Older Adults and Serious Mental Illness: What We Know and What We Imagine

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What We Know

Approximately 15% of older adults in the United States live with a mental health condition, and 3% of older adults live with a serious mental illness (SMI). Schizophrenia, bipolar disorder, and recurrent major depression contribute significantly to disability.

Unfortunately, health disparities are prevalent among many people with SMI who do not have access to or receive effective treatments. The Treatment Advocacy Center has documented that from the 1950s to 2016, the number of state hospital psychiatric beds in the United States decreased by almost 97% (D.A. Fuller et al., "Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds, 2016," Treatment Advocacy Center, 2016; https://bit.ly/3kIH9Kk). The need for community capacity for adults with SMI has outstripped the development of effective community-based care.

Health Profile of Consumers With SMI

Geriatric neuropsychiatrist Dilip Jeste, MD, an expert on accelerated biological aging in patients with schizophrenia, has noted that individuals with schizophrenia typically develop various diseases at younger ages than the general population, including cognitive diseases.

A number of physical conditions have a prevalence at least two times greater in patients with schizophrenia than among the general population, including obesity, the metabolic syndrome, diabetes mellitus, cardiovascular disease, and respiratory disease. The prevalence of human immunodeficiency virus (HIV) infection is at least eight times greater in patients with schizophrenia than among the general population. The increased prevalence of these somatic comorbidities contributes to a fivefold risk of death, with 25 years of potential life lost (*Issues Ment Health Nurs* 2011;32:589–597).

There are a number of contributing factors to these comorbidities, including the stigma of mental illness, poorer access to quality health care, homelessness, polypharmacy and medication side effects, and unhealthy lifestyle behaviors such as low physical activity, poor diet, smoking, alcohol and substance abuse, and risky sexual behavior.

Impact of Relapse and Recurrence

Medication adherence is poor across most chronic conditions, and the risk of relapse is higher when patients stop their medication. Adherence problems in SMI begin early and can worsen over time. The patient's insight into his or her illness and perceived need for continuous medication can fluctuate — our patients often believe that they don't need their medications.

Too often after diagnosis, the first episode of SMI is followed by a deteriorating course of repetitive relapses, with chronic residual symptoms and an increased incidence of treatment resistance. We know that with every relapse our patients are at risk of irreversible lifetime functional decline.

Repeated relapses disrupt health, relationships, education, employment, and housing, while increasing the likelihood of involvement with the criminal justice system (*BMC Psychiatry* 2013;13:50). Repeated episodes also carry significantly higher and more stigmatizing consequences than somatic chronic illnesses, thus further exacerbating health disparities and inequities.

Impact of Institutional Settings

The psychological effects of an extended stay in an institutional setting contribute to deficits or disabilities in social and life skills, sometimes leading to institutional syndrome. The setting is structured, supervised, and paternalistic to ensure safety and prevent danger. Individuals thus lose independence and responsibility for self, leading to learned helplessness, lack of initiative, and self-neglect. This can make it difficult for patients to manage the demands of everyday life without prompting and assistance. Additionally, the longer the length of the stay, the more significant the impact is on the patient's life (*BMC Psychiatry* 2013:13:169).

What We Imagine: Person-Centered Planning

Person-centered planning looks at individuals holistically rather than focusing on one aspect such as SMI, legal status, homelessness, or their somatic needs.

For an individual to be successful in the community, the first step is housing. When determining an approach to housing, a functional assessment of the individual's needs is necessary to determine where the individual needs assistance, such as with toileting, dressing, or bathing.

For individuals with SMI, supervision may also include medication monitoring or helping the individual when he or she is experiencing symptoms associated with the diagnosis, such as hearing voices, or when experiencing mood swings, as is associated with bipolar disorder.

Individuals can also feel overwhelmed by the process of integrating back into the community after an extended hospitalization. Having a plan that focuses on their strengths and provides the necessary support is critical for individuals to be successful.

A Promising Future

Comorbidities and institutional syndrome in older adults with SMIs have too often contributed to their premature placement in nursing homes. Discharge to an assisted living facility (ALF) may present the best match of care needs and community-based services. Steve Bartels, MD, and colleagues at the Dartmouth Centers for Health and Aging have outlined evidence-based, integrated care models and promising practices for adapting ALFs to the needs of older adults with SMI (*Psychiatr Clin North Am* 2018; 41:153–164). Their framework includes:

1. Psychosocial skills training
2. Illness self-management
3. Collaborative care and behavioral health homes

They see a variety of innovations contributing to a better future, including telehealth and mobile health, peer support, technology, social media, and reverse innovation workforce solutions adapted from lower income countries.

Our experiences during the pandemic have increased our recognition of the need for innovation, giving us a window of opportunity to adapt care practices in ALFs to serve the needs of older adults with SMI. We can widen the window by using the Community Options Waiver to offset the cost of ALF placements.

The ALFs that have best served our patients and remained our trusted care providers before and during the pandemic have integrated these evidence-based interventions and promising practices, thereby providing person-centered care to these vulnerable adults in the communities of their choice.

Dr. Stevens is a geropsychiatric clinical specialist in Maryland and Washington, DC. For the past 30 years, as the Long Term Care Health Educator & Care Consultant at Behavioral Health System Baltimore, she has been responsible for a care coordination program for adult and geriatric patients with serious mental illness deinstitutionalized from state psychiatric hospitals to the community. Ms. Mannino has been a clinical social worker for 30 years working with individuals with serious mental illness (SMI) in a variety of settings including school, hospital, residential treatment center, and outpatient mental health center. For the past 13 years, she has focused on individuals with SMI who have forensic involvement.