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Mental Health and Aging in the 21st Century

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This article reviews pressing issues in mental health care for older adults in the 21st century. After examining current forces for change in older adults' mental health care and coverage, the authors discuss barriers to accessing mental health care resulting from the fragmentation of the United States health care system as well as the history behind the multiple and competing systems of care for older adults. The article continues with a discussion of goals for the provision of good mental health service delivery for older adults and concludes by addressing potential responses and future target areas regarding mental health care for older adults as well as a potential realistic collaboration to address mental health and aging.

KEYWORDS aging, mental health, mental illness, older adults, policy

INTRODUCTION

The effects of mental disorders among older adults are both substantial and wide-reaching for both the individuals living with the disorders as well as those who provide care for them. They also exert a significant toll in terms of morbidity, mortality, and financial burden on both a micro and macro

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level (Karlin & Fuller, 2007). However, mental disorders and mental health programs and policy are often paid little or no attention in discussions about health policy and aging policy. A failure to address these issues directly has consequences for the optimal care of older adults with mental disorders and also directly affects their health care, because mental disorders can affect physical health as well as the adherence to health care plans (Knight & Maines, 2001). In this article, we review the forces for changes in mental health care for older adults in the 21st century. We then discuss the difficulties older adults face accessing mental health care due to the multiple systems of care inherent in the United States. We conclude by discussing potential responses and future target areas as well as a potential realistic collaboration aimed at improving mental health care for older adults.

FORCES FOR CHANGE IN THE 21ST CENTURY

Mental health care and coverage is a policy and public health issue that applies to individuals of all ages. However, this issue is particularly relevant to older adults for several reasons. First, the number of older adults (aged 65 years or older) is expected to rise significantly with the imminent advent of the elderly baby boom population and increases in life expectancy (e.g., Halpain, Harris, McClure, & Jeste, 1999; He, Sengupta, Velkoff, & DeBarros, 2005). Coupled with this increase in the number of older adults is the fact that the baby boom population has higher rates of mental disorders than the current older adult cohort (e.g., Koenig, George, & Schneider, 1994; Piazza & Charles, 2006). Cohort changes in the prevalence of mental disorders include higher rates of depression, anxiety, substance abuse, and dementia (e.g., Gfroerer, Penne, Pemberton, & Folsom, 2003; Hebert, Scherr, Bienias, Bennett, & Evans, 2003; Jeste et al., 1999). Jeste et al. (1999) predicted that the number of older adults with mental disorders will increase from 4 million in 1970 to 15 million in 2030. In addition, the future cohort of older adults is likely to experience more chronic illnesses and disabilities than prior cohorts of older adults due to increasing life expectancy (e.g., Zarit, Johansson, & Malmberg, 1995) and will likely require more mental health services as a result.

Second, not only will the need for treatment of mental disorders among older adults increase but so too will the demand for such treatment due to cohort changes. Knight and Shurgot (2008) reported that compared to older cohorts, the baby boom cohort has been much more likely to seek mental health services for less severe mental illnesses, a trend that will likely continue as this cohort reaches older age. In addition, there are cohort changes associated specifically with the histories of individuals with more serious mental illnesses (SMIs), such as schizophrenia and bipolar disorder. The coming years will bring this latter cohort of older adults living with SMIs

with histories of limited, sporadic, or no treatment into both community-based services for the elderly and the long-term care system and are likely to pose new challenges for these systems of care (Knight & Maines, 2001).

Third, rates of dementia increase with age, and the dementia care system, consisting of various components such as medical and mental health care, aging services, long-term care, and caregiving resources, is especially fragmented. Mental health care and coverage for older adults will thus become a more pressing issue as dementia prevalence increases due to the rapidly growing number of older adults (Zarit & Zarit, 2007). Fourth, Medicare represents a critical source of funding for older adults' mental health care coverage (Bartels & Smyer, 2002), which, as will be discussed later, suffers from circumstances that make older adults' access to mental health services both limited and challenging. Finally, the fragmented nature of the health care system, which will also be discussed later in this review, may be especially perplexing for older adults who may consequently withdraw from seeking service, calling attention to the urgency of addressing the limitations of the U.S. mental health service system for older adults.

MULTIPLE SYSTEMS OF CARE FOR OLDER ADULTS

The current U.S. system of mental health care is not so much a single system as it is a hodgepodge of discrete care systems backed by private, voluntary, and public powers (Brown, 2008). Knight and Kaskie (1995) described this complicated network as multi-system (i.e., many distinct webs of care provision), multi-level, and diagnosis-specific. The multiple systems include the systems for acute and chronic mental health care, acute medical health care, long-term care, dementia care, substance abuse treatment and rehabilitation systems (including informal systems, such as 12-step programs), and the network of aging services. Older adults with mental health problems may be present in any of these systems due to the complexity of the problems of older age and the common comorbidity of problems from more than one of these domains (Knight, 2004).

To comprehend better how the multi-system network of mental health care came to be in the United States, it is essential to scrutinize the history of its development. Over the past several decades, the different systems have gradually changed in response to the influence of specific historical, economic, and political forces; they continue to evolve to this day as a result of these forces. Accordingly, U.S. mental health care is the outcome of multi-layered growth and change as opposed to being the result of poor planning within a united system. In the following sections, we discuss the history of mental health care systems in the Unites States and later consider the future of these systems.

The History Leading to Multiple Systems of Care for Older Adults

The inception of formal care for the mentally ill in the United States

Knight, Kaskie, Woods, and Phibbs (1998) noted that the state hospital system for psychiatric care in the United States began in the late 19th century and was the first form of formal care for individuals with mental illness. In contrast, the United Kingdom and other European countries already had an institutional system responsible for providing care for the mentally ill at this time. Before the use of state hospitals for psychiatric care in the United States, in most cases, families either provided care for their mentally ill relatives or the individuals with the mental illness lived in overcrowded almshouses and prisons (Rosen, Pancake, & Rickards, 1995). In the late 19th century, Dorothea Dix spearheaded a movement to substitute almshouses and prisons with more humane settings for the mentally ill. The main public response to mental disorders (a mix of SMIs, depressive disorders, and dementias) was a state- and locally funded and operated inpatient system that remained in existence until the late 1950s. After World War II, the federal government began playing a larger role in mental health issues due to the passage of the National Mental Health Act in 1946, which created the National Institute of Mental Health. In 1955, Congress passed the Mental Health Study Act that provided federal funding for the Joint Commission on Mental Illness and Health, whose task was to supply an investigation and reassessment of the human and economic troubles associated with mental health problems (Knight & Maines, 2001).

Because of concerns about both overcrowded state hospitals and the cost of erecting more hospitals, as well as the introduction of effective psychoactive medications, large-scale deinstitutionalization of some patients and "trans-institutionalization" (i.e. ending up in different institutions rather than in the community) of others, especially older adults, began. During the early 1960s, the Kennedy Administration pushed for the passage of the Community Mental Health Centers Act of 1963 that financially supported the creation of comprehensive mental health centers (CMHCs) to supply services to both deinstitutionalized mentally ill individuals and those requiring sporadic care (Knight et al., 1998). Congress did not order that CMHCs provide specialty care to older adults until 1975, but even then, the CMHCs placed minimal weight on services for older adults.

In 1965, the enactment of Medicare and Medicaid by the federal government led to the growth of long-term care for older adults. This growth was principally a physical medicine program, and long-term care facilities were mainly intended to transfer long-stay, physically frail older adults out of acute care medical-surgical hospitals (Knight & Maines, 2001). Nonetheless, many of the deinstitutionalized chronically mentally ill older adults who were forced out of the state hospital system ended up in long-term care

facilities (Gatz & Smyer, 1992). Many of these individuals did not require specialized nursing care even though the admission criteria and care planning for such facilities are based on the need for nursing services, not on the mental disorder (Smyer & Qualls, 1999, 240–241).

The shift from federal to state responsibility

In the late 1970s, the Carter Administration made older adults a priority target population for the CMHCs by enacting both the Presidential Commission on Mental Health in 1977, which highlighted a need for better community-based services, and the Commission's 1980 Mental Health Systems Act, which supplied special staffing and grants for CMHCs with programs focused on aging (Knight & Maines, 2001). This leadership on mental health policy contrasted with the trend, begun under the Nixon administration, to shift the federal government out of providing services and toward a management and technical advice role.

In the 1980s, the Reagan Administration further extended the changes started by the Nixon administration by restricting the federal government's role in mental health. Federal policy changes began to shift the responsibility and financing for mental health programs back to the state level, which proved unfortunate for the expansion of mental health services for older adults. When President Reagan signed the Omnibus Budget Reconciliation Act (OBRA) of 1981, the Mental Health Systems Act was revoked. As a result, mental health and substance abuse treatment and rehabilitation service programs were combined into a single block grant that allowed each state to manage its allocated funds. The shift included an initial 25% decrease in federal funding, with even more decreases in subsequent years. Thus, the federal government's role in services for the mentally ill evolved into one of supplying technical aid to augment the capacity of state and local providers of mental health services as a result of the revocation of the community mental health legislation and the creation of block grants (National Institute of Mental Health, 2000). At that point, it appeared as though the backdrop of public services for the mentally ill, particularly those with SMIs, had regressed to the times before Dorothea Dix, when the norm was family-provided care, prison-based care for those who committed certain crimes, and a variable assortment of public and private clinic services for those able to locate them (Knight & Maines, 2001).

A return to federal oversight

In response to the relocation of mentally ill older adults into long-term care facilities and a study by the Institute of Medicine, Committee on Nursing Home Regulation (1986) highlighting poor quality of care in nursing homes

at the time, the U.S. federal government passed the Nursing Home Reform Act of 1987, which required that nursing homes perform initial examinations on patients to assess for psychiatric illness. In cases in which a patient had a diagnosed mental illness, the nursing home was obligated to supply proper psychiatric care or disallow admission to the individual and/or transfer the individual to a more suitable facility (Smyer, 1989). Reports indicated that the provision of mental health services in nursing homes abruptly increased after the enactment of this law (Knight & Kaskie, 1995; Office of Inspector General, Department of Health and Human Services, 1996) rather than an increase in the number of older adult patients with mental health problems being discharged from nursing homes. A recent study demonstrated that there was substantial provision of mental health services in a sample of 146 Florida nursing homes, with approximately 50% of the nursing homes sampled reporting that psychologists, psychiatrists, and other medical doctors provided mental health services on a weekly basis (Molinari, Hedgecock, Branch, Brown, & Hyer, 2009). In contrast, other studies have reported that the availability of mental health services in nursing homes across the United States has not improved since the passage of the Nursing Home Act of 1987. For example, Li (2010) examined survey data collected from a nationally representative sample of 1,174 nursing homes and reported that by 2004, 22% of U.S. nursing homes did not provide mental health services to residents and only 25% of nursing homes provided such services on a regular basis or at regularly scheduled times. Smaller or rural nursing homes in particular were the least likely to provide such services. Moreover, a recent literature review reported that the quality of mental health care in U.S. nursing homes, when available, tends to be poor along a range of various measures of quality, such as mental health consultations and medication appropriateness (Grabowski, Aschbrenner, Rome, & Bartels, 2010). The differences across these studies may be attributable at least in part to the vastly different sample sizes and the locations and sizes of the nursing homes sampled in each study.

The growth of the private sector and managed care

Since the 1980s, the outpatient sector of mental health services has also evolved significantly. Mental health services have undergone privatization in that their concentration largely shifted from organized clinics such as CMHCs to outpatient care provided by private practitioners. This care is reimbursed by Medicare in one form or another. This change came after both the downfall of public-sector community mental health centers under the devolution policies of the Reagan era as well as the liberalization of mental health coverage compared to previous standards under Medicare in the 1989 OBRA changes. This liberalization brought expansions in coverage of private practice outpatient visits by eliminating prior ceilings on outpatient care and expanding covered providers to include psychologists and

clinical social workers in addition to private-sector inpatient and partial hospitalization visits (Knight & Maines, 2001). More recently, the first year of the Obama Administration saw the passage of mental health parity legislation that will phase in the elimination of the higher co-payment for mental health services compared to medical services under Medicare (Daly, 2009). This change should continue the expanded availability of outpatient mental health services to older adults in the private sector. Although less directly connected to mental health care, the addition of Medicare Part D coverage in the Bush Administration may have increased access to psychotropic medications by providing reimbursement for prescription drugs of all kinds (Karlin & Humphreys, 2007).

In the early 1980s, managed care organizations (MCOs) became a key part of the medical and mental health systems both under Medicare as well as in the private sector. Beginning in 1982, MCOs started enrolling Medicare patients and obtaining a fixed monthly per capita payment from the government to pay for services. Because the payments not used on services can be retained by the MCOs, they thus have financial incentives to discover ways to reduce expenses and, perhaps, restrict access to care. The move from fee-for-service to managed care reimbursement of medical and mental health services care in many regions of the United States led to Medicare's developing into a more competitive payment source for private-practice mental health professionals. Medicare rates remained generally stable while other rates of pay decreased to or below Medicare's reimbursement level and occasionally required even more review and bureaucratic involvement than the government program. Knight and Kaskie (1995) noted that this change could have had advantageous effects for older adults' mental health services, because MCOs could bring together medical and mental health services and were inclined to promote outpatient over inpatient care. Kaskie, Wallace, Kang, and Bloom (2006) reported that differences in MCOs' administrative policies could affect the number of older adults getting mental health services. The precise effects of managed care principles and policies on access to mental health care by older adults need further study.

Knight and Maines (2001) noted that neither the private-sector outpatient services nor the long-term care services available at that time (which were also increasingly offered by MCOs) laid emphasis on proficiency in geriatrics and gerontology among their providers. Rather, as is the case in other areas of managed care to this day, the emphasis was on using generalists rather than specialists, since the latter tend to cost more money. With regard to older adults' mental health services, this reality presented potentially severe problems, given that expert knowledge is needed to differentiate between various mental illnesses in older adults (Zarit & Zarit, 2007) and among medical and mental health as well as social services issues (Knight, 2004). Moreover, older adults and those connected with them (e.g., family, primary care physicians, aging network services workers) are less

likely to identify and refer for mental health issues as compared to younger populations. Knight, Rickards, Rabins, Buckwalter, and Smith (1995) noted that active case finding has been a central component of all model programs for providing mental health services to older adults.

The Current Status of the Multiple Systems of Care for Older Adults

An examination of all of these changes in the delivery of mental health services for older adults reveals a mixture of both positive and negative outcomes. The prior public-sector systems of both state hospital care and community mental health centers have declined significantly and been largely replaced with the private-sector services at the inpatient, outpatient, and day-treatment levels and in long-term care settings with much more consideration to older adults. Although these services are operated by private, often for-profit providers, the majority of this activity is funded by public funds (i.e., Medicare and Medicaid). Kaskie, Linkins, and Estes (2000) reported that minimal or no information is available on which individuals receive mental health services, for what kinds of problems, and from what types of mental health professionals.

The transference of mental health services and policy from the federal to state governments during the years between Presidents Nixon and Reagan brought mental health policy back to the individual states, where it has been for most of the history of the Unites States' mental health policy, with the exception of the short time beginning with the Kennedy administration. For example, in their summary of the history of dementia care policy, Kaskie, Knight, and Liebig (2000) noted that individual states were the initial policy makers beginning in the 1930s and are presently the key players in dementia policy. Certainly, state policies are decidedly variable, which can be either beneficial if the policies reflect responsiveness to local needs and wishes or harmful if they reflect disordered variation resulting from self-interest on the part of legislators and politicians and other political issues that are unconnected to public need for services. Knight and Maines (2001) summarized these trends in mental health care policy in the United States by stating that the prior systems of care that highlighted public-sector services based in state psychiatric hospitals and later in community mental health centers have largely ended. The substitutions for these prior systems have included (a) the transfer of mental health patients into long-term care facilities and the medical care system, (b) the privatization of mental health services financed by federal funds, (c) a current dependence on managed care payment and organizational options, and (d) a return to state-level accountability for mental health policy and services that is not managed by private providers.

An emerging area of policy emphasis is the role of local Medicare policies, decisions made by the private insurers that administer the Medicare system, and their effects on mental health services to older adults. Kaskie,

Imhof, and Wyatt (2008) noted that these decisions by private insurers are an important source of variability in Medicare coverage for mental health services for older adults.

LOOSELY COUPLED AND COMPETING SYSTEMS OF CARE

A common conceptualization of the shortcomings of the mental health care system for older adults is frequently referred to as "falling through the cracks" (e.g., Bartels & Smyer, 2002). According to this view, community mental health services often underserve older adults and lack age-appropriate services. Moreover, they often are short of staff members trained to address medical needs. As a result, many older adults with mental health service needs "fall through the cracks" and are instead treated in primary care or long-term care settings that tend to lack specialization in older adults' mental health treatment. In our opinion, it appears as though the mental health care system in the United States is not really one system with cracks but actually a conglomeration of multiple, separate systems of care, as described above.

In fact, a defining characteristic of the U.S. health care system is that it is hardly a system at all. As discussed by Brown (2008), the system is really a "nonsystem, a fragmented assemblage of private, voluntary, and public powers" (326). At best, there are multiple systems of care with some components containing multiple subsystems themselves. According to the Administration on Aging (2000), the benefits of a decisive move away from mental health treatment in psychiatric hospitals and nursing homes to community-based settings today are at risk of being destabilized by the fragmentation of the U.S. health care system and inadequate availability of services. As noted earlier, the systems involved in the provision of mental health services to older adults include specialty mental health, acute medical, long-term, dementia, and substance abuse care as well as the aging services network. Each of the systems has its own distinct history and culture with different rules for how patients or clients move through each system. In the cost-cutting political climate, the systems are often in direct conflict with one another. The current system is at best an example of a loosely coupled system (Myrtle & Wilber, 1994), with much of the coupling occurring at the front line service provider level when front line providers can and do focus on the needs of older clients.

No matter which conceptualization one chooses to explain the lack of mental health service provision to older adults, the outcomes remain the same and just as dire. Kaskie, Gregory, and Cavanaugh (2008) noted that older adults with clinical mental health disorders are less likely than any other population group to receive specialty mental health care. Similarly, Karlin, Duffy, and Gleaves (2008) found that older adults were three times less likely than younger adults to report getting treatment for mental health problems.

The picture is further complicated by the need for different kinds of services by different subgroups of older adults with mental health problems. In general, older adults with acute mental health disorders (e.g., depression, anxiety) are likely to need outpatient services. In contrast, those with SMIs (e.g., schizophrenia, bipolar disorders, paranoid disorders) likely need a more complex range of services from mental health specialists. Persons with dementia move among medical, mental health, long-term, and dementia care settings. Mental health specialists are most likely to be needed at the time of diagnosis of dementia and when behavior problems due to dementia are part of the picture as well as for therapy in the earlier phases of dementia with the patient and throughout with the caregiver. Whether substance abuse treatment is part of mental health care or a distinct system varies by locality.

GOALS FOR GOOD SERVICE DELIVERY

Good service provision for older adults with mental health problems will depend on expert assessment and diagnosis. Assessment is more complex with older adults because of both the pervasive question of whether certain symptoms are due to a dementing illness as well as the widespread comorbidity of mental health and medical problems (Knight, 2004). In addition, the assessment and guidance for treatment is likely to necessitate some expertise in geriatric psychopharmacology. Older adults also have trouble navigating the complex and loosely coupled systems that exist to serve them and do not always present in the correct system for care. Thus, every system needs to consider whether the best course of action for assessment and/or treatment lies elsewhere. The assessment is of little practical use if it is not followed by active treatment with medication and/or psychological interventions.

After reviewing model programs in community mental health, Knight et al. (1995) noted that common elements included the use of interdisciplinary teams and home-based service delivery, active case-finding methods, community education, a focus on active treatment, and interagency collaboration. The health professions appear to have been somewhat responsive to the needs of older adults with mental health problems. There has been greater attention to specialization in geriatric care by several professional groups (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009; Landefeld, Winker, & Chernof, 2009). In addition, assessment of mental health problems in older adults has improved because there is now more sophistication about the diagnosis of dementia, an improved ability to detect progressive dementias in early stages, and greater awareness of the distinctions among dementia, delirium, normal aging, and depression (Zarit & Zarit, 2007), although recognition of other disorders such as anxiety (Lauderdale & Sheikh, 2003) and substance abuse lags (Barry, Blow, & Oslin, 2002).

With the changes in Medicare reimbursement for psychological services, recognition of the Medicare market has allowed for private-sector service provision to older adults (Karlin & Duffy, 2004), although not necessarily by specialists (Bogner, de Vries, Maulik, & Unützer, 2009).

POTENTIAL RESPONSES AND FUTURE TARGET AREAS

Clearly, there remains a great deal of work to be done in terms of improving older adults' access to mental health services from both policy and practical standpoints. Karlin and Duffy (2004) recommended that psychologists who provide services to older adults be active supporters for both their clients as well as their profession as a whole at lawmaking and regulatory levels to improve access and reimbursement for their psychological services (see Karlin & Duffy, 2004, for a review on mechanisms by which psychologists may stimulate change in this area). Karlin and Humphreys (2007) similarly encouraged psychologists to engage in strategic advocacy for the extension of Medicare coverage for psychological services, mainly in the areas of prevention, screening, and early intervention.

Other authors have called for the integration of mental health and primary care services as a means of increasing access to mental health services. Such integration has been shown to be related to both improved clinical and functional patient outcomes as well as higher levels of patient satisfaction (Chen et al., 2006; Hedrick et al., 2003; Katon et al., 2002; Unützer et al., 2002). Zeiss and Karlin (2008) reported on the Veterans Affairs medical centers' models for integrating primary medical and mental health care within their extensive national system.

Primary medical care is not the only system in which older adults with mental health needs present, however. Kaskie, Gregory, and Cavanaugh (2008) noted that access to mental health care in the California community mental health system depended in part on the local availability of complementary service systems in health, long-term care, and aging services as well as possible formal or informal referral networks among them. Kaskie, Linkins, and Estes (2002) pointed to an increasing role for the aging network in advocating for and providing mental health services, although the focus in their study was primarily on advocacy for persons with dementia and their families. As another example of a system connected to older adults with mental health needs, Schonfeld, Larsen, and Stiles (2006) reported on the mental health needs of older adults calling abuse-reporting hotlines. Note also that older adults with mental health problems often turn to their religious institutions as well as to medical and psychosocial professionals. The decline in institutional care for individuals with SMIs who are aging in place within prisons makes services for older adults in prisons an emerging area of need.

CONCLUSION: A POTENTIAL REALISTIC COLLABORATION TO ADDRESS MENTAL HEALTH AND AGING

In closing, we urge those interested in improving services for older adults with mental health problems to recognize the multiple systems of care with their distinctive histories, organizational cultures, and rules for serving clients. This image is more complex and more accurate than the conceptualization that there is one coherent system that would work well if there were simply more age-appropriate services and mental health staff members with an understanding of how to address medical needs. There are many reasons the systems do not work well together, including that they were designed in different times to accomplish different tasks. Increasingly, the politics of public cost-cutting pit the systems against one another for survival, an environment that is not conducive to extensive collaboration. However, older adult clients do sometimes get good services because of the collaboration of health professionals. Much of the collaboration that does work happens when client-centered professionals work together informally to make things happen for specific clients. As noted earlier, Kaskie, Gregory, and Cavanaugh (2008) suggested that the greater level of mental health service use by older adults in certain regions of California could be due to formal and informal referral patterns among nursing homes, hospitals, and mental health services employees whereby such facilities relied on county mental health departments to aid in the care of older adults with mental illnesses. If this ground-level collaboration can be encouraged effectively at higher levels of policy and planning, older adult clients may benefit from a more effective though still loosely coupled system of services to meet their mental health needs.

A national response to the needs of older adults with mental health problems would likely have the most impact if implemented through the Medicare and Medicaid systems. Both can influence large numbers of providers by changes in regulations and payment structures that incentivize mental health assessment and treatment of older adults. Greater thought needs to be given to the entire range of mental health problems that older adults face (e.g., depression, dementia, anxiety, psychoses, substance abuse) to the range of care settings needed to respond to these diagnoses (outpatient, inpatient, partial hospitalization, community-based, and institutional long-term care) and to the most effective matches between the two.

The utilization of geriatric expertise in both the planning process and delivery of services would be beneficial to future policy in this area as well. As noted here, the last few decades have seen an increased understanding among specialists of the complexity of problems, services, and the multiple systems of care. Much of the success of these decades has been the increasing inclusion of older adults in generic mental health services. Future progress will depend on including experts in geriatric mental health

in the planning process and increasing the role of geriatric specialists in the provision of mental health services to older adults.

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