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WORKFORCE DEVELOPMENT TO MEET THE MENTAL HEALTH NEEDS OF OLDER ADULTS

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Abstract

The growth of the older adult population with mental disorders over the next quarter century creates great workforce development challenges with regard to both the size of the workforce and its clinical and cultural competence. At the request of the New York Southern Area Aging Network (NY-SAAN), The Geriatric Mental Health Alliance convened a "caucus" to identify key geriatric mental health workforce development challenges and to develop recommendations to meet these challenges. The Caucus noted workforce development needs not just with regard to mental health providers but also with regard to service providers in the health and aging systems and in the community settings such as houses of worship and elder law practices. The Caucus also noted that building a workforce of adequate size and competence is extremely complicated and will necessarily be a multi-year endeavor. It recommended that this effort begin with the establishment of a Center for Excellence in Geriatric Mental Health that would, over time, address a broad range of needs including developing clinical and cultural competence, increasing the size of the workforce, and developing policy recommendations regarding how to overcome a broad range of barriers to building a workforce capable of meeting the mental health challenges of the elder boom. The Caucus also recommended that efforts begin immediately to draw on the strengths of retired people to create opportunities for elders to help elders with mental health problems.

BACKGROUND

- The growth of the older adult population with mental disorders over the next quarter century presents many challenges including access to services, the quality of those services, the need for service integration, and workforce development.

- Currently service capacity is too limited, access to services is too difficult, quality is exceedingly uneven, service integration is the exception rather than the rule, and the workforce is both too small and too poorly trained to meet the mental health needs of older adults

- These problems are likely to become even more serious over time because of the growth of the population of older adults in both numbers and proportion of the population.

- Over the next 25 years, the number of older adults will double from 35 million to 70 million,[1] and the number of older adults with mental and/or substance abuse disorders will grow from 7 million to 15 million[2].

[1] U.S. Bureau of the Census. (2000). Population projections of the United States by age, sex, race and hispanic origin: 1995-2050, *Current Population Reports*, P25-1130.

- In addition, the proportion of older adults will increase by 7%, and the proportion of the working age population will decrease by 5%.[3]

- It is these demographic shifts that drive our nation's concerns about the future viability of Social Security and Medicare.

- They should also raise alarms about who will provide the support and care that older adults with disabilities will need.

- Here is just a glimpse of the current and pending shortage among geriatric mental health professionals:

    - There are roughly 2,425 geriatric psychiatrists with an estimated current need of 4,400 and a pending need of 8,840. There are only 450 geropsychologists with an estimated current need of 4,400 and a future need of 8,840. As for geriatric social workers, there are only 6,000 nationwide with a current need of 32,600 and a future need of 65,480.[4] [5] In addition, only 640 psychiatric nurses have a sub-specialization in geriatrics.[6]

- Shortages exist in the private sector as well as the public sector. Even very wealthy people find it difficult to find qualified geriatric mental health professionals.[7]

- In addition to addressing the shortage of mental health providers, it is critical to address problems of quality. Many mental health providers are not clinically and culturally competent to serve the geriatric population. For example, The National Co-Morbidity (NCS-R) prevalence study conducted in 2000 revealed that for all populations mental health professionals provide minimally adequate services less than 50% of the time.[8] It is likely to be less for older adults because so few mental health professionals have special geriatric training.

- Working effectively with older adults with mental, behavioral, or substance abuse problems differs in several important ways from working with younger adults. It often requires more intensive management, including regular communication with caregivers and more coordination of treatment with medical professionals. It also

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[2] Gallo, J.J., & Lebowitz, B.D. (1999). The epidemiology of common late-life mental disorders in the community: Themes for the new century. *Psychiatric Services,* 50, 1158–1166.
[3] U.S. Bureau of the Census. (2000). Population projections of the United States by age, sex, race and hispanic origin: 1995-2050, *Current Population Reports*, P25-1130.
[4] Halpain, M.C., et al. (1999). Training in geriatric mental health: Needs and strategies. *Psychiatric Services*, 50 (9), 1205-1208.
[5] Jeste, D.V., et al. (1999). Consensus statement on the upcoming crisis in geriatric mental health. *Archives of General Psychiatry*, 56, 848-853.
[6] The Annapolis Coalition on the Behavioral Health Workforce. (2007). *An action plan for behavioral health workforce development*. Author. p. 205.
[7] Abrams, R.C., & Young, R.C. (2006). Crisis in access to care: Geriatric psychiatry unavailable at any price." *Public Health Reports,* 121, 646-649.
[8] Wang, P.S., et al. (2005). Twelve month use of mental health services in the United States. *Archives of General Psychiatry*, 62, 629-640.

requires an understanding of the physical and mental declines that are common as people age. Which are unavoidable? Which can be reversed with changes in lifestyle or good treatment? It is also critical to understand the major developmental changes older adults experience.

- Because a spectrum of social problems also contributes to the onset and maintenance of mental health problems,[9] these problems tend to co-occur, with many older adults carrying significant psychosocial burden. As a result, those who work with older adults with mental disorders need to be able to also address social and economic issues.

- In fact the population of older adults with mental, behavioral, and substance abuse problems is a complex, heterogeneous population including:

    - People with long-term psychiatric disabilities who are aging
    - People who become psychotic in old age—some transient, some recurrent, and some long-term
    - People who develop dementia
    - People with severe depression, anxiety, and/or paranoid disorders that contribute to high suicide rates, social isolation, and behavioral problems that increase the risk of placement in institutions
    - People with less severe (but quite painful) anxiety and/or depressive disorders
    - People with substance abuse disorders: almost entirely alcohol abuse or misuse of prescription or over-the-counter medications
    - People experiencing emotional problems making the transition to old age.

- It is exceedingly unusual for mental health professionals to have expertise in working with all these populations.

- It is also very unusual for mental health professionals to have expertise in the prevention, recognition, and treatment of physical disorders.

- This is important because people with mental illness generally are at elevated risk for physical illness.[10]

- People with serious mental illness are at extremely high risk for obesity, high blood pressure, diabetes, heart disease, pulmonary conditions, and more. Their poor health and the poor health care they generally receive are major contributors to their having a life expectancy that is 10-25 years lower than the general population.[11] [12]

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[9] Arean, P.A. & Reynolds, C.F. (2005). The impact of psychosocial factors on late-life depression. *Biol Psych,* 58, 277-282

[10] U.S. Department of Health and Human Services, (1999). *Mental health: A Report of the Surgeon General* Rockville, MD: Author.

[11] Dembling, B.P., Chen, D.T., & Vachon, L. (1999). Life expectancy and causes of death in a population treated for serious mental illness. *Psychiatric Services*, 50 (8), 1036-1042.

[12] Colton, C.W., & Manderscheid, R.W. (2006). Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing*

- Cultural competence will also become increasingly important over the next 25 years because the minority population of older adults will increase from 16% to 25%.[13] Currently there is a shortage of bilingual workers, translators prepared to interpret for people with mental health problems, and professionals and paraprofessionals with in depth understanding of the cultures of the communities they serve. In addition, inclusion of members of these communities in the lay and professional leadership of the organizations that serve them is rare.

- Improving clinical and cultural competence regarding older adults with mental or substance abuse problems is a challenge not just for mental health personnel.

- Many of the needs of older adults with mental health problems are addressed by professionals and paraprofessionals working in the health or aging systems. They are also addressed in a variety of specialized residential settings. In addition, older adults and their families frequently turn to lawyers and advocates for help regarding housing, entitlements, and issues of autonomy. And family caregivers are the primary source of care and support for older adults with disabilities who need help to remain in the community.

- <u>The Health System: Primary Care</u>

    - Most older adults who seek professional help for mental health problems go first to primary care physicians. Although some primary care physicians and geriatricians provide good mental health services, it is rare. According the NCS-R, primary care physicians provide minimally adequate care only 12.7% of the time.[14]

    - Other studies indicate that primary care physicians frequently fail to identify mental illness. For example, 70% of older adults who complete suicide have seen their primary care physicians within one month of taking their own lives. 30% have seen their physician with one week.[15]

    - In addition primary care physicians are likely to make errors in prescriptions, sometimes under-prescribing and sometimes over-prescribing.[16]

    - There are a number of evidence-based approaches to improving identification of mental illness or substance abuse[17] and to improving outcomes in the treatment of

Chronic Disease 3 (2), 1-14.

[13] U.S. Bureau of the Census. (2000). Population projections of the United States by age, sex, race and hispanic origin: 1995-2050, *Current Population Reports*, P25-1130

[14] Wang, et al. "Twelve Month Use of Mental Health Services in the United States: Results from the National Comorbidity Survey Replication." *Archives of General Psychiatry*. June 2005.

[15] Clark, D.C. (1992). Remarks at the *Too Young To Die Conference* on the National Suicide Survey.

[16] Jeste, D. V. et al. (1999). Consensus statement on the upcoming crisis in geriatric mental health. *Archives of General Psychiatry*, 56, 848-853.

[17] Bartels, S. et al. (2002). Evidence-based practices in geriatric mental health care. *Psychiatric Services*, 53 (11), 1419-1431.

depression by primary care physicians.[18] Screening instruments appear to be relatively easy to use and to not be inordinately costly. Improving treatment outcomes, however, requires the provision of care managers to follow up with patients in the community. This is costly, and it's not easy to fund.

- Other health services

  - Virtually all older adults with mental disorders have co-morbid physical disorders; and older adults with chronic health problems such as diabetes, heart disease, or neuromuscular disorders are at high risk for depression and/or anxiety.

  - Despite common co-occurrence of physical and mental disorders, most providers in the health system - home health workers, day program workers, and nursing home workers - are not trained to identify, refer, or to intervene effectively with older adults with mental health, substance abuse, and/or behavioral problems.

- Aging Services

  - Providers in the aging system, including senior centers, NORC-SSPs, social adult day programs, and Adult Protective Services are generally not knowledgeable about how to identify, refer, or intervene effectively with older adults with mental health needs.

  - Aging service sites have great potential as settings where screening and/or treatment can take place. Unfortunately, both are exceptions rather than the rule.

  - Linkages between aging services and health and mental health providers are also not common.

- Residences

  - Although most older adults live in their own homes or with family until the end of their lives, an increasing number are moving to specialized housing including subsidized senior housing of various kinds (often with on-site services), retirement communities, assisted living, and life care communities. Recent studies of assisted living facilities indicate that upwards of 2/3 of residents have mental and/or behavioral problems.[19] Some of these facilities make special provisions for people with dementia, but few—if any—make special provisions for residents with mental illnesses such as depression, anxiety, or paranoia. On-site staff are generally not prepared to work with these residents, who are either

[18]Oxman, T., Dietrich, A., & Schulberg, H. (2005). Evidence-based models of integrated management of depression in primary care. *Psychiatric Clinics of North America,* 28, 1061-1077.
[19] Rosenblatt, A. et al. (2004). The Maryland assisted living study: Prevalence, recognition, and treatment of dementia and other psychiatric disorders in the assisted living population of central Maryland. *Journal of the American Geriatrics Society*, 52 (10), 1618–1625.

referred out for treatment or purchase care privately from mental health professionals who come to their facilities.

- Community organizations and "gatekeepers"

  - Older adults also turn to helping figures in the community such as houses of worship, social clubs, etc. Personnel in these places also are generally poorly prepared to respond to older adults' mental health needs.

  - Older adults also have routine contact with many people who could be helpful by identifying those who may have mental health problems that should be professionally addressed. This includes primary care physicians (discussed above) but also policemen, people who deliver meals on wheels, mailpersons, etc. Studies indicate that training these "community gatekeepers" to identify signs of trouble and to contact designated service providers is an effective early intervention strategy[20] [21]. Three community gatekeeper programs were recently funded in NYS. Obviously, more would be helpful.

- Lawyers and advocates

  - Older adults and their families frequently contact lawyers for assistance with estate planning, entitlements, landlord-tenant disputes, guardianships, and more. They also sometimes turn to lay advocates to help them to get the services, benefits, and quality of care to which they are entitled.

  - Unfortunately, for people who cannot afford a lawyer in private practice, access to good legal representation or to lay advocacy can be quite limited.

  - In addition, elder care attorneys and advocates are frequently at a loss with regard to their clients' mental health problems.

- Informal caregivers

  - Informal caregivers (primarily family members) provide 80% of the care for older adults with disabilities. They generally are not knowledgeable about the role that is thrust on them by circumstance and their own good will. Many are stressed out by their responsibilities, and they are at high risk of depression, anxiety, and physical illness. Many "burn out" as caregivers and ultimately place their relatives in nursing homes before that is absolutely necessary.
- Elder care managers

[20] Substance Abuse and Mental Health Services Administration. (2002). Gatekeepers, Spokane, WA, in *Promoting older adult health: Aging network partnerships to address medication, alcohol, and mental health problems.* U.S. DHHS Publication No. (SMA) 02-3628. Washington, DC: Author. pp. 31-36.
[21] Buckwalter, K., Smith, M., Zevenbergen, P., & Russell, D. (1990). Mental health of the rural elderly outreach program. *The Gerontologist*, 31 (3), 408-412.

- Families who have enough money can turn to elder care managers for help. These professionals assist older adults to meet the full-range of their needs from decent living situations to getting entitlements to engaging in activities to getting needed physical and mental treatment. Usually they are social workers or nurses with a background in geriatrics. Frequently they have clinical training and experience as well.

- Although some not-for profit organizations provide elder care management at affordable rates, for the most part elder care managers are only available to people of means.

Care Coordination

- The complex needs of some older adults with mental disorders require appropriate care coordination. Care coordination is primarily for people with multiple, chronic conditions but also has great potential to be a prevention and maintenance service. It typically involves care plan development, coordination with a multi-disciplinary team of providers and others, medication management, and patient and family education. This will be part of the future of the long-term care system in NYS. However, there is a lack of an adequately trained workforce who can be 'care coordinators'

- Research

  - There is also a shortage of geriatric mental health researchers. And research about geriatric mental health has so far neglected a number of vital areas such as the treatment of paranoia (which often is a barrier to accepting help), the management of behavior problems that lead to premature placement in nursing homes, and a variety of psychosocial interventions that have emerged despite lack of research about them.

  - There is also a shortage of people who are skilled at translating research findings into practice in the real world.

Barriers to Having an Adequate Workforce

- Ageism

  - Participants in our workgroup on workforce development generally agreed that distaste about aging in our society discourages people in the helping professionals from choosing to work with older adults. They tend to think of old age as a hopeless stage of life when little can be done to help people to overcome the frailties of mind and body or to help them to lead satisfying and meaningful lives. They also view the field as one that is unrewarding and depressing to work in.

- Systems Structure

- Effective work with older adults often entails integrating mental health, physical health, and aging services, which is very difficult to do because our service systems are organized without regard to the need for integration. Regulations, funding structures, methods, and even goals differ from system to system, creating obstacles to integration; and there are no incentives to enhance collaboration.

- In addition, education and training of personnel are geared to the dominant goals and methods of each service system. There is little time for additional training, and cross-training is, therefore, exceedingly difficult to arrange.

- Finance

  - There are financial *dis*incentives to work with older adults with mental disorders.

  - Medicare generally pays 50% for mental health services and 80% for physical health services. There are opportunities to get the 80% for some limited mental health services, but providers are generally not knowledgeable about these opportunities.

  - In addition, Medicare does not permit enrolled providers to charge more than the Medicare rate even for patients who can afford more. As a result, providers who are in high demand often drop out of the program and charge higher rates for patients who pay for themselves.

  - Medicaid also creates obstacles. For example, lack of a special rate for home visits creates an incentive to focus on office-based practice. In addition, NYS's Medicaid neutrality cap* may limit program expansion.

- Direct care workers, including home health aides, and nursing home aides, are not paid adequate wages. This contributes to reliance on people with limited education and to high staff turnover—a major problem.

- Educational Limits

  - Professional education for physicians, nurses, psychologists, and social workers includes little regarding older adults, let alone geriatric mental health. Continuing education for these professions is also lacking regarding geriatric mental health.

  - Paraprofessional education also lacks content regarding how to identify mental health problems among elders and how to make a referral for treatment.

* "Medicaid neutrality" means that new programs that rely on Medicaid will not be approved unless there will be no overall growth of Medicaid expenditures by NYS or the state formally decides to spend more on Medicaid for this program.

- Immigration Limits

  - Immigrants provide a very large portion, if not most, non-professional health care services and a rapidly increasing proportion of professional services—especially nurses.

  - Current limits on immigration and the possible crackdown on illegal immigration could result in an increasing shortage of home health, nursing home, hospital, and other workers.

  - Conversely a loosening of immigration policy so as to attract both professional and non-professional workers could go far to ease the growing shortage of working age adults in this country.

- Failure to Use Older Adults to Help Older Adults

  - Contrary to popular perception, most older adults are healthy (despite minor chronic illnesses) and able (despite some diminishment of physical and mental skills over time.) There are a great many people—especially those 65 to 75—who have invaluable experience and remarkable strengths and who want to find meaningful activity after they retire. Some are professionals who would like to work part-time. Some are people without experience in helping vocations who would like to help others now that they are retired.

  - The Metlife Foundation/Civic Ventures New Face of Work Survey shows that the majority of older adults interested in working after retirement want to pursue careers of service, but many think it would be difficult to find such a job.[22]

  - This population is a great potential resource—potentially a big portion of the workforce of the future—but little has been done to marshal them into a workforce. New roles have not been created nor have new work-rules that would provide the flexibility that many older adults want after they retire.

Workforce Development Recommendations

[22] MetLife Foundation/Civic Ventures. (2005). *New face of work survey*. San Francisco: Author.

Developing an adequate workforce to meet the mental health challenges of the elder boom is a vast and complex undertaking. We strongly recommend as a first step that New York State establish a Center for Excellence for the Development of a Competent Geriatric Mental Health Workforce. We also recommend that efforts begin immediately to draw on the strengths of retired people to create opportunities for elders to help elders with mental health problems.

The Center for Excellence Would:

- **Provide training** to improve the clinical and cultural competence of the current workforce of mental health, health, and aging services and other personnel who provide assistance to older adults with mental health problems.
- Seek to **influence professional education**.
- Develop and disseminate approaches to **recruitment and retention.**
- Foster the widespread **development of family psycho-education and support.**
- Lead the **development of a workforce of older adults** prepared to serve older adults with mental health problems especially by developing new roles for paraprofessionals and volunteers.
- Develop **recommendations for policy changes** needed to overcome barriers to workforce development including:
  - Structural changes
  - Legal and regulatory changes
  - Finance policy changes
  - Addressing ageism
  - Changes in immigration policy

Below are some specific recommendations that emerged from the caucus process.

How to Improve the Clinical and Cultural Competence of Providers

- General Recommendations

  - Provide training and technical assistance to implement state-of-the-art practices in the real world
  - Promote improved professional and paraprofessional education
  - Encourage the creation of a designated amount of geriatric mental health training into the CEU requirements of licensing boards & professional organizations
  - Provide training and technical assistance to promote integrated service delivery
  - Provide mental health training that includes teaching about the range of psychosocial problems older people confront
  - Promote the use of non-traditional mental health services especially outreach and service delivery in the home and in community locations such as senior centers and NORCs

- Promote the development of formal or informal local networks
- Establish local learning collaboratives to support innovation
- Establish comprehensive information and referral services regarding older adults
- Provide training in cultural competence
- Recruit bilingual and minority staff
- Create promotional and leadership opportunities for minority staff.

- Recommendations for Mental Health Professionals:

  - Develop training programs on working with older adults and on the use of evidence-based, promising, and innovative mental health, substance abuse, and behavior management practices.

  - Also provide training regarding health maintenance and the management of physical illness in people with mental illnesses.

- Recommendations for Mental Health Programs

  - Licensed mental health clinics that serve older adults should recruit staff with expertise in serving older adults and/or provide specialized training in geriatric mental health to some of its clinical staff. These staff should also have some expertise regarding the health needs of older adults.

  - Licensed and unlicensed mental health day programs should develop services and activities that are developmentally appropriate for older adults and which are responsive to their health needs. Staff with relevant expertise should be recruited and/or specialized training in geriatric mental health should be provided to some of the professional and paraprofessional staff.

  - Licensed and unlicensed mental health housing providers should develop residential models for older adults with serious and persistent mental illness. Staff with relevant expertise should be recruited and/or specialized training in geriatric mental health should be provided to some of the professional and paraprofessional staff.

- Recommendations for Providers in the Aging System:

  Providers in the aging system are quite diverse including senior centers, information and referral services, NORC-SSPs, adult protective services, case management, senior housing providers, and more. Each of these service types needs to be able to respond appropriately to the mental health needs of older adults. To do so they should:

  - Include mental health training in the general training programs for aging services personnel. This should include information about:

- Engaging effectively with older adults with mental disorders
- Screening for and identifying mental disorders
- How to make an appropriate referral

In addition many aging services providers need to be able to work directly with older adults with mental disorders. It is not reasonable to expect all senior service workers to be skilled at this. Therefore, we recommend that aging services providers instead

- Develop cadres of personnel with the disposition and the special training needed to work with older adults with mental, substance use, or behavioral problems.

- <u>Recommendations for Providers in the Health System:</u>

  - Include mental health training in the general education and training programs for health care personnel. This should include information on screening, referral, and collaboration targeted to the various providers including those in primary care, home health, adult medical day, adult homes, assisted living, and nursing homes.

  - Train primary care providers to screen for depression and other mental illnesses in primary care and encourage them to use care managers for those diagnosed with depression

  - Develop cadres of home health personnel with special training to work with older adults with mental, substance use, or behavioral problems

  - Promote the development of a "recovery" orientation in adult medical day care

  - Promote collaboration between on-site mental health staff and adult home staff

  - Provide training regarding screening for depression and other mental illnesses in assisted living and regarding referral and intervention

  - Provide unit-based mental health training and consultations for all levels of staff in nursing homes

- <u>Recommendations for Helping Figures in the Community:</u>

  - Develop training programs on recognizing and screening for mental disorders as well as on how to connect to appropriate mental health services

  - Establish community gatekeeper programs

- Recommendations for Elder Lawyers and Lay Advocates

  - Provide training for elder lawyers and lay advocates regarding mental health

  - Provide training for service providers and family members regarding the law and how to access competent legal services

  - Train elder lawyers and lay advocates on the one hand and service providers on the other to enhance linkages between advocacy and service provision.

- Recommendations for Informal Caregivers

  - Provide psycho-education

  - Provide support for family and other informal caregivers including respite, education, training, mental health treatment, support groups, and tax policy

  - Build respect for family caregivers among formal caregivers

How to Recruit and Retain Staff

- Provide incentives to become geriatric mental health, health, and social service professionals and paraprofessionals as well as geriatric mental health researchers, especially for people who are bilingual and bicultural. This could include:

  - Scholarships
  - Loan forgiveness
  - Higher compensation
  - Career ladders
  - Intellectual stimulation
  - Enhanced value of the work

- Develop initiatives to improve education in professional schools of medicine, nursing, social work, and psychology to provide better general education about geriatrics and to provide more specialized courses on geriatrics.

- Develop initiatives in paraprofessional schools to improve basic education about aging and mental health.

- Provide peer support groups and networking activities for paraprofessionals so as to alleviate some of the stress of the caregiving role

- Provide mentors for students who show an interest in working with older adults. Mature professionals would pair with students and provide them with advice, work experience, networking contacts, and access to good jobs

- Counter ageism and build a better image about working with older adults

How to Develop Roles for Older Adults and for Volunteers

- Develop a cadre of retired professionals with job sharing opportunities to permit part-time and part-of-the-year work

- Establish initiatives to develop roles for paraprofessionals, including peers and family members, to take over some of the current functions of professionals under professional supervision, i.e. unbundle current roles

- Develop peer-to-peer initiatives

- Promote and enhance volunteer roles for older adults. Roles could include friendly visitors**,** telephone support**,** respite**,** peer counselors**,** peer medical care managers, etc.

- Develop mechanisms for older adults to be trained as professionals

How to Improve Research and Translation of Research into Practice

- Increase research to foster the development of evidence-based practices, particularly with regard to mental conditions and psychosocial needs for which evidence-based practices currently don't exist

- Develop partnerships between researchers and service providers to improve translation of research into practice and to foster research that will be useful in the field

How to Address Financial Disincentives

- Provide higher compensation for direct care workers

- Develop training programs and technical assistance initiatives around Medicare optimization for mental health services

- Advocate for Medicare reform

- Advocate for changes in Medicaid

- Advocate for changes in commercial coverage—especially full parity

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