

The Underside of the Silver Tsunami — Older Adults and Mental Health Care

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Approximately 5.6 million to 8 million Americans 65 years of age or older have mental health or substance-use disorders, and the Institute of Medicine (IOM) estimates that their numbers will reach

10.1 million to 14.4 million by 2030.¹ Yet the American Geriatrics Society estimates that there are fewer than 1800 geriatric psychiatrists in the United States today and that by 2030 there will be only about 1650 — less than 1 per 6000 older adults with mental health and substance-use disorders. The IOM's 2012 workforce report on this topic, aptly subtitled *In Whose Hands?*, confirms that we will never be able to train enough specialists in geriatric medicine and geriatric psychiatry to care for this rapidly growing and highly vulnerable population. Indeed, more than half the fellowship positions in geriatric medicine or geriatric psychiatry go unfilled each year (see graph),

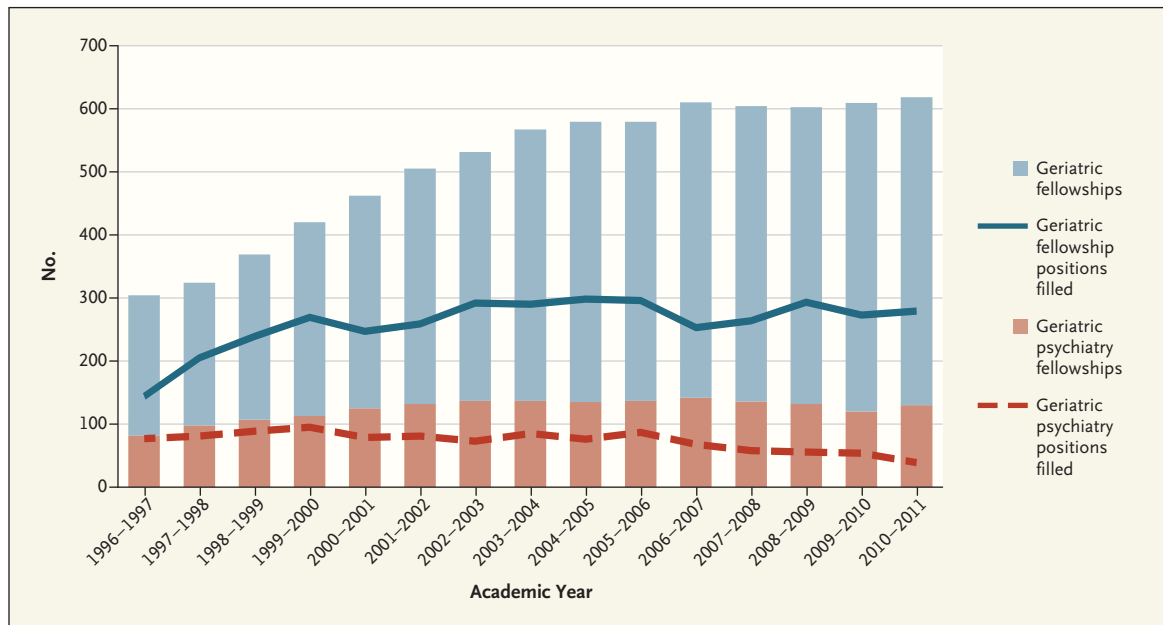
and according to the American Psychological Association, only 4.2% of psychologists focus on geriatrics in clinical practice.

Older adults with mental health disorders have greater disability than those with physical illness alone, as well as poorer health outcomes and higher rates of hospitalization and emergency department visits, resulting in per-person costs that are 47% to more than 200% higher.^{1,2} Yet mental health services account for only 1% of Medicare expenditures.¹ Formulating and implementing policies to build the geriatric mental health workforce to address these needs has been notoriously difficult, especially since different federal agencies hold

responsibility for mental health services and aging services.

Fortunately, the IOM report resists declaring yet another “crisis” requiring the training of more geriatric specialty physicians — an alarm and recommendation that has been repeated in vain for more than 90 years.³ Instead, the unprecedented aging of the population requires an unprecedented shift in the delivery paradigm for geriatric mental health care.

The new Medicare Annual Wellness Visit highlights for primary care physicians this challenge of meeting the health care needs of older adults: it requires screening for depression as well as the detection of cognitive impairment, thus adding newly identified disorders but without additional resources, trained personnel, or additional reimbursed time to provide follow-up services. The IOM report begins to address the shortfall of geriatric mental health



Percentage of Filled Geriatric Medicine and Geriatric Psychiatry Fellowship Programs, 1996 to 2011.

Data are from the American Geriatrics Society and the Geriatric Workforce Policy Studies Center, Association of Directors of Geriatric Academic Programs, 2010. Reprinted with permission from the Institute of Medicine.¹

providers by recommending that training in evidence-based treatment of mental health and substance-use disorders be provided to all primary care clinicians, nurses, care managers, allied health care professionals, and social service providers who care for older adults. Beyond promotion of these broad training initiatives, additional novel solutions will probably be needed. For example, clinical capacity could be extended by developing a workforce of health coaches and lay community health workers trained to provide screening and brief interventions for geriatric mental health and substance-use disorders.

Evidence of the potential effectiveness of such solutions comes from unconventional sources. Consider, for example, developing countries where mental health care providers are scarce.⁴ A randomized trial involving 2796 patients in Goa, India, showed the

effectiveness of having lay health counselors provide stepped-care screening for and treatment of common mental health conditions in collaboration with primary care physicians and a consulting mental health specialist. Other trials from India, Chile, Pakistan, and Uganda have similarly shown that a workforce largely comprising nonmedical mental health workers can successfully deliver interventions for depression, anxiety, and schizophrenia (see table).⁵ Although none of these programs specifically target older adults, all age groups were included, so it may be feasible to use “reverse innovation” to adapt these solutions from resource-poor countries to compensate for the U.S. workforce shortfall. Employing lay counselors might also more effectively engage elderly people from ethnic and racial minority groups — the fastest-growing group of U.S. seniors and one less likely than white se-

niors to seek care from conventional mental health providers.

Other potential solutions might capitalize on older adults’ increasing use of Internet-based and mobile health technologies, which offer opportunities to provide screening and treatment that might otherwise be inaccessible, or not sought, owing to lack of transportation, limited mobility, or stigma. For example, smartphone applications can support detection, monitoring, and self-management. Brief psychotherapy can be delivered to at-risk older adults through telehealth systems or automated Internet-based programs. In addition, social media may be leveraged to engage peer support that may help prevent depression by allowing older adults to overcome isolation caused by a spouse’s death or their own disability from chronic illness.

Thus, our response to the inquiry “In whose hands?” is twofold. First, it will take many types

Innovative Approaches for Addressing Common Mental Health Conditions Across Diverse Age Groups in Limited-Resource Settings.*						
Country	Setting	Design	Sample	Intervention	Workforce Demands	Results
India	Primary care settings in Goa	Cluster-randomized, controlled trial	2796 men and women with common mental health disorders	Collaborative stepped care with lay health counselor case managers	Lay health counselors with 2-mo training and no prior health care background	Recovery from common mental health disorders at 6 mo: 65% for intervention vs. 53% for enhanced usual care (P=0.05)
India	Rural villages in the state of Madhya Pradesh	Prospective trial	207 socially disadvantaged men and women with psychiatric disorders	Community-based rehabilitation	Mental health workers from local community who completed a 60-day training program	At end point (median, 46 mo), overall psychosocial functioning: 50% with marked improvement and 40% with moderate improvement over baseline; medication adherence: 63% with marked improvement and 36% with moderate improvement over baseline (P<0.001)
Chile	Primary care in deprived urban areas of Santiago	Randomized, controlled trial	240 women with depression	Multicomponent stepped-care program for depression	Nonmedical health worker	Recovery from depression at 6 mo: 70% for intervention vs. 30% for usual care (P<0.001)
Pakistan	Urban community of Karachi	Randomized, controlled trial	366 women with depression or anxiety	Home-based counseling sessions	Lay female counselors from the local community who completed a 4-wk training program	Mean reduction in anxiety and depression scores at 8 wk: 35% for intervention vs. 14% for control (P<0.001)
Uganda	Villages in Masaka and Rakai provinces	Cluster-randomized, controlled trial	248 men and women with depression	Group interpersonal psychotherapy	Minimally trained local Ugandans with no previous mental health or counseling experience	Recovery from depression at 6 mo: 88% for intervention vs. 45% for control (P<0.001)

* Data are from studies cited in a review by Patel et al.⁵ and in a commentary by Reynolds and Albert.⁴

of trained hands, including unconventional providers, to address the growing mental health needs of older adults. While still calling for repayment of educational loans and other financial incentives for training geriatric specialists to act as educators, leaders, and expert consultants, the IOM report stresses the need to train diverse direct care and peer-support providers who can perform screening and brief interventions for geriatric mental health problems and substance-use disorders. For example, nurse practitioners, physician assistants, and social workers in primary care settings could receive brief training in evidence-based geriatric mental health and substance-abuse management, without requiring specialized internship or fellowship training. Evidence-based practices consisting of screening and brief interventions for geriatric depression could be implemented with the use of the existing workforce of 29,000 Aging Network service providers who reach more than 10 million older adults each year in senior centers, senior housing, and home-delivered meal programs. Finally, by training peers and lay health workers and deploying new technology, it may be possible to fill the vast gap between the availability of specialists and the population need.

Second, the report concludes that at the federal level, the plight of older adults with mental health and substance-use disorders is in no one's hands: no single government agency is accountable for this vulnerable, high-cost, rapidly growing population. Workforce development falls into a crack between federal agencies responsible for mental health and substance use and those responsible

for aging. Highlighting the field's orphan status, a decade-long initiative by the Substance Abuse and Mental Health Services Administration implementing evidence-based geriatric mental health and substance-abuse programs throughout the country was recently eliminated, just as the wave of Baby Boomers turning 65 began to crest.¹ On the research front, National Institutes of Health policy has inexplicably allowed the systematic exclusion of study participants over 65 years of age in federally funded research involving adults (but requires detailed justification for research that excludes women, minority groups, and children). This policy forces clinicians to extrapolate from findings on the safety and effectiveness of treatments that have been tested only in younger adults, and it perpetuates what has been called the "evidence-free" practice of geriatrics.

We believe that steps should be taken to mandate the inclusion of older adults in federally funded research unless there is scientific justification for excluding them, and we agree with the IOM that immediate steps are needed to re-

store the national program supporting the implementation of geriatric community mental health and substance-use programs. Emerging Medicare accountable care organizations should integrate geriatric mental health and substance-use expertise as components of health coaching and chronic disease management for patients with complex, high-cost health conditions. The potential for prevention must also be tapped, in part through the adoption of evidence-based psychological interventions that reduce the incidence of depression among patients with health conditions associated with greater risk, such as stroke and macular degeneration. Finally, the fragmentation and neglect of services and research may be addressed by creating a dedicated federal office responsible for overseeing funding and coordination across the different agencies responsible for aging, mental health, and substance-use disorders.

Although these reforms are necessary first steps, they will be insufficient without dramatic changes in what we do and how we do it. If we recognize that

mental health care is a core component of general health care for aging Americans and transform the health care workforce accordingly, there may be hope that we can weather the approaching "silver tsunami."

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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This article was published on January 23, 2013, and updated on February 7, 2013, at NEJM.org.

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- DOI: 10.1056/NEJMp1211456
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U.S. Governors and the Medicaid Expansion — No Quick Resolution in Sight

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With President Barack Obama's reelection in November, the Affordable Care Act (ACA) will remain the law of the land for the foreseeable future. But since the Supreme Court ruling on the ACA, states have been grappling with the option the Court presented — whether to participate in the expansion of

Medicaid eligibility to all adults with family incomes at or below 138% of the federal poverty level. In the aftermath of the 2012 election, it is uncertain how this process will play out, but what the states decide will play a critical role in the future of the U.S. health care system.

We undertook an in-depth ex-

ploration of the views expressed by governors about the ACA Medicaid expansion from the time of the Supreme Court ruling in June through 1 month after the November election. Although governors are, of course, only part of the state-level policymaking process, they directly oversee each state's Medicaid program