Mental Health Resources for Older Adults: An Integrated Approach

Breanna Wilhelmi, Ph.D., Caroline Kalai, Psy.D.
Anahita Gheytanchi, Ph.D., Jennifer Levine, Psy.D.

1527 4th Street, 2nd Floor
Santa Monica, CA 90401
(310) 394 - 9871
Overview:

Population Changes

Mental Health Needs of Older Adults

Ageism

Integrated Approach to Mental Health Services

Best Practices for Working with Older Adults

Models of Integrated Health Care

WISE & Healthy Aging Integrated Approach
A Century of Population Change in the Age and Sex Composition of the Nation
Figure 1.
Population Aged 65 and Over for the United States: 2012 to 2050
Figure 1.
Age and Sex Structure of the Population for the United States: 2010, 2030, and 2050
Mental Health Needs of Older Adults

At least 20% of adults aged 65+ meet criteria for a mental disorder.
A Critical Need for Geropsychologists:

“There is an insufficient supply of trained professionals available to provide mental and behavioral health services to older adults.”

There are few opportunities available for formal geropsychology training at the graduate level, with only 10-15 programs offering a specialized geropsychology track.

Although only 4.2% of practicing psychologists identify geropsychology as their primary focus of work, 39% of all psychologists report delivering services to adults over the age of 65 each week.

Without additional specialized educational and training opportunities, psychologists will be unable to meet the increasing demand for mental and behavioral health services as our nation’s population ages.
More than 50% of residents have some form of cognitive impairment.\textsuperscript{30}

Many nursing home patients have personality disorders exacerbated by chronic health problems.

Increasing diversity in the older population will affect the provision of mental health/substance use services, requiring training in the provision of culturally competent care in the coming decades.\textsuperscript{11}

Older adults with evidence of mental disorder are less likely than younger and middle aged adults to receive mental health services.\textsuperscript{43}

Older adults are less likely to receive care from a mental health specialist.\textsuperscript{74}
Depression & Anxiety

15-20% of older adults in the US have experienced depression.

Approximately 11% of older adults have anxiety disorders.¹

Anx/Dep more likely to cause adverse effects to pre-existing medical conditions.

Adversely, older adults are more susceptible to anxiety and depression as a consequence of medical conditions.

Even mild depression lowers immunity and may compromise a person’s ability to fight infections and cancers.¹²
Depression & Anxiety

Causes
Disabling illness
Incontinence
Insomnia
Loss of a spouse or loved one
Retirement
Moving out of the family home
Isolation
Stressful event
Other late life problems that cause dep/anx to be overlooked.\textsuperscript{12, 49}

Psychotherapy can be effective for people diagnosed with \textit{late-life} depression who are at high risk for poor response to antidepressant medication.\textsuperscript{72}
Suicide

Depression is a major risk factor for suicide in older adults.

In 2006, 14.22 of every 100,000 people age 65+ died by suicide (11.16 per 100,000 in the general population).

Non-Hispanic white men age 85+ are at the greatest risk for suicide, with a rate of 49.8 suicide deaths per 100,000.\(^\text{26}\)

Tragically, many of these suicides may have been prevented, as many older adults who die by suicide reached out for help:

- 20% see a doctor the day they die
- 40% the week they die
- 70% the month they die
Alzheimer’s Disease and Dementia

1 in 8 people 65+ has Alzheimer’s disease (approximately 5.4 million older Americans). This number will continue to grow as the proportion of the U.S. population over the age of 65 increases.\(^2\)

Can lead to anxiety, depression, and paranoia.

Clinicians’ differential diagnostic skills are essential.

Need to assess capacity.

Need to learn effective coping strategies (behavioral & environmental).

Psychotherapy, support groups, and memory training strategies help reduce stress & optimize cognitive abilities.
Substance Abuse

In 2010, at least 5.6 to 8 million older adults had one or more mental health/substance use conditions.

Illicit drug use nearly doubled among people age 50-59 between 2002 and 2007, increasing from 5.1% in 2002 to 9.45 in 2007.\textsuperscript{41}

Older adults in need of substance abuse treatment is estimated to increase from 1.7 million in 2000 and 2001 to 4.4 million in 2020.\textsuperscript{33}

Tx Needs:
Identify underlying causes
provide evidence-based treatments
identify circumstances that trigger these behaviors
teach new methods to cope with high-risk situations
Chronic Disease

Approximately 80% of older adults have at least one chronic health condition.\(^{29}\)

Approximately 60-65% have two or more conditions.\(^{72, 73}\)

Poor nutrition, inactivity, smoking and alcohol misuse contribute to onset.\(^{37}\)

Tx Needs:
help manage multiple chronic diseases through treatment adherence
behavioral interventions
physical activity
biofeedback
nutrition
stress reduction techniques\(^{12}\)
FIGURE 1. Estimated prevalence of major psychiatric disorders by age-group
Inadequate insurance coverage
Shortage of trained geriatric mental health providers
Lack of coordination among primary care, mental health and aging service providers
Stigma surrounding mental health and its treatment
Denial of problems
Access barriers such as transportation

Older adults often prefer psychotherapy to psychiatric medications.\textsuperscript{15, 16, 19}

However, psychological interventions are often not offered as an alternative.
Ageism
Ageism

“Ageism describes the subjective experience implied in the popular notion of the generation gap. Prejudice of the middle-aged against the old, in this instance, and against the young in others, is a serious national problem. Ageism reflects a deep seated uneasiness on the part of the young and middle-aged--a personal revulsion to and distaste for growing old, disease, disability; and fear of powerlessness, "uselessness" and death.”

Robert Butler, M.D.²²
Forms of Ageism

Personal ageism - ideas, attitudes, beliefs, practices on part of the individuals against individuals/groups because of age.

Unintentional ageism - ideas, attitudes, rules, or practices, that are carried out without perpetrator's awareness that they are biased against persons/groups because of age.

Intentional ageism - ideas, attitudes, rules, or practices carried out with the knowledge that they are biased against persons or groups because of age.

Institutional ageism - missions, rules, and practices that discriminate against individuals and/or groups because of age.
Personal Ageism

Ideas, attitudes, beliefs, practices on part of the individual against individuals/groups because of age.

We are living in the age of ageism. It is in everything we see, hear, and do.

Everyone is ageist.

Gerontophobia - the unreasonable fear and/or irrational hatred of older people by society and by themselves.²¹

Internalized gerontophobia is similar to other forms of internalized oppression (e.g., internalized homophobia, internalized racism, etc.) in which the individual comes to fear and hate aspects of the self which are associated with the marginalized identity.³¹
**Unintentional Ageism**

Ideas, attitudes, rules, or practices, that are carried out without perpetrator's awareness that they are biased against persons/groups based on their older age.

Terror Management Theory: Knowing our own death is inevitable causes us to do things to avoid perception of our mortality.\(^{47}\)

In group/out group prejudice: Death anxiety makes us see older adults as outsiders and treat them in negative ways. Ageism is thus a deflection of death anxiety.\(^{34}\)

Implicit ageism: Stereotypes and prejudice we are not aware of but are part of our daily lives. Includes “age blindness” and “age negotiation.”\(^{45}\)
Unintentional ageism

Harvard University Project Implicit: Age Implicit Association Test
**Intentional Ageism**

Ideas, attitudes, rules, or practices carried out with the knowledge that they are biased against persons or groups based on older age.

Occurs when attitudes, rules, or policies that discriminate are maintained even when we know they're wrong. Can be personal or institutional.\(^\text{22}\)

Examples in mental health care:
- Over-medicating older adult patients “to make them more comfortable.”\(^7\)
- Spending less patient consultation time “because they’re really old.”
- Marketing/advertising targeting gerontophobia and death anxiety.
- Programs which infantilize older adults despite functional capacity.
- Prohibiting clients from receiving psychotherapy due to aging disorders (e.g., early memory loss, dementia, delirium).
Intentional Ageism

Language has a key role in intentional ageism:\(^3\)

- Assumptions/judgments
- Older people as different
- Uncharacteristic characteristics
- "Old" as negative
- "Young" as a positive
- Infantilizing
- Internalized ageism
- Internalized microaggression
**Institutional ageism**

Missions, rules, and practices within institutions that discriminate against individuals and/or groups because of age.

Directly tied to socioeconomics, industrialized societies, and labor changes.\(^{35}\)

Agrarian societies → Industrial societies = Increased institutional ageism

Cycle of ageism: Individual ageist beliefs and ideas used in policy trickle down throughout agencies, organizations, and programs, which then reinforce ageist beliefs and ideas.
An Integrated Approach to Mental Health Resources for Older Adults
What is Integrated Health?

The sharing of information and process of integrating all the information, from multiple perspectives, offered by diverse team members.

Interdisciplinary/interprofessional health care.

High degree of collaboration among various professionals in:

- assessment
- treatment planning
- treatment implementation
- outcome evaluation

“Biopsychosocial” approach

Biological needs of the patient (e.g., a physician), the psychological needs of the patient (e.g., psychologist), and the social needs of the patient (e.g., a social worker), in order to provide a full assessment.
New Freedom Commission on Mental Health

President Bush’s Executive Order 13263 in 2002

“...to improve America's mental health service delivery system for individuals with serious mental illness and children with serious emotional disturbances.”

“...to evaluate the quality and effectiveness of the nation's mental health service delivery system, to identify unmet needs and barriers to services, and to provide recommendations on methods for improving the mental health system.”
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<th>Issue</th>
<th>Recommendation</th>
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| **A mismatch between the current system of care and the needs and preferences of older adults** | **Outreach and integrated services**  
- Direct CMS to revise payments to support integrated mental health services in primary care, residential settings, and senior service programs.  
- Allow same-day medical and mental health procedures.  
- Integrate mental health screening and outreach in routine senior services.  
- Support care management, care plan oversight, and other case management models through payment mechanisms that coordinate home and community-based services.  
- Design reimbursement policies that support outreach programs, including multidisciplinary outreach, residential support, crisis services, and telemedicine.  
- Deliver services by clinicians with culturally appropriate training and backgrounds. |
| **A fragmented system of mental health care for older persons**     | **Service coordination**  
- Direct CMS, the AoA, and other relevant federal agencies to develop mechanisms to coordinate funding resources and community-based services across different service providers, agencies, and payers delivering mental health, medical, social, and long-term care services to older persons with mental disorders. |
| **Co-payments, prescription coverage, and rate adjustments**        | **Medicare co-payment, prescription coverage, and rate adjustments**  
- Eliminate discriminatory 50% co-payments under Medicare for psychological services, and implement 20% co-payments consistent with medical procedures and services.  
- Enact a comprehensive Medicare prescription drug benefit that ensures access to safe and effective psychiatric medications.  
- Develop Medicare reforms that address the growing gap between provider costs and rates of payments that are associated with physicians and managed-care systems declining to re-enroll as providers for Medicare beneficiaries. |
| **Stigma associated with mental illness and advanced age**          | **Stigma and cultural sensitivity**  
- Develop and implement a public education campaign under HHS, AoA, and other appropriate agencies promoting public and professional awareness that mental disorders in older adults are a public health problem that can be prevented and treated.  
- Technical assistance could be provided to states on increasing knowledge of late-life mental disorders through public information campaigns.  
- Encourage and support partnerships between federal agencies, foundations, and advocacy organizations to implement strategies that reduce stigma.  
- Incorporate age-appropriate mental health services into education and clinical practice. |

*Note: CMS: Center for Medicare and Medicaid Services; AoA: Administration on Aging; HHS: Health and Human Services.*
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<td>A gap between research on effective interventions and practice</td>
<td><strong>Implementation of evidence-based practices</strong>&lt;br&gt;• Federal research and regulatory agencies should sponsor a national campaign to disseminate and implement geriatric evidence-based mental health practices in routine service-delivery settings, including aging network, long-term care, primary care, and other settings where older adults receive services.&lt;br&gt;• This effort should build upon established methods and current initiatives aimed at implementation of evidence-based mental health services for younger adults.</td>
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<td>An inadequate research infrastructure dedicated to mental health and aging</td>
<td><strong>Mental health and aging research</strong>&lt;br&gt;• Direct congress to increase funding to NIMH, CMHS, AHRQ, NIA, and other federally supported research agencies for research on the causes of mental illness and on effective mental health interventions and services for older adults.&lt;br&gt;• Enhance research infrastructure (e.g., designate an Aging Branch at NIMH).&lt;br&gt;• Require the inclusion of persons age 65+ in federally funded research studies.&lt;br&gt;• Support training mechanisms for early-career investigators in mental disorders of aging, including: loan forgiveness programs, training supplements to existing RO-1 grants, early-career development awards, undergraduate research programs, and support for centers of excellence that prioritize research training and mentoring.</td>
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<td>Need for services that promote full recovery from mental illness in late life</td>
<td><strong>Promotion of full resolution of residual symptoms and recovery</strong>&lt;br&gt;• Develop interventions to eliminate residual symptoms of mental illness in older persons.&lt;br&gt;• Incorporate consumer preferences in shaping the goals of mental health treatment.&lt;br&gt;• Direct healthcare regulatory agencies, providers, and educators to ensure active involvement of older adults and their families in treatment-planning and decision-making.&lt;br&gt;• Direct publicly funded social, acute, and long-term care services toward maximal independent functioning and integration in community activities (i.e., vocational, social).</td>
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<td>Lack of preventive interventions and services</td>
<td><strong>Screening and prevention</strong>&lt;br&gt;• Identify the prevention of mental disorders in older persons as a public health priority by state and federal agencies.&lt;br&gt;• Prevention efforts should include universal, selective, and indicated components, including public education, outreach, and targeted interventions.&lt;br&gt;• Prevention and screening programs reimbursed by private health insurance programs and Medicare should include mental health, cognitive screening, and education on health behaviors associated with mental well-being.</td>
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*Note:* CMHS: Center for Mental Health Services; AHRQ: Agency for Healthcare Research and Quality; NIA: National Institute on Aging.
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<td>A shortage of professional providers with expertise in mental health and aging and in geriatrics</td>
<td><strong>Increase the number of providers with expertise in mental health and aging.</strong></td>
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<td>• A systematic evaluation should be undertaken to evaluate future workforce needs with respect to healthcare providers trained in geriatric psychiatry and in allied professions. Specific attention is warranted in identifying factors that contribute to the failure of geriatric residency programs to fill training slots and to create strategies to improve recruitment into geriatric specialty training programs.</td>
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<td>• Explore incentive programs, including loan repayment programs and increased authorization of graduate medical education (GME) payments.</td>
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<td>• Required training in geriatrics should be expanded for long-term care nurses, certified nursing assistants, and other allied professionals in addressing psychiatric disorders and behavioral symptoms of dementia.</td>
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<td>• Approaches to increasing the number of providers with geriatric mental health training include early educational awareness of geriatrics as a potential healthcare career path, development of multidisciplinary training environments for aging and mental health; increasing provider competencies through information-technology mechanisms; and increasing the proportion of educational programs with training in the identification, assessment, and management of late-life mental disorders.</td>
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<td>A need for enhanced support and services for family and peer caregivers</td>
<td><strong>Enhance caregiver and peer support services</strong></td>
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<td>• Mental health services should be incorporated into current programs designed to support caregivers.</td>
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<td>• Enhance educational programs on home-based management of mental disorders and increased knowledge on aging, dementia, mental health, caregiving skills, resources, and options of care.</td>
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<td>• Provide enhanced support services, direct care services, and mental health services for family caregivers.</td>
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<td>• Increase the number of peer-support programs by promoting partnership between federal programs and advocacy organizations and directing state and county health systems to support development of peer-support programs.</td>
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Best Practices for Working with Older Adults
American Psychological Association (APA) Guidelines for Psychological Practice with Older Adults

Created 2004, revised 2013

Frame of reference for engaging in clinical work with older adults.

Basic information and references.

Recommendations for professional behavior, endeavors, and conduct for psychologists.
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<td>Assessment</td>
<td>Intervention, consultation, and other service provision</td>
<td>Professional issues in education</td>
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Competence and Attitudes

Work within your scope of competence.

Recognize how your attitudes and beliefs impact treatment.

Consult and educate yourself.
Competence and Attitudes

Resources:

Pikes Peak Competency Assessment Tool

Gerontological Social Work Competencies

APA Ethical Principles of Psychologists and Code of Conduct

Code of Ethics - National Association of Social Workers

Continuing Education Offerings - GeroCentral
General Knowledge

Theory and Research

Psychosocial Dynamics

Diversity

Biology and Health
General Knowledge

Resources:

American Federation for Aging Research

National Institute on Aging

National Council on Aging

Diversity - American Society on Aging

AoA Diversity Toolkit

CDC Healthy Aging

Multicultural Competency in Geropsychology
Clinical Issues

Cognitive changes
Functional capacity
Psychopathology and prevalence
Clinical Issues

Resources:

Geriatric Neuropsychology: Assessment and Intervention

NIH Instruments to Detect CI in Older Adults

Assessment of Older Adults with Diminished Capacity: Handbook for Psychologists

Substance Abuse Among Older Adults
Assessment

Theory, research, and practice

Culture and psychometrics

Accommodations and contexts

Cognitive and functional ability
**Assessment**

Resources:

US Preventative Services: Cognitive Impairment in Older Adults Screening

Alzheimer’s Association Cognitive Assessment Toolkit

Comprehensive Geriatric Assessment
**Intervention, Consultation, and Other Service Provision**

Theory, research, and practice

Cultural and environmental adaptations

Practice settings and issues

Prevention and health promotion

Multidisciplinary collaboration

Ethical and legal issues
Intervention, Consultation, and Other Service Provision

Resources:

Wellness and Psychosocial Treatment for the Emotional and Cognitive Challenges of Aging

APA Resource Guides: Psychotherapy and Older Adults Psychological Services for Long Term Care Depression and Suicide in Older Adults
Professional Issues and Education

Policies, laws, and business

Training and supervision

Consultation and education
Professional Issues and Education

Resources:

Elder Law

American Bar Association Commission on Law and Aging

2017 Medicare Handbook

Council of Professional Geropsychology Training Programs

GeroCentral
Models of Integrated Mental Health Care
Basic Model of Integrated Health Care

- Individual assessments
- Shared information
  - Team goals
  - Intervention plan & strategies
- Individual delivery of care
Continuum of Collaborative Team Models

Unidisciplinary  Multidisciplinary  Interdisciplinary  Transdisciplinary

Lesser

- Inclusion of other professionals
- Training and cross-training
- Communication
- Problem solving
- Role diffusion
- Clients’ self-determination and autonomy
- Robustness and durability of agreements

Greater
Core Competencies for Integrated Behavioral Health and Primary Care

1. Interpersonal Communication
2. Collaboration and Teamwork
3. Screening and Assessment
4. Care Planning and Coordination
5. Intervention
6. Cultural Competence and Adaptation
7. Systems-Oriented Practice
8. Practice Based Learning and Quality Improvement
9. Informatics
Experimental Models of Integrated Health Care

- **Improving Mood-Promoting Access to Collaborative Treatment (IMPACT):** Collaborative care approach to treat depression or dysthymia that involves a trained depression care manager, patient, primary care provider and psychiatrist.

- **Wellness Initiative for Senior Education (WISE):** Health promotion program related to health behaviors, the aging process, managing care, medication management and signs of alcohol misuse and depression.

- **EnhanceWellness:** Helps older adults with chronic health conditions manage their illness and avoid psychiatric medications, physical inactivity, depression and social isolation.

- **Senior Reach:** Training for community partners to identify older adults experiencing mental health and related concerns and help get them into recovery-oriented behavioral health treatment.

- **Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors):** A program that integrates depression awareness and management into existing case management services.

- **Program to Encourage Active, Rewarding Lives (PEARLS):** Community-based intervention for individuals with depression or dysthymia that helps reduce symptoms and suicidal ideation through problem-solving, social and physical activation and pleasant activity scheduling.
Experimental Models of Integrated Health Care

- **Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT):** Primary care intervention to recognize depression and suicidal risk and manage treatment.
- **Resources for Enhancing Alzheimer’s Caregiver Health II (REACH II):** At home and telephone based intervention to reduce caregiver burden and depression, improve self-care and offer social support.
- **PRISM-E:** Integrated behavioral health care program targeting depression and substance use.
- **RESPECT-D (Re-Engineering System in Primary Care Treatment of Depression):** Integrated management of depression in primary care.
- **UPBEAT (Unified Psychogeriatric Biopsychosocial Evaluation and Treatment):** Interdisciplinary mental health treatment and care coordination to elderly veterans whose comorbid depression, anxiety, or alcohol abuse may result in overuse of inpatient services and underuse of outpatient services.
Real World” Applied Models of Integrated Care

- Erickson Model
- VA Model
- WISE & Health Aging Approach
WISE & Healthy Aging, a nonprofit social services organization serving older adults and their families and caregivers throughout Los Angeles County. WISE & Healthy Aging works to promote and improve the well-being, independence and self-esteem of seniors, and to prevent premature institutionalization whenever possible.

MISSION -- WISE & Healthy Aging enhances the independence, dignity and quality of life of older adults through leadership, advocacy and innovative services.

VISION -- WISE & Healthy Aging will be a nationally recognized trusted source and trusted voice on aging.
Integrated Approach

Multiple services provided include:

- Benefits Enrollment Center
- Caregiver Support
- Caregiver Training Academy
- Care Management (In-Home Services)
- City and County of LA Long-Term Care Ombudsman Program
- Club 1527
- Elder Abuse Prevention Services
- FAST (Financial Abuse Specialist Team)
- Financial and Legal Clinics
- WISE Diner Healthy Lunches Program (City of Santa Monica)
- WISE HomeCare

- Adult Day Service Center
- Medicare Insurance Counseling
- **Mental Health Services**
  - Peer Counseling Program
  - Support Groups
  - Training & Education Center
  - Transportation & Mobility Program
  - Information & Referral Services
  - Volunteer Opportunities
Mental Health Services

- Psychotherapy: individual, couple, family and group
- Psychiatry: consultations and evaluations, prescriptions, and medication management
- Psychological Assessments
- Case Management Services
- Field Capable Clinical Services Program for Older Adults (FCCS)
- Counseling for Elder Abuse Survivors
- Peer Counseling and Support Groups
Integrated Approach to Mental Health Services

Multidisciplinary team

Individual and group psychotherapy, psychological testing, and may involve intra/interagency consultation regarding a particular client.

Clients receiving mental health services also receive a psychiatric medication evaluation and, if indicated, ongoing medication management from our psychiatrist.

Our mental health services are provided by clinicians at all levels, including doctoral level psychology interns and postdoctoral fellows, all of whom are supervised by licensed clinical psychologists.
References


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