental disorder, they do often stir up considerable emotional distress, for which people can get help. In addition, prevention of developmental distress may be possible through such activities as retirement planning, family life education, and changes in lifestyle. Because spiritual interest often is magnified as people confront the inevitability of death, linkages between mental health providers and the clergy can be extremely helpful.

CHRONIC PHYSICAL CONDITIONS

Older adults with mental disorders almost always also have chronic physical conditions—for three reasons. (1) Most older adults develop chronic physical conditions such as hypertension, arthritis, diabetes, etc. People with mental disorders are at least equally susceptible to the frailties of old age. (2) Some mental illnesses create greater risks of developing physical conditions. For example obesity, high blood pressure, diabetes, and heart conditions are associated with serious mental illness. (3) Many physical illnesses have psychological correlates. People with cardiac disease,

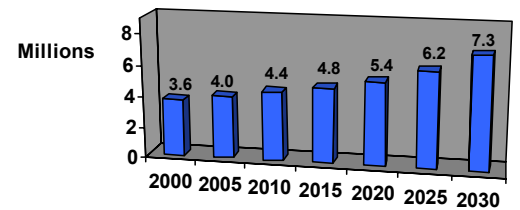
dementia, Parkinson’s Disease, and other serious illnesses are at greater risk of anxiety and/or depressive disorders and of cognitive impairment, sometimes of psychotic proportions.

For this reason integrated treatment of health and mental health conditions becomes increasingly important as people age. This can be done in several ways: (1) incorporate mental health professionals into primary care practices, (2) enhance the ability of primary care providers to identify and treat mental disorders, (3) incorporate mental health expertise into home health services, (4)

improve linkages between mental health and specialty services (5) provide telephone consultation (6)

incorporate health and mental health services in community settings such as senior centers and social service programs in naturally occurring retirement communities (NORCs), and (7) especially for people with long-term psychiatric disabilities, incorporate physical health care into mental health settings where they are already being served.

Projected Dementia Population by Year



FAMILY CAREGIVERS

Family caregivers are the major source of care and support for people with mental or physical disabilities, whether old or young. A study of family caregiving in 1997 estimated that the economic value of their services was nearly \$200 billion (the equivalent of about 18% of health expenditures in the United States that year.)

But the economic value of the caregiving does not begin to measure how much family caregiving adds to quality of life.

In the context of the needs of older adults, we tend to think, of course, about the care provided by younger family members for older family members. And this is indeed critical.

But we need also to be aware that older family members provide considerable care for younger family members. Older adults with grown children with long-term psychiatric or developmental disabilities frequently provide care until they become too disabled to do so or die. In addition, grandparents raising their grandchildren have become increasingly common in the United States.

Caregiving takes its toll on the family members who provide it, increasing their risk of anxiety and/or depression and of physical illnesses. Therefore, support for family caregivers needs to be included as a core component of any service system designed to meet the mental health needs of older adults.

PROBLEMS OF ACCESS

Many older adults with mental disorders or their families encounter difficulties getting service because (1) services are in short supply, (2) they cannot afford them, (3) they cannot travel to places where services are provided, and (4) service providers cannot speak their language or otherwise understand their culture.

IGNORANCE, STIGMA, AND AGEISM

In addition older adults, their families, and their primary care physicians frequently choose not to seek mental health services. In part this reflects ignorance about what mental illness is, that it can be treated effectively, or where to go for treatment. In part this reflects a denial of mental illness rooted in a sense of shame and embarrassment. And in part their choice reflects ageist assumptions common to our society—beliefs that, for example, depression or severe cognitive decline is a normal part of aging, which they are not.

A WORKFORCE SHORTAGE

There is a substantial shortage of mental health professionals who are trained to serve older adults. To address this shortage there will need to be incentives to become geriatric mental health

professionals, better education in professional schools, and on-the-job training initiatives.

However, it is extremely unlikely that there will ever be enough geriatric mental health professionals. It will be necessary, therefore, to make innovative use of paraprofessionals

and volunteers, especially of people who are themselves old, but who can become an important part of the workforce serving older adults with mental health problems. Clergy also can play a useful role.

RESEARCH

The greatest hope for being able to meet the mental health needs of the elder boom population is a major breakthrough in research. Unfortunately there has not been a substantial investment in

research regarding geriatric mental illness nor has there been an adequate effort to translate what is known from research into practice. To address these shortfalls, the federal government should develop a long-term plan for research regarding geriatric mental health, and NYS should encourage its research institutes to focus more efforts on this area.

FINANCING PROBLEMS

Financing problems are a major cause of underservice of older adults with mental disorders. These problems relate not only to the inadequate amount of funding that is available but also to a number of structural problems.

In general, current funding models do not support the use of best practices and innovative services and do not promote integrated service delivery.

Specific issues include:

- The use of only a fee-for-service, medical model for reimbursement by Medicare and private insurers
- Lack of equal coverage of health and mental health conditions (“parity”) by Medicare and private insurers
- Lack of a reasonable rate for home and community-based services among all payers
- Restrictions on the expansion of mental health programs that use Medicaid as a source of support
- Inadequate prescription drug coverage.

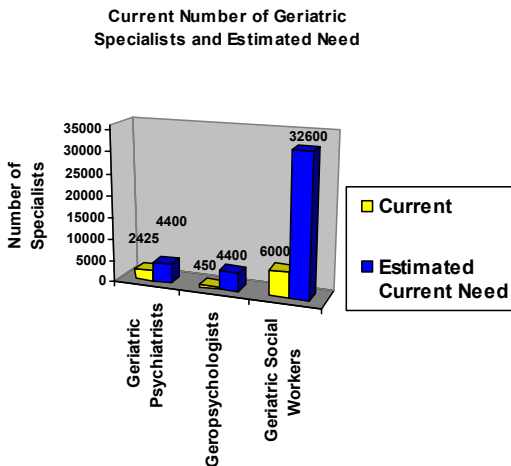
NEED FOR GOVERNMENT PLANNING

Some progress has been made in gaining recognition of the importance of geriatric mental health issues. For example, the Federal Administration on Aging issued a major report on geriatric mental health a few years ago, and the Substance Abuse and Mental Health Administration (SAMHSA) has established a section on geriatric mental health and has begun to give grants. In New York State, the legislature and the governor have taken major first steps by enacting the Geriatric Mental Health Act, which establishes an Interagency Geriatric Mental Health Planning Council and a services demonstrations grants program.

But much remains to be done to improve the quality of services currently provided and to confront the mental health challenges of the elder boom. And it will take ongoing commitment from federal, state, and local governments to meet these challenges.

To join the **Geriatric Mental Health Alliance of New York** please call (212-614-5753), fax (212-529-1959) or email (center@mhaofnyc.org) with your:

- Name
- Title
- Organization
- Address
- E-mail Address
- Phone Number



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