The Impact of the Older Adult Mental Health Workforce Shortage on the Public Mental Health System

The number of older Americans is growing rapidly and will continue to do so in the future. The workforce needed to address the behavioral health needs of older adults is not adequate today and is projected to be even worse as time goes by. The Institute of Medicine of the National Academies (IOM) Report, *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands*?, (2012) put it bluntly that *"The workforce is not prepared—in numbers, knowledge, and skills—to care for the mental health and substance use needs of a rapidly aging and increasingly diverse population."* In 1999 the *Mental Health: A Report of the Surgeon General* said this workforce issue would "…become a major public health problem in the near future…" The NASMHPD Older Persons Division (OPD) believes that the near future envisioned in that report has arrived. The OPD realizes that solving the older adult behavioral health workforce shortage is a complex issue beyond what the public mental health system can address alone. Addressing the workforce problem will require the sustained efforts of multiple federal agencies, professional organizations, state agencies, academia, insurance companies, etc. The purpose of this paper is to summarize the current landscape and to offer recommendations on how the public mental health system can respond to the behavioral health needs of older adults while addressing the workforce shortage to the extent possible.

Two factors inhibiting progress are that not all federal agencies recognize older adults as being any different from other populations of adults ages 18-59 or even agree on the age at which one becomes an older adult. The *Older Americans Act* considers anyone age 60 or over to be an older adult while Medicare and Medicaid use 65 and over. This makes data analysis across systems very difficult. The OPD uses age 60 and over to be consistent with Aging Network programs. The OPD and many other agencies and organizations see older adults as a distinct population requiring special attention. The following factors are cited in IOM Report as reasons why older adults should be considered as a special or separate population:

- The possible presence of other medical conditions, cognitive impairment, functional limitations, and/or multiple mental health or substance use conditions
- Frequent use of multiple medications for concurrent physical health or other behavioral health conditions
- Different goals of care and treatment and overall health care decisions
- Loss and grief are common among older adults

After the IOM issued the *Retooling for an Aging America: Building the Health Care Work Force* report in 2008, Congress quickly realized the focus of the report had been on physical health care and the workforce for older adult mental health and substance use disorders had received little attention. In response Congress commissioned the IOM to convene a committee of national experts in mental health and aging to study the issue and develop a report that included policy recommendations on how to address the workforce shortage. NASMHPD participated in an open meeting of the Committee in June of 2011 to present their views. The majority of the information contained in this paper comes from the IOM study and report unless otherwise noted in the text.

The Demographic Imperative

The aging of America, and particularly the aging of the Baby Boomers, has often been referred to as the approaching "Silver Tsunami." The Silver Tsunami has arrived and is gathering strength. Data from the U.S. Census Bureau estimates that the age 65 and over population increased from 13 percent to 14.1 percent of the total population between 2010 and 2013. The 2010 Census found that there were 40.3 million individuals 65 and over in the country and estimated that this population had grown to over 44.5 million by 2013. This trend is expected to continue and by 2030 it is projected that the 65 and over population will increase to 72.1 million (Vincent and Velkoff, 2010). Part of this increase is also a result of people living longer with individuals over 85 being the fastest growing segment of the population.

America is also becoming more diverse in terms of racial and ethnic composition. The IOM Report estimates that from 2010 to 2030, although the number of the older Caucasians will increase by 60 percent, their proportion of the total older adult population will decrease from about 80 percent to about 71 percent. During the same time period the number of African-Americans will increase by about 115 percent and the Hispanic-Latino population will increase by over 200 percent. The African-American percentage in the overall older adult population will increase from 8.5 percent in 2010 to 10 percent in 2030. The percentage of Hispanic/Latino older adults will surpass the number of African-Americans in the older adult population by increasing form 8 percent to 12 percent of the total U.S. population during the same time period.

The changing demographics will have a significant impact on older adult mental health and substance use care and treatment. The IOM Report estimated that nearly one in five (20 percent) of individuals age 65 and over in the United States has one or more mental health and/or substance use conditions. This translates to about 8 million older Americans currently having one or more such conditions with approximately 2 million having a serious mental illness. The study identified anxiety disorders, post-traumatic stress disorder (PTSD), bipolar disorder, depressive disorders, schizophrenia, and substance use disorders as the most prevalent conditions among older adults. Other conditions include behavioral and psychiatric symptoms of dementia, complicated grief, fear of falling, severe self-neglect, and suicidal ideation. Depressive disorders and behavioral problems secondary to dementia were identified as the most prevalent diagnoses among older adults. The use of illicit drugs, especially marijuana, is likely to increase as well as non-medical use of prescription drugs. Prescription drug abuse will continue as a major problem. Data also indicates that older veterans are at greater risk of developing mental health and/or substance use conditions than the general population.

Suicide is a major concern with older adults as evidenced in 2010 data from the CDC that the suicide rate for persons 65 and over is 14.9 per 100,000 compared to 12.4 per 100,000 for the general population. This rate actually gets worse as people age especially for men. The rate for males 75 and over is 36 per 100,000 and increases to 47.3 per 100,000 for Caucasian men age 85 and over which is the greatest risk for all age-gender-race groups.

According to the Administration on Aging (AoA), which is now part of the Administration for Community Living (ACL), *"It is estimated that only half of older adults who acknowledge mental health problems receive treatment from any health care provider, and only a fraction of those*

receive specialty mental health services." A study in San Diego (Palinkas et al.2007) that included interviews and focus groups with 66 consumers age 55 and over along with 99 mental health service providers, family caregivers, and other older adults identified the following factors why older adults don't seek mental health care:

- Stigma (63 percent)
- Lack of information about available services (50 percent)
- Lack of age-appropriate and culturally and linguistically appropriate services, including translators in mental health settings (44 percent)
- Lack of transportation to services (38 percent)
- Lack of money or insurance to pay for services (23 percent)

This is consistent with the findings in the IOM study. In data provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2008 only 5 percent of the 6.3 million people of all ages who received State Mental Health Agency (SMHA) operated or SMHA- funded mental health services were age 65 and older or about 315,000 people. Most of the individuals who are receiving care, which is usually medication, are getting it from primary care physicians who frequently have little or no training in mental health.

Workforce Challenges

One of the biggest challenges is determining who makes up the older adult behavioral health workforce. The IOM Report points out that the term "workforce" usually means "*…a cohesive, definable group of professionals, paraprofessionals, and others who are employed with a common purpose."* That definition really doesn't apply to the older adult behavioral health workforce since the majority of the services are not being provided by specialty providers. The American Geriatrics Society estimates that there are less than 1,800 geriatric psychiatrists in the country today and that number will reduce to about 1,650 by 2030. Geriatric psychiatrists are aging out of the field and the next generation is not coming along to take their place. The number of geriatric psychiatry fellowships is about the same as it was in the 1990s but more than half of these slots go unfilled each year. The status of geriatricians is about the same with just 7,500 in the country and only 149 of 362 available fellowships being filled in the 2011-2012 academic year. The status of geriatric psychologists is equally disturbing. The American Psychological Association (APA) estimates that only 4.2 percent of psychologists have a primary focus on geriatrics in their clinical practice. The IOM Report cites similar results with other professions identified as mental health specialty providers.

Reported data makes it clear that the idea of addressing the older adult mental health workforce shortage by training more specialty providers is not realistic. There is also little evidence that the change in Medicare to cover 80 percent of outpatient mental health services or the passage of the Mental Health Parity and Addiction Equity Act of 2008 has had any significant impact on the workforce shortage. Other factors frequently cited as reasons why the specialty provider workforce shortage exists include stigma associated with serving older adults, inadequate and complicated funding streams, outdated Medicare and Medicaid coverage policies, and the extra education and training required for certification. The location in which specialty providers choose to or actually practice is also an issue especially in rural areas where there are few such professionals.

If we accept that there is and will continue to be a current and future shortage of specialty behavioral health providers, then we must begin to view the older adult behavioral health workforce as much more inclusive and broader than a list of specialty providers alone. We suggest the older adult behavioral health workforce includes, but is not limited to:

- Primary Care Physicians
- Physician Assistants
- Nurses (RNs, LPNs, Advance Practice Nurses)
- Pharmacists
- Occupational and Physical Therapists
- Case Managers
- Board Certified Behavior Analysts
- Direct Care Workers including Certified Nurse Assistants (CNAs) and Psychiatric Attendants
- Home Health Aides
- Personal and Home Care Aides
- Peer Counselors and Peer Support Specialists
- Outreach workers
- SMHA Older Adult Specialists

The reality of this broader workforce makes it imperative that behavioral health professionals receive training in aging and that professionals in the field of aging receive training in mental health and addiction. Cross training and educational opportunities must be developed and/or expanded and made accessible. This needs to be a priority at both the state and federal level.

Federal Activities

There are numerous federal programs related to older adult mental health, substance use, and workforce development across multiple federal agencies, however, no single entity is responsible for oversight and coordination. The National Health Care Workforce Commission, established by the *Affordable Care Act*, would be a logical forum to address the issue but the Commission was not funded and has never met. There have been multiple instances when federal agency administrators were asked about older adult mental health issues and they responded that it wasn't their agency's responsibility and suggested another agency. "In Whose Hands?" remains an unanswered question.

The IOM Report asked the Secretary of Health and Human Services (HHS) to designate a responsible entity within HHS to take the lead for older adult mental health and substance use and to assume responsibility for coordinating the programs and services across all of the HHS agencies. The IOM Report also requested that the secretary ensure that all HHS agencies including AoA, AHRQ, CMS, HRSA, NIDA, NIMH, and SAMHSA assume responsibility for building the capacity and facilitating the deployment of the mental health and substance use workforce for older Americans. As of August 2014 none of these recommendations have been addressed.

Funding Opportunities

It is a major concern that while the number of older adults with mental health and/or substance use conditions is rapidly increasing, and the current and projected future workforce to address their needs is inadequate, the federal priorities seem to be going in the opposite direction. SAMHSA, for example, had a targeted capacity expansion (TCE) grant program to help states implement evidence-based practices for older adults with mental health and/or substance use conditions. During the last cycle ten (10) three year grants for up to $410,000 a year were awarded and a technical assistance center (TAC) was created to help the states implement the projects, achieve sustainability, and to track outcomes of the individuals being served by the projects. NASMHPD received the three year contract for the TA Center in 2009. The results were outstanding. Although none of the projects were implemented at full fidelity, primarily due to local differences, the outcome measures of the participants showed significant improvement. At the end of the federal funding 9 of the 10 projects were sustained and the tenth was partially continued.

Following the end of the TCE grant program there was a brief, 15 month (September 2011 – March 2013), project partnering the AoA, SAMHSA and the National Council on the Aging (NCOA), to establish the Older Americans Behavioral Health Technical Assistance Center to work with five of the TCE grantees to further enhance the EBPs. In addition, 10 webinars and 14 fact sheets/issue briefs were developed and are available on the AoA, SAMHSA and NCOA websites. Beginning in March of 2012 Policy Academy meetings were conducted in five locations across the country. Each state, territory, and the District of Columbia were invited to send teams that, at a minimum, included representatives from the state unit on aging, mental health authority, and Medicaid authority. The primary goals of the academies were to establish relationships between team members, foster interagency collaboration between the agencies, and to develop a joint state mental health and aging plan that the team would work together to implement once they returned home.

While the Older Adult Mental Health TCE Grant Program, the two technical assistance centers, and the policy academies were seen as successful, all of these programs were ended by 2013. SAMHSA currently has no grant initiatives specifically for prevention and treatment of older adults with mental illness or substance use disorders.

The proposed SAMHSA Strategic Plan, *"Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018,"* contained no mention of older adults although several lists of targeted populations were included. **When SAMHSA asked for public comment, NASMHPD OPD members gave feedback to SAMHSA on this as we believed this to be a significant oversight. We remain hopeful that SAMHSA's vision of addressing all issues across the lifespan will result in a more balanced focus on all ages and populations.**

The Changing Landscape

Older adults with mental health and/or substance use conditions have historically been an underserved population both in the community and in institutional settings. The landscape is rapidly changing. The Supreme Court's decision in *Olmstead v. L.C.* in 1999 found that inappropriate institutionalization was a violation of an individual's civil rights under the

Americans with Disabilities Act (ADA). Following the *Olmstead Decision* there was a lot of activity in states to develop plans on how the state was going to address the problem but over time the emphasis faded and enforcement was not a priority with the U.S. Department of Justice (DOJ). However, since the current administration took office Olmstead compliance has become a high priority. A July 23, 2014 posting on the DOJ website reports 45 enforcement activities in 24 states has taken place with 18 actions in the past 12 months alone. There have been 8 statewide settlements affecting over 46,000 individuals. The New Hampshire settlement is highlighted on the DOJ website and indicates a substantial increase in the state mental health budget.

Similar to Olmstead enforcement the Centers for Medicare and Medicaid Services (CMS) oversight of the Pre-Admission Screening and Resident Review Program (PASRR) was not a priority for many years. The *Omnibus Budget Reconciliation Act of 1987* (OBRA 87) created PASRR and for the first time state mental health authorities (SMHAs) were mandated to become directly involved with nursing facility applicants and residents with mental illness. Under OBRA 87 state mental health authorities (SMHAs) are required to review independent evaluations of Medicaid certified nursing facility applicants and residents who have been identified as having serious mental illness and determining if (1) the nursing facility to which they have applied is an appropriate placement, and (2) whether the individual needs "specialized services" to address their mental health condition. This is a Medicaid program and includes an enhanced federal rate (FFP) of 75% for **all** activities related to PASRR. The statute does not obligate the SMHA to provide or arrange for the services necessary to address the individual's mental health needs. The nursing facility has that responsibility. However, the "state" is responsible for providing the "specialized services." Some new CMS interpretations and initiatives highlighted below will expand the role of the public mental health system in the care and treatment of these individuals.

The increased DOJ enforcement of the *Olmstead Decision* has raised the level of importance of PASRR and resulted in increased CMS oversight of the program. PASRR is now seen as an integral part of a state's long-term-care system. It is a valuable tool to prevent inappropriate institutional placements and a way to assist states in moving institutional residents, who don't need to be there, to more appropriate community settings. The following PASRR related changes are likely to increase the older adult workforce needs of state mental health authorities.

- **Increased CMS oversight.**

Lead PASRR staff members have been designated in all 10 CMS Regional Offices and training conferences for state level PASRR staff have been conducted in all regions. CMS has made changes in the federal nursing facility survey process and the Minimum Data Set (MDS) nursing facility evaluation instrument to identify residents with mental illness and to determine if they are receiving appropriate care.

- **Establishment of the PASRR Technical Assistance Center (PTAC).**

PTAC was created to provide technical assistance to states in order to assist them in achieving full compliance with federal regulations and to improve their programs. PTAC provides a wide range of services to states at no cost. For more information their website is www.pasrrassist.org.

- **Increased use of PASRR information.**

Nursing facilities and Money Follows the Person (MFP) programs are being strongly encouraged to use the information and recommendations in the PASRR Level II evaluation report in developing the individual's person-centered plan of care and determining appropriate placement.

• **Change in the interpretations of "state" and "specialized services".**
The "state" is responsible for providing the "specialized services" that a resident needs. While "state" and "specialized services" are not currently defined in federal regulations, the newest CMS interpretation is that "state" means the state in general, not just the Medicaid agency, and that "specialized services" focuses on services that the resident requires to address their mental health condition which are not included in what Medicaid is paying for, or the facility is providing, as nursing home services.

All of these changes have the potential of increasing the public mental health system's role in serving nursing home residents with mental illness and serving individuals who have been discharged to or diverted into community-based care. The good news is that the majority of these individuals will be eligible for Medicare and/or Medicaid. The enhanced federal PASRR rate can't be used to pay for services but Medicare and other Medicaid programs, such as Medicaid State Plan Services, can be used to serve eligible individuals.

Federal Opportunities

There are several federal initiatives that include opportunities to develop and expand behavioral health services for older adults and provide support for much needed expansion of the older adult mental health and substance use workforce.

Aging and Disability Resource Centers (ADRCs)

The ADRCs are a joint program of the ACL, CMS, and the VA to establish locations where individuals of any age or income level can get information and options counseling which includes assistance in accessing long-term care services. The centers are usually located in area agencies on aging (AAAs) and as of 2012 there were 471 sites in 51 states and covered 70 percent of the nation's population. In data provided by the ACL the lead state ADRC agency had some type of partnership with the state mental health agency in 40 states, and 158 ADRCs in 38 states had some type of relationship with community mental health clinics. However, only 4.8 percent of ADRC clients from April 2012 to September 2012 had a mental illness. The data presented shows an opportunity for increased participation by the public mental health system.

In 2014 the ACL, CMS, and VA offered a grant opportunity to states for a one year, up to $225,000, planning grant for *"Transforming State LTSS Access Programs and Functions into a No Wrong Door System for All Populations and All Payers."* The intended outcome of the grant is a three year plan to transition the state's ADRC program and/or Balancing Incentive Program into a No Wrong Door (NWD) System with emphasis on person centered counseling and streamlined access to public programs. The state mental health authority was a required partner in the application.

CMS Opportunities

CMS has several opportunities that can be used to serve older adults with mental health needs in the community. Two of the most obvious are the Home and Community-Based Services (HCBS) Waivers and the 1915(i) State Medicaid Plan Option. For many years states believed that a HCBS for mental health wasn't possible because of the cost offset requirement. Since Medicaid couldn't

pay for adults between the ages of 21 and 65 in Institutions for Mental Diseases (IMDs), including state hospitals, how could a state show a cost offset? It was finally realized by some creative planners that the majority of institutionalized older adults are not in IMDs but in nursing facilities. Therefore, the cost of care of nursing facility residents with mental illness was used as the cost offset and CMS approved the waivers. CMS has been very helpful with states in exploring creative options.

One of the reasons the 1915(i) Option was created was to assist states in providing mental health care to Medicaid recipients and three of the original allowable services were specifically included for that purpose. CMS has since allowed more flexibility for states to target specific populations.

Over the past decade there has been a movement toward states adopting managed long term services and supports (MLTSS) which can include home and community-based and/or institutional-based services. According to CMS currently about 18 states use the MLTSS model; with the implementation of new Medicare-Medicaid financial alignment models, CMS expects an increased uptake of the MLTSS model. Although the model clearly includes behavioral health services, there are concerns that without substantial oversight at the state level providers may not adequately address the behavioral health needs of enrollees.

Treatment Models and Evidence-Based Practices

The OPD agrees with the Centers for Disease Control and Prevention (CDC) which strongly supports a public health model for addressing older adult mental health. The CDC recommends home or clinic-based depression care management (DCM) and cognitive behavior therapy (CBT) as effective models for treating late life depression.

There are a number of evidence-based practices that have been developed specifically for older adults with mental illness and /or substance use disorders. Many of the practices utilize the broader older adult behavioral health workforce and promote partnerships between the Aging Network providers, the public mental health system, and local specialty and non-specialty providers. The following examples are among the most replicated programs.

- **Healthy IDEAS** (Identifying Depression, Empowering Activities for Seniors) focuses on underserved, frail, community-dwelling adults age 60 and older who are receiving case management services. The program provides depression care in the participant's home and most commonly utilizes personnel without professional licensure under the general supervision of a licensed mental health professional.
- **IMPACT** (Improving Mood—Promoting Access to Collaborative Treatment) is primarily a clinic-based depression care management program for older adults with major depression or dysthymic disorder. It employs a trained nurse, social worker, or psychologist, who teaches clients problem-solving techniques, in coordination with a primary care physician who may prescribe antidepressant medications. A psychiatrist provides consultation and supervision as needed.
- **PEARLS** (Program to Encourage Active, Rewarding Lives for Seniors) is a home-based depression care management program for minor depression and dysthymia in adults aged 60 years and older who are receiving home-based social services from

community services agencies. A trained depression care manager, usually a social worker or mental health counselor offers in-home counseling and maintenance follow-up telephone calls.

More information on treatment models and evidence-based practices for older adults with mental illness and substance use disorders can be found on the on National Registry of Evidence-Based Practices (NREPP) which can be accessed through the SAMHSA website, (www.SAMHSA.gov) and the CDC website (www.CDC.gov).

Mental Health and Aging Coalitions

Although not technically meeting the criteria to be classified as an evidence-based practice mental health and aging coalitions have proven to be a successful and cost-effective approach to improving the quantity and quality of older adult behavioral health prevention and treatment services by fostering collaboration and coordination between multiple partners. The National Coalition on Mental Health and Aging (NCMHA) was formed in 1991 and currently includes over 80 members representing national professional, consumer and advocacy organizations, federal agencies, and state and local mental health and aging coalitions. NASMHPD was a founding member of the Coalition and continues to be an active participant. The Coalition has a long list of accomplishments including leading a successful advocacy effort to get mental health on the agenda for the 2005 White House Conference on Aging (WHCoA). The result was mental health being cited in the Washington Post as one of the top three issues coming out of the WHCoA.

With the success of the NCMHA, the Center for Mental Health Services (CMHS) believed that the concept could be replicated in states and local communities and provided grants in the late 1990s to the AARP Foundation and NASMHPD to provide training and technical assistance to states and local communities on developing mental health and aging coalitions. There are now over 30 state and local coalitions across the country. Examples of their success include the Geriatric Mental Health Alliance of New York obtaining legislation which includes $2 million in annual funding to support mental health and aging programs and the Florida Coalition for Optimal Mental Health getting older adults with mental illness recognized in statute as a target population.

The OPD strongly believes that coalition building should be a major priority at both the state and federal level and that adequate resources should be provided. A list of the state and local coalitions and information about coalition building is available free of charge from the NCMHA on their website www.ncmha.org.

Recommendations

The NASMHPD OPD would like to submit the following recommendations as first steps toward addressing the behavioral health needs of the rapidly increasing number of older Americans.

1. Encourage SAMHSA to embrace and implement the recommendations for behavioral workforce development in the Institute of Medicine Report "The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?" Specifically SAMHSA should:

- Devote sufficient attention to the capacity of the behavioral health workforce to provide both geriatric mental health and geriatric substance use services.
- Restore funding of the Older Adult Mental Health Targeted Capacity Expansion Grant Program including reestablishment of the Older Americans Behavioral Health Technical Assistance Center.
- Require states that receive MH/SU block grants to document and report how the funds are used to support local capacity to serve older adults.

2. All state behavioral health agencies should have at least one senior level professional, who by training or experience, has expertise in the changing demographics and diversity of the older adult population, as well as older adult mental health and substance use prevention and treatment. The individual(s) should have knowledge of the programs and services provided by the Aging Network and other state agencies and seek opportunities for collaborations, such as development of mental health and aging coalitions.

3. Develop a self-assessment tool that could be used by state behavioral health agencies to measure where they are in serving older adults with behavioral health conditions and to identify any gaps in services and/or technical assistance that might be needed. The OPD would be pleased to take the lead in developing and assisting in the utilization of the self-assessment tool.

Conclusion

As expressed throughout this paper the NASMHPD Older Persons Division is deeply concerned about the status of older adult behavioral health services today and the alarming projections for the future. Unless action is taken quickly the nation will not be prepared to address the future behavioral health needs of a rapidly growing older adult population and will not have the necessary workforce in place. The OPD stands ready to work with NASMHPD and state mental health directors to move the public mental health system forward in improving the quantity and quality of older adult behavioral health services and developing the workforce necessary to provide services that are available, accessible, cost-effective, and age, gender, and culturally appropriate.