Attachment 1

White Paper on Why Older Adult Mental Health Matters

Older Adult Mental Health Needs

The population of older adults in the U.S. will nearly double over the next 20 years. More importantly, adults 65 and older will increase from 13% to 20% of the population, roughly equal to the population of children under age 18.

If the prevalence of mental health disorders among older adults remains unchanged, over the next two decades the number of older adults with mental health and/or substance disorders will nearly double from about 9 million people to about 18 million people. That is staggering growth, and our service systems are not prepared.[1,2]

At least 25 percent older adults – one in four - have one or more mental health or substance use conditions which present unique challenges for their care.[3] Unfortunately, fewer than 40% of older adults with mental health and/or substance use disorders get treatment. Of those who receive treatment, most go initially to primary care physicians, who provide minimally adequate care less than 15% of the time.[4]

Why Older Adult Mental Health Matters

Mental health and substance use disorders are major impediments to living well in old age. They cause considerable personal suffering and make it difficult for older people to

[1] Grayson, V., and Velkoff, V., (2010), *THE NEXT FOUR DECADES, The Older Population in the United States: 2010 to 2050, Current Population Reports, P25-1138,* U.S. Census Bureau, Washington, DC. Retrieved from: http://www.census.gov/prod/2010pubs/p25-1138.pdf.

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

[3] Institute of Medicine. (2012). *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* Washington, DC: National Academies Press. Updated by CDC and Census Bureau reports.

[4] Wang PS, Lane M, Olfson M, Pincus H, Wells KB, Kessler RC (2005). Twelve-Month Use of Mental Health Services in the United States: Results from the National Comorbidity Survey Replication. Archives of General Psychiatry. 62: 629-640.

achieve their potential in old age. This is a population in critical need of education, targeted prevention and early intervention.

Untreated mental health and substance use disorders among older adults exacerbate health conditions, decrease life expectancy, and increase overall health care costs.[5,6,7]

Mental health disorders, particularly depression and anxiety, are major contributors to—and are exacerbated by—social isolation, which results in diminished quality of life, further barriers to intervention and premature institutionalization.[8]

Older adults have one of the highest suicide rates in the nation, completing suicide nearly 30% more than the general population. In particular, white males 85 and over complete suicide at nearly four times the rate of the general population. As life expectancy increases, it is reasonable to anticipate that increasing numbers of older adults will probably die by suicide.[9]

- Depression, one of the conditions most commonly associated with suicide in older adults, is a widely under-recognized and undertreated medical illness.[10]

- Many older adults who die by suicide — up to 75 percent — visited a physician within a month before death.[11]

Untreated mental health disorders among both older adults with physical disabilities and family caregivers are a major cause of avoidable placements in institutional settings.[12,13,14]

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

[6] Husaini, B,A, et. Al (2000). Prevalence and cost of treating mental disorders among elderly recipients of Medicare services. *PsychiatricServices,* 51, 1245-1247.

[7] Katon,W., Ciechanowski, P. (2002). Impact of major depression on chronic medical illness. *Journal of Psychosomatic Research, 53*, 859-863.

[8] Warner, J. P.(1998) Quality of life and social issues in older depressed patients. *International Clinical Psychopharmacology*, 13, Supplement 5, S19–24.

[9] Mortality Reports. National Center for Injury Prevention and Control. Centers for Disease Control and Prevention. http://www.cdc.gov/ncipc/wisqars/

[10] Blazer, D. (2009). Depression in late life: Review and commentary. *FOCUS,* 7, 118-136.

[11] Luoma, J., Martin, C., & Pearson J. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *Am J Psychiatry.* 159 (6), 909-916.

[12] Grabowski, D.C., Aschbrenner, K.A., Feng, Z., & Mor, V. (2009). Mental illness in nursing homes: Variations across states. *Health Affairs*, 28 (3), 689-700.

[13] Dorenlot P, Harboun M, Bige V, Henrard JC, Ankri J. (2005). Major depression as a risk factor for early institutionalization of dementia patients living in the community. *Int J Geriatric Psychiatry*, 5, 471-8.

[14] Buhr, G., Kuchighatla, M., & Clipp, E. (2006). Caregivers' reasons for nursing home placement: Clues for improving discussions with families prior to the transition. *The Gerontologist*, 46, 52-61.

Treatment Works

There are effective, evidence-based interventions that can improve the quality of life of older adults with mental health and substance use disorders, including dementia. Unfortunately, mental disorders among older adults are all too often neglected in our society due to the following factors:

- Ageism – the false belief that mental disorders, particularly depression and dementia, are normal in old age. This belief is held not only by older adults, family members, and service providers, but is also rampant within society at large.
- Stigma – the shame of having a mental disorder. Stigma discourages older adults and their family members from acknowledging mental health needs and pursuing treatment, ultimately decreasing quality of life.
- Ignorance – the lack of education and understanding regarding age related vulnerabilities and impact of mental health disorders on older individuals. Without education on the diversity and severity of behavioral conditions in later life, problems are not identified, treatment is not accessed and recovery is not obtained.

It is imperative that we develop geriatric mental health workforce capacity and competency to meet the growing and unique needs of late life mental illness and substance use disorders, and translate research findings into practice, invest in evidence based practices.

These investments are needed to improve the lives of older adults and their families and reduce overall costs to the health care system. In addition to the moral obligation we have to our older citizens, optimizing late life behavioral health benefits our families and communities in multiple ways:

- Healthy older adults make valuable contributions as employees in our workforce and as volunteers in communities and organizations with need.
- Family members can remain engaged in the workforce and personal pursuits as they do not need to prematurely leave the workforce to care for older loved ones with functional and health declines attributable to untreated behavioral health disorders.
- Unnecessary, premature and costly institutionalization can be delayed or avoided and caregiver burden and symptoms of depression reduced with effective programs of counseling and support for caregivers of persons with dementia.[15,16]

[15] Mittelman MS, Haley WE, Clay OJ, Roth DL. Improving caregiver well-being delays nursing home placement of patients with Alzheimer disease. Neurology. 2006 Nov 14;67(9):1592-9.

[16] Substantial literature confirms that family caregivers are the primary source of care in the community for persons with dementia and behavioral disturbances of persons with dementia are associated with caregiver depression including: Covinsky KE, Newcorner R, Fox P, et al. Patient and caregiver characteristics associated with depression in caregivers of patients with dementia. J Gen Intern Med. 2003;18(12):1006-1014.

Conclusion

Unless new public policies are implemented, the impending “silver tsunami” of behavioral health conditions that older adults will experience will overwhelm our ability – governments, communities, and family caregivers -- to address the mental health and medical needs of older persons.

Expand Access in Rural Areas and Among Underserved Minority Populations:

Twenty (20) percent of individuals aged 55 and older experience some type of mental health problem. According to the Health Resources and Services Administration, there are approximately 4000 Mental Health Professionals Shortage Areas in the United States, and half of all counties in the U.S. have no practicing psychiatrists, psychologists or clinical social workers.

As a direct result of this lack of access, beneficiaries with chronic medical conditions and major depression (nearly 2 million senior citizens nationwide) have significantly higher rates of disability than those with either condition alone.

Improve Medicare Purchasing of Mental Health Care:

Inpatient psychiatric hospital utilization by Medicare beneficiaries is extraordinarily high – particularly when compared to psychiatric hospitalization rates for patients covered by Medicaid, VA, TRICARE and private insurance. Inpatient care is very expensive, and it is strikingly clear that additional community-based mental health services provided by would reduce many unneeded hospitalizations.

One-third of these expensive inpatient placements are caused by clinical depression and addiction disorders that can be treated for much lower costs when detected early through the outpatient mental health services.

The lack of access to mental health care increases the burden of disability on beneficiaries and their communities as well as the financial burden on the program.

The time is now to bring the Medicare program and mental health policies into the 21st century.

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