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The Mental Health and Substance Use Workforce for Older Adults

In Whose Hands?



The aging of America holds profound consequences for the nation. The number of adults age 65 and older is projected to soar to 72.1 million by 2030—up from 40.3 million in 2010. During the same period, the ethnic, racial, and cultural makeup of the older adult population will become more diverse than ever, and the health care demands and costs resulting from these demographic shifts are expected to be unprecedented.

In 2008, the Institute of Medicine (IOM) issued *Retooling for an Aging America: Building the Health Care Workforce*, which highlighted the urgency of expanding and strengthening the geriatric health care workforce. Because of similar concerns about older adults' mental health and substance use (MH/SU) conditions, the Department of Health and Human Services (HHS), as directed by Congress, asked the IOM to undertake a complementary study on the geriatric MH/SU workforce. An IOM expert committee assessed the needs of this population and the workforce that serves it and presents its findings and recommendations in *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* In this report, “substance use” refers to the abuse or misuse of, or dependence on alcohol and drugs—illicit or legal.

A Vulnerable, Underserved Population

The MH/SU needs of older adults are complex, typically occur with other health problems, and are often inadequately met by today's health care system. At least 5.6 million to 8 million—nearly one in five—older adults in America have one or more MH/SU conditions, which present unique challenges for their care. Depressive disorders and dementia-related behavioral and psychi-

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atric symptoms are the most prevalent, but substance use is a significant problem as well.

Age alters the way people metabolize alcohol and drugs. Commonly used medications may worsen physical or mental health problems and increase an older person's risk for dangerous overdose. Losses that occur frequently in old age, such as the death of a spouse, may trigger or worsen depression and lead to severe, debilitating symptoms. Differentiating between major depression and grief in a person with significant loss is often difficult. Cognitive, functional, and sensory impairments also may complicate detection and diagnosis of MH/SU conditions.

The geriatric MH/SU workforce includes a wide range of workers who provide diagnosis, treatment, and care—ranging from personnel with minimal education to specialty professionals with the most advanced psychiatric and neurological training. Across the workforce, there is little, if any, training in geriatric MH/SU. MH/SU specialists are not trained in geriatrics, and geriatric specialists are not trained in MH/SU. Primary care and other essential providers are not trained in either area.

Overall, the number of individuals working in or entering fields related to geriatric MH/SU is disconcertingly small. Geriatric MH/SU specialists, who are the most highly trained to handle complex MH/SU cases, are in very short supply. Relatively few opportunities exist for health care professionals to specialize in geriatric MH/SU. No financial incentives encourage geriatric MH/SU providers to enter and stay in the field, and there is little support or mentorship for people who pursue specialization.

Two decades of research show that effective delivery of MH/SU services—particularly for depression and substance use—to older adults requires these essential ingredients:

- Systematic outreach and diagnosis
- Patient and family education and self-management support

- Provider accountability for outcomes
- Close follow-up and monitoring to prevent relapse

These elements are best obtained when care is patient-centered, in a location easily accessed by patients (such as in primary care, senior centers, or individuals' homes), and coordinated by trained personnel with access to specialty consultation. Care managers are critical to effective care.

Needed: National Leadership—and Action

In addition to the lack of a pipeline producing the type of workforce that is needed, many federal agencies with significant influence over the makeup, competence, and capacity of the workforce to deliver MH/SU services fail to exert that influence in the way they could or should, the committee notes. The Centers for Medicare & Medicaid Services (CMS), for example, could influence the delivery of geriatric MH/SU services, but its reimbursement rules deter, rather than facilitate, access to effective, efficient services. There is a fundamental mismatch between older adults' need for coordinated care and Medicare's fee-for-service reimbursement, which precludes payment for trained care managers and psychiatry consultation.

The Health Resources and Services Administration has the potential to support the training of key health personnel, yet none of its geriatric training programs require exposure to MH/SU conditions. The Substance Abuse and Mental Health Services Administration is the lead federal agency charged by Congress to direct services and resources to people with MH/SU conditions, yet it has consistently devoted only a small fraction of its budget to older adults. And while the missions of several institutes at the National Institutes of Health relate to aging, mental health, or substance use, none focuses on geriatric MH/SU.

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National Health Care Workforce Commission, which was authorized under the Patient Protection and Affordable Care Act (ACA) to serve as a national resource that focuses on evaluating and meeting the need for health care workers. Central among the commission's top priorities should be identifying, developing, and refining methods to improve recruitment and retention of geriatric MH/SU personnel—and to build a workforce that reflects the diversity of the older adult population that it serves. Congress also should appropriate funds for the ACA workforce provisions that authorize training, scholarships, and loan forgiveness for people who work with or are preparing to work with older adults with MH/SU conditions. (See Insert.)

Each member of the broad workforce that encounters older adults, from primary care doctors to geriatric specialists, needs to have the basic knowledge, skills, and competence to meet the needs of older adults with MH/SU conditions. To this end, the committee also calls for revamping how the health care workforce is trained and licensed. Most organizations that educate, train, accredit, and certify the various workforce sectors are not focused on ensuring providers' competence in geriatric MH/SU. Therefore, state licensing boards, as well as organizations responsible for accreditation, certification, and professional examination should modify standards, curriculum requirements, and credentialing procedures to require professional competence in geriatric MH/SU for all personnel who care for the diverse

needs of older adults. HHS agencies should assume responsibility for building the geriatric MH/SU workforce and for facilitating its deployment. For example, CMS should evaluate alternative funding methods for personnel who provide evidence-based care to older adults with MH/SU conditions. This should include reimbursing care managers as well as psychiatrists and other mental health specialists who supervise their work. Similarly, the National Institute of Mental Health should conduct research on increasing the capacity of the mental health workforce to provide competent and effective care for older adults, whether they live in the community or in group residential settings, such as nursing homes.

Conclusion

For decades, policymakers have been warned that the nation's health care workforce is ill-equipped—in numbers, knowledge, and skills—to care for a rapidly aging and increasingly diverse population. In the specific disciplines of mental health and substance use, there have been similar warnings about serious workforce shortages, insufficient workforce diversity, and lack of basic competence and core knowledge in key areas. These past calls to remedy inadequate training and to reverse serious shortages of personnel for MH/SU care have gone unheeded.

The breadth and magnitude of the problem have grown to such proportions that no single approach, nor a few isolated changes in dispa-



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rate federal agencies or programs, can adequately address the issue. Overcoming these challenges will require focused and coordinated action by each of the entities that the committee identifies in its recommendations. 

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The Mental Health and Substance Use Workforce for Older Adults

In Whose Hands?

The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands report offers recommendations, excerpted here, for implementation by key stakeholders to address the unique needs of an aging population.



Recommendation 1

Congress should direct the Secretary of the Department of Health and Human Services (HHS) to designate a responsible entity for coordinating federal efforts to develop and strengthen the nation's geriatric mental health substance use (MH/SU) workforce.

The committee urges Congress to fund the already authorized National Health Care Workforce Commission to serve in this capacity. In the absence of congressional action, the Secretary of HHS should act as soon as possible to designate an alternative body.

The coordinating body should have the following priorities with respect to the geriatric MH/SU workforce:

- Identification, development, and refinement of methods for improving recruitment and retention of geriatric MH/SU personnel, including ways to build a workforce that reflects the increasingly diverse older adult population.
- Promotion and support of wide-scale implementation of evidence-based models of geriatric MH/SU care that effectively deploy personnel.
- Identification, development, and refinement of model curricula and curriculum development tools in geriatric MH/SU, including effective models of training for integrated rehabilitation, health promotion, health care, and social services for older adults with serious mental illness.
- Identification, development, and refinement of core competencies in geriatric MH/SU for the entire spectrum of personnel who care for older adults, including direct care workers, peer support specialists, primary care physicians, nurses (at all levels), physician assistants, substance use

counselors, social workers, psychologists, rehabilitation counselors, and marriage and family therapists.

- Evaluation and dissemination of all of the above.

Recommendation 2

The Secretary of HHS should ensure that its agencies—including the Agency for Healthcare Research and Quality, Administration on Aging, Centers for Medicare & Medicaid Services (CMS), Health Resources and Services Administration (HRSA), National Institute on Drug Abuse, National Institute on Mental Health (NIMH), and Substance Abuse and Mental Health Services Administration (SAMHSA)—assume responsibility for building the capacity and facilitating the deployment of the MH/SU workforce for older Americans:

CMS

- CMS should evaluate alternative methods for funding primary care and other personnel who provide evidence-based models of care to older adults with MH/SU conditions. This should include reimbursing care managers as well as the psychiatrists and other mental health specialists providing supervision of their work.
- CMS should evaluate alternative payment methods to encourage effective deployment of the workforce to provide integrated primary care, chronic disease self-management, and health promotion for older adults receiving care in Community Mental Health Centers and other specialty mental health settings.

- CMS should explore approaches and strategies for improving care delivery to older adults with MH/SU conditions through its contracts with Quality Improvement Organizations.
- CMS should enforce and monitor implementation of Preadmission Screening and Resident Review Program (PASRR) and Minimum Data Set (MDS) nursing home requirements regarding residents' mental health. The agency should also ensure that PASRR and MDS mental health assessments inform residents' care plans and that nursing home personnel implement the care plans accordingly.

HRSA

- The HRSA Administrator should ensure that the National Center for Health Care Workforce Analysis devotes sufficient attention to geriatric MH/SU with guidance from the national coordinating body described below.
- The HRSA Administrator should ensure that the Geriatric Academic Career Awards career development grants include awards to geriatric MH/SU specialists if they commit to working with older adults who have MH/SU conditions in acute and long-term care settings.
- The HRSA Administrator should ensure that the Geriatric Education Centers and the Comprehensive Geriatric Education Program institutional awards fund programs that train individuals in geriatric MH/SU care.

NIMH

- The Director of NIMH should ensure that the institute conducts research on methods for increasing the capacity of the mental health workforce to provide competent and effective care for older adults who reside in the community or in nursing homes or other congregate residential settings.

SAMHSA

- The SAMHSA Administrator should ensure that the agency devotes sufficient attention to the capacity of the behavioral health workforce to provide both geriatric mental health and geriatric substance use services.
- The SAMHSA Administrator should ensure that the agency restores funding of the Older Adult Mental Health Targeted Capacity Expansion Grant program.
- The SAMHSA Administrator should require states that receive MH/SU block grants to document and to report how the funds are used to support local capacity to serve older adults.

Recommendation 3

Organizations responsible for accreditation, certification, and professional examination, and state licensing boards should modify their standards, curriculum requirements, and credentialing procedures to require professional competence in geriatric MH/SU for all levels of personnel that care for the diversity of older adults.

These efforts should include requirements for recertification and professional development for already licensed and certified personnel.

Recommendation 4

Congress should appropriate funds for the Patient Protection and Affordable Care Act workforce provisions that authorize training, scholarship, and loan forgiveness for individuals who work with or are preparing to work with older adults who have MH/SU conditions. This funding should be targeted to programs with curricula in geriatric MH/SU and directed specifically to the following types of workers who make a commitment to caring for older adults who have MH/SU conditions:

- Psychiatrists, psychologists, psychiatric nurses, social workers, MH/SU counselors, and other specialists who require skills and knowledge of both geriatrics and MH/SU.
- Primary care providers, including geriatricians and other physicians, registered nurses (RNs), advance practice registered nurses (APRNs), and physician assistants.
- Potential care managers for older adults who have MH/SU conditions, including RNs, APRNs, social workers, physician assistants, and others.
- Faculty in medicine, nursing, social work, psychology, substance use counseling, and other specialties.
- Direct care workers and other frontline employees in home health agencies, nursing homes, and assisted living facilities (including personal care attendants not employed by an agency).
- Family caregivers of older adults with MH/SU conditions.

Recommendation 5

HHS should direct a responsible entity (as described above) to develop and coordinate implementation of a data collection and reporting strategy for geriatric MH/SU workforce planning. Data collection and reporting should include the following:

- Prevalence data for Diagnostic and Statistical Manual of Mental Disorders-defined diagnoses and other MH/SU conditions. Representative data on subgroups are essential.
- Use of MH/SU services by subgroups.
- Comprehensive and comparable information on the full range of geriatric MH/SU personnel with sufficient detail to assess the workforce supply.