Evidence-based Mental Health Practices for Older Adults: Transforming the System of Care

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May 12, 2005

Presentation Overview

- The Context and Problem
- What Works
- Implementation Challenges
- Moving Forward: Examples from the Field

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Context & Problem

- Dramatic growth of aging population
- Major direct and indirect impact on health outcomes, service use, and cost
- We know treatments that work, but these are not reaching those in need
- Mismatch between need and investment in knowledge dissemination and service coverage

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Two Populations - Different Needs, Different Approaches

- Aging SMI – history of institutionalization; aging in the state mental health system
- Elders with acute episodes – e.g., late on-set depression – show up in HCBS

- Present different needs to the System

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Severe Mental Illness in Older Adults

- Rapid growth projected (Jeste, et al., 1999)
- Lack of community living skills associated with nursing home and high cost services (Bartels 1999)
- Lack of Rehabilitation Interventions
- High Medical Comorbidity (Goldman 1999)
- Poor Health Care and Increased Mortality (Druss 2001)

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Projected Growth in Older Adults with Mental Illness

- Population aged 65+ will increase from 20 million in 1970 to 70 million in 2030
- Older adults with mental illness will increase from 4 million in 1970 to 15 million in 2030

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Mental Disorders in Older Adults

- Alzheimer's and other memory disorders (30-40% complicated by depression or psychosis)
- Depression, anxiety disorders, alcohol misuse
- Suicide, highest rate: age 75+

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Depression Associated with Poor Health Outcomes

- Poor outcomes
  - Hip fractures
  - Myocardial infarction
  - Cancer (Penninx et al. 2001; Evans 1999)
- Increased mortality rates
  - Myocaridal infarction (Frasure-Smith 1995)
  - Long term Care Insitutionalization (Rovner 1991)

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Suicide in Older Adults

- 65+: highest suicide rate of any age group
- 85+: twice the national average (CDC 1999)
- Older people: 13% of population, 19% of suicides (Hoyert 1999)
- Peak suicide rates:
  - Increases continuously for men
  - Peaks at midlife, then declines for women
- 1/3 of older men visited primary care physician in the week before completing suicide; 70% within the prior month

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Under-recognition?

Uncapher & Arean, 1999 JAGS

- 98% of PCPs recognized depression
- 95% recognized suicidal statement
- Only 30% said the statement was serious (compared with 98% who said younger patient was serious)
- Only 40% said they'd refer to treatment

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Unmet Need for Community Treatment

- < 3% of older adults receive outpatient mental health treatment by specialty mental health providers (Olfson, et al., 1996)
- Only 1/3 of older persons living in the community and in need of mental health services receive them

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Poor Care Quality for Older Persons with Mental Disorders

- Increased risk for inappropriate medication treatment (Bartels, et al., 2002)
  - > 1 in 5 older persons given an inappropriate prescription (Zhan 2001)
- Less likely to be treated with psychotherapy (Bartels et al., 1997)
- Lower quality of general health care and associated increased mortality (Druss 2001)

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Nursing Facilities

- Primary provider of institutional-based care for older persons with mental disorders
- 65-80% of NF residents have a diagnosable mental disorder
- Most common disorders:
  - Dementia
  - Depression -- up to 44% (Teresi et al., 2001)
  - Anxiety and Psychotic Disorders – 8% (Phillips & Spry 2000)

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Unmet Mental Health Service Needs in Nursing Facilities

- Over one month: 5% of residents with mental illness received services (Burns, et al., 1993)
- Over one year: 19% in need of mental health services receive them
  - Least likely: Oldest and most physically impaired (Smyer et al., 1994)
- Services most likely to be provided include medication management and case consultation (Linkins, et al, in press, Psych Srvcs.)

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Summary

- Comorbid depression and medical conditions are common in older adults
  - Associated with worse health outcomes
  - Greater use and costs of medications
  - Greater use and costs of health services
    - Medical outpatient visits, emergency visits, and hospitalizations
- Growing unmet need for MH services as people are aging in place in the community

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We Know What Works

- Integrated and coordinated services (e.g., mental health and primary care; mental health and home & community based services) and Outreach Models
- Evidence-based therapies (e.g., for depression, alcohol misuse, agitation associated with dementia)

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Evidence-Based Treatments

- Systematic Reviews of the Highest Levels of Evidence for Geriatric Mental Health Interventions and Services:
  - 26 Meta-analyses
  - 8 Systematic evidence-based reviews
  - 12 Expert consensus statements

Bartels SJ, Dums AR, Oxman TE, Schneider LS, Areán PA, Alexopoulos GS, Jeste DV. Psychiatric Services, 53, 53:1419-1431, 2002

What's the Problem?: Implementation Challenges

Gap between Effective Treatment and Those in Need

- **System Barriers:** Fragmentation across systems, especially integration of behavioral health in primary and long term care systems
- **Financial Barriers:** Mismatch of covered services and treatment advances (e.g., EBPs) in Long-term and Community-based Care

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Gap between Effective Treatment and Those in Need (cont.)

- **Workforce & Training Barriers:** Traditional academic approaches lack training in geriatric mental health – need to change provider behaviors and attitudes (e.g., ageism & cultural competence)
- **Consumer Barriers:** Stigma and lack of education/understanding re: mental health

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System Issues

Service Delivery System for Older Persons is Fragmented/Uncoordinated

- Primary Care
- Hospitals (including Discharge Planners)
- Nursing Facilities
- Assisted Living
- Home Care
- Adult Day Health Care
- Aging Network Services
- Specialty Mental Health
- Family Caregivers

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Coordination between SMHA and SUA Lacking

- Inter-agency partnerships difficult to develop without sustained support – on both State and local levels
- Fragmentation due to separate funding streams

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Limited Coordination: Community Mental Health & Other Providers

- Community Mental Health Services
  - Under-serve older persons
  - Lack staff trained to address medical needs
  - Often lack age-appropriate services
- Primary Care and Long-term Care are the most common providers of mental health services for elders, yet there is limited coordination with community mental health

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Financing Issues

Financing: Medicare

- Medicare: Lack of mental health parity
- Requires 50% contribution from clients for outpatient mental health services
- Requires psychiatrist on staff
- Covers limited array of mental health services

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State Mental Health Programs Increasingly Rely on Medicaid

- Between 1987 and 2001, the percentage of State Mental Health Authority budgets funded by Medicaid rose from less than 40% to more than 60%
- Medicaid now accounts for 18% of state psych. hospital revenue, and 24% community mental health center revenue

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Many square peg/round hole problems applying Medicaid to mental health

- Collision of **paradigms --** health insurance vs. public health (public good)
- Tension over **services** – medical model vs. holistic services
- Stringent eligibility levels – excludes many elders
- Restrictive licensure and billing policies – creates burden/barriers for mental health providers

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Medicaid Challenge: Restrictive Reimbursement Policies

- Coverage often doesn't cover full array of services needed (e.g., case management, outreach)
- Billing same day primary care – mental health not allowed
- Rates insufficient to sustain complex programs (e.g., psychosocial rehabilitation, involving assessment, treatment plan development, individual/group psychotherapy, client-centered consultation)
- Complex mental health interventions – all components not covered

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Service Coverage

- Services needed by older adults are often not reimbursed:
  - Failed face-to-face contacts with clients (outreach/engagement)
  - Services delivered by telephone
  - Transportation
  - Education

Workforce and Training Issues

Lack of Knowledge about Geriatric Mental Health

- Primary care providers
- Nursing facility, residential care, home care staff
- Mental health providers: workforce shortage of geriatric psychiatrists and psychologists
- Ageism among providers: belief that mental health issues are “normal” aging conditions

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Common complaints about MH system by non-MH providers (Arean, et al., in press)

- Mental health system is "The black hole"
- "not enough communication with MH"
- "There must be a shortage of MH providers. I can never find anyone to take my patients"
- "No ready access to consultation"
- Inflexibility: "Three strikes, you're out" mentality of some psychotherapists

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Consumer Issues

Stigma Concerns

Alvidrez & Arean, 2002, IJPM

- Losing their rights
- Provider won't understand needs
- Worried what others would think (family, friends, and service providers)
- Don't want to take more pills
- Depression not seen as "serious" enough to seek treatment, especially from MH professional

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Service Use Patterns

- Very unlikely to be seen in specialty mental health settings
- Majority tend to seek care or be treated in ambulatory medicine

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Barriers to Seeking Specialty Mental Health

- Stigma concerns & issues of cultural competence
- Seeking services in non-mental health settings (e.g., primary care)
- Under-recognition by providers
- Insurance/Coverage Issues
- Availability of preferred treatments

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Research on Older Minority Treatment Preferences

Arean et al, 2002 The Gerontologist

- Prefer talking to Primary Care Provider
- 50% will work with nurse or social worker
- Very few would use group-based services
- Tendency to not want medication management
- Majority will engage in individual counseling

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Preference for Individual Psychotherapy/Counseling

- 50% of African Americans state a preference for counseling services *(Cooper-Patrick, 1999)*
- 75% of low-income elderly say they would use individual counseling *(Areán and Alvidrez, 2002).*
- 56% of older, minority primary care patients prefer psychotherapy *(Areán, Gum, Tang, Unutzer)*

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Moving Forward: Examples from the Field

Examples of Strategies that Work

- Aging & Disability Research Centers
- Integrated MH & Primary Care Services
- Mental health training, consultation, and treatment in residential care facilities

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Common Goals of these Strategies

- Focus on enhancing service access & quality
- Create linkages across systems, organizations, and providers
- Consumer-centered, emphasize involvement
- Establish a foundation/structure for implementing Evidence-Based clinical treatments, such as Cognitive Behavioral Therapy (CBT) or Problem Solving Therapy (PST)

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Aging and Disability Resource Centers – Systems Change Strategy

Aging and Disability Resource Centers: Systems Change Vision

Consumer
Philosophy of self-direction and individual control in legislation, policies, and practices

Coherent Systems Management

Access
Comprehensive information, simplified eligibility, and single access points

Financing
A seamless funding system supporting individual choice

Services
Responsive supports across settings and provider types

Quality Improvement
Comprehensive systems that assure quality of life and services

Aging in Place

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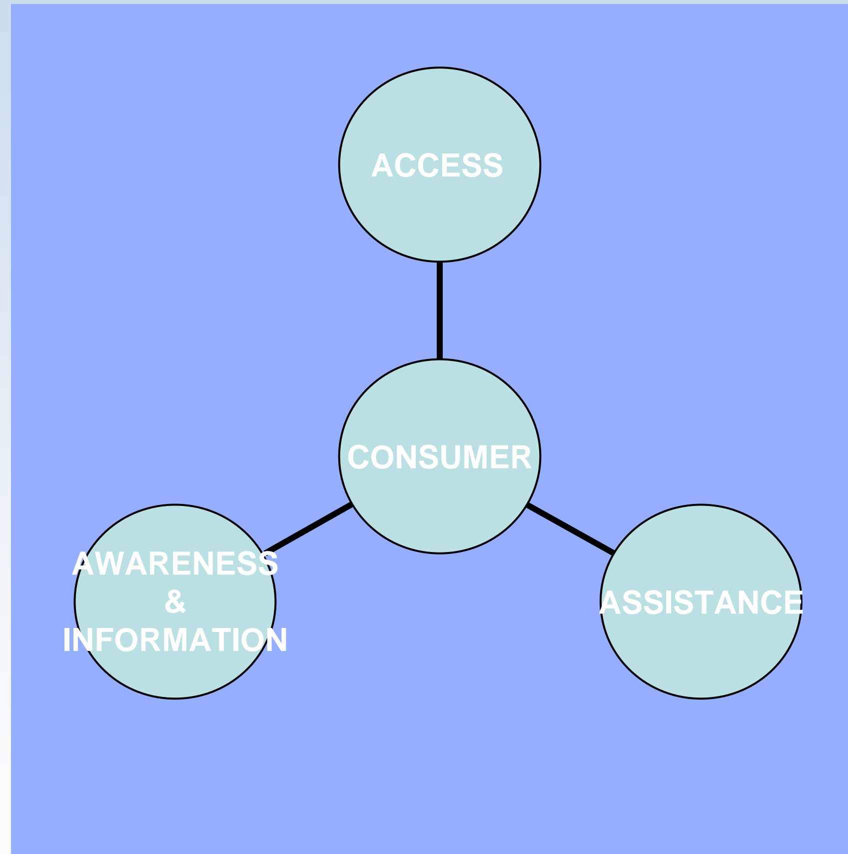
Functions/Services of an ADRC

- **Awareness & Information**
  - Public Education
  - Information on Options
- **Assistance**
  - Benefits Counseling
  - Employment Options Counseling
  - Referral
  - Crisis Intervention
- **Access**
  - Private Pay Services
  - Comprehensive Assessment
  - Medicaid Financial Eligibility Determination
  - One-Stop Access to all public programs



Goals ADRC Program

- Create partnerships among the Aging Network, Medicaid, and other State Agencies to implement consumer-directed care (some states including mental health)
- Increase visibility of long term support within state government
- Promote meaningful involvement of consumers & other stakeholders

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Lessons Learned: Wisconsin's 6 Year Experience

- Be willing to give up organizational turf to work as team and to put clients first
- Recognize staff training needs:
  - Customer service orientation
  - Ability to work with different "systems" and consumers
  - What consumer direction really means
- Don't reinvent wheel – leverage existing community resources and agency experience from both public and private sectors

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Lessons Learned from Wisconsin Experience (cont.)

- Adopt a civic process and develop state & local partnerships
  - Public and private sector integration
- Leverage other grants at State & local level
  - Real Choice Systems Change, AoA Family Caregiver, HUD, Medicaid Infrastructure Grants, etc.
- Emphasize performance monitoring & flexibility to ensure program improvement
- Establish attainable short term goals and objectives but keep sight of the long term goals

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Integration of MH and Primary Care – System & Organizational Change Strategy

Integrated Mental Health in Primary Care

- Recent national studies are informing clinicians and policy makers on optimal strategies for integrating mental health in primary care for older persons
  - PRISMe (SAMHSA)
  - PROSPECT (NIMH)
  - IMPACT (Hartford Foundation)

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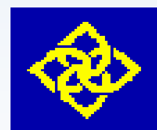
PRISMe

- 11 sites throughout US
- Older primary care patients 65+
- Depression, anxiety, alcohol misuse.
- Integrated care versus enhanced referral



SAMHSA

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Key Integrated Model Features

- Primary care based interventions – MH services co-located in primary care setting
- Collaborative, multidisciplinary care
- Shared clinical information systems
- Cross-training of Staff – primarily medical, but also administrative in screening for MI and substance misuse

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PRISMe Findings

- Far better access to services with integrated care *(Bartels et al, 2003)*
- Far greater participation in services with integrated care
- Issues of stigma diminished among providers and clients

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Engagement Rates by Intervention and Ethnicity

	White		**African American**	
	Referral	Integrated	Referral	Integrated
% Engaged	46%	66%	11%	77%
Days to first visit	63	22	63	31

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Lessons Learned: What you need to integrate MH in Primary Care

- Leadership - often administrative and physician champion
- Clinical information system
- Care management, augmenting MH services
- Staff benefit from team approach – shared responsibility for clients with complex needs - show them evidence of results

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Steps to Integrating

- Determine what you have and what you need
- Cost/benefits of retraining existing staff rather than hiring new
- Identify an opinion leader (Administrative and Physician Champions)
- Quality improvement/Performance monitoring – be flexible, learn along the way, and measure outcomes

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Cross Training Staff: Lessons Learned

- Good, detailed manual
- Lots and lots of supervision
- Start with open-minded trainees (or risk takers)
- Frequent availability for consultation
- Some exposure to mental health is nice, but not required

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MH Training, Consultation, and Treatment in Residential Care Facilities: Workforce Strategy

Senior Behavioral Health Services

- Treatment model for delivering services to older adults in residential facilities through:
  - Training for providers and front-line staff to identify and treat depression and agitation
  - Promoting collaboration among mental health, medicine, social work, and assisted living staff to implement evidence-based treatments

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Agency & Staff Training:

- Dementia
  - Defining and Diagnosing Dementing Illness
  - Medication Management for Dementia and Depression
  - Creating Restraint Free Environments in the Management of Agitation in Dementia
- Depression
  - Diagnosing Depression in older adults
  - Problem Solving Therapy for Depression
- Tracking, measuring, and monitoring clinical outcomes

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Training is Essential

- Trainings in these areas can improve:
  - staff knowledge and attitudes
  - self-efficacy
  - job satisfaction
- Resulting in:
  - Improved quality of direct care to residents
  - More frequent and effective collaboration with other professionals involved in resident's care

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Organizational Fit: *"Lessons Learned"*

- Organizational "readiness"
  - Is the service a match with current mission of the organization?
  - Does leadership in the organization have the expertise to support the clinical team?
  - What knowledge/skills are needed by staff within the organization for successful implementation?
    - *Training PRECEEDS implementation!!!!*

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Other Information Sources for Locally Developed Model Programs

"Promoting Older Adult Health through Aging Network Partnerships"

- Education and prevention
- Outreach
- Screening, referral, intervention, and treatment
- Service improvement through coalitions and teams

SAMHSA & NCOA (2002). *Promoting Older Adult Health: Aging Network Partnerships to Address Medication, Alcohol, and Mental Health Problems* (DHHS Publication No. MS 02-3628).

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Vision and Values for Improving Services

- Enhance independent functioning
- Aging in place
- Quality of life
- Home and community-based alternatives
- Integrated care
- Quality medical care
- Rehabilitation
- Recovery
- Access to mental health services (parity) and needed medications (drug benefit)
- Aging with dignity
- Support of meaningful activities
- Community integration
- The "right" to evidence-based treatments

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Benefits of EBPs and Practice Guidelines

- Standardize and facilitate education
- Decrease variation in practice
- Raise the standard of care
- Stimulate additional research
- Encourage funding – measurable outcomes, evidence of effectiveness
- Consumer and family education, can help reduce stigma

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When you know a thing, to hold that you know it; and when you do not know a thing, to allow that you do not know it - this is knowledge.

Confucius, *The Confucian Analects*

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