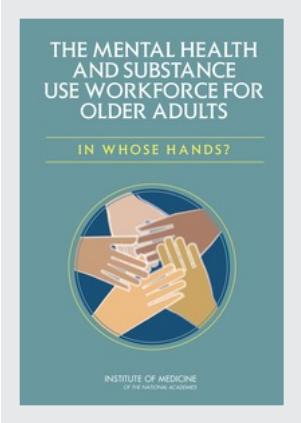

The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?

DETAILS

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Summary[1]

The aging of America has and will continue to have profound consequences for the nation's economy and society for years to come. The U.S. Census Bureau projects that the number of adults age 65 and older will increase from 40.3 million to 72.1 million between 2010 and 2030. Service providers, health care researchers, workforce experts, demographers, and others have long warned policy makers that with the aging of the baby boomer population, the nation faces a "silver tsunami" with the potential to overwhelm the nation's health care system. Similar calls have been made to address the nation's inadequate training and shortages of personnel for mental health and substance use (MH/SU) care. A health care workforce that is not prepared to address either MH/SU problems or the special needs of an aging population is a compelling public health burden.

In 2008, the Institute of Medicine (IOM) issued a report, *Retooling for an Aging America: Building the Health Care Workforce*, which highlighted the urgency of expanding and strengthening the geriatric health care workforce to meet the demands of our rapidly aging and changing population. The following year, Congress mandated that the IOM undertake a complementary study focusing on the geriatric MH/SU workforce needs of the nation. Thus, the IOM entered into a contract with the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services (HHS). The IOM Committee on the Mental

[1]This summary does not include references. Citations for the findings presented in the Summary appear in subsequent chapters.

Health Workforce for Geriatric Populations was appointed in early 2011 to carry out the charge. The 16-member committee included experts in geriatric psychiatry, substance use, social work, psychology, nursing, direct care, epidemiology, workforce development, labor economics, long-term care, health care delivery and financing, and health care disparities.

The committee's core charge was to assess the MH/SU needs of adults age 65 and older and to recommend how the nation should prepare the MH/SU workforce to meet these needs (Box S-1). The committee focused on the full spectrum of workers who are engaged in the detection, diagnosis, treatment, care, and management of MH/SU conditions in older adults—ranging from personnel who may have minimal education to specialty professionals with the most advanced psychiatric and neurological training. This includes

- MH/SU specialists such as general psychiatrists, psychologists, social workers, psychiatric nurses, and substance use counselors who may provide services to patients of any age;
- primary care providers, such as general internists, family medicine practitioners, advanced practice registered nurses, and physician assistants who may provide services to patients of any age (but may have daily contact with older adults who have MH/SU conditions);
- primary care providers with specialized training in the care of older adults, such as geriatricians and geriatric nurses;
- MH/SU providers with specialized training in the care of older adults, such as geriatric psychiatrists, gerontological nurses, geropsychologists, and gerontological social workers;
- direct care workers (DCWs) who, with minimal training, are employed to provide supportive services either in facilities or in the home;
- peer support providers who, with special training, teach peers the skills and behaviors to self-manage their mental illness; and
- informal caregivers such as family members, friends, and volunteer community members with the potential to identify and support older adults who may need MH/SU services.

The committee limited its scope in accordance with the sponsor's suggestions. The study's target population was older adults who have a prevalent MH/SU condition for which there were sufficient data for study (including the behavioral and psychiatric symptoms of dementia). The principal diagnoses of Alzheimer's disease and other dementias, intellectual disability, and autism spectrum disorder were excluded. Also out of scope were the effectiveness of individual therapeutic interventions,

BOX S-1
Charge to the IOM Committee on the Mental Health Workforce for Geriatric Populations

At the request of the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation, the Institute of Medicine (IOM) will convene an ad hoc committee to determine the mental and behavioral health care needs of the target population—the population of Americans who are age 65 years and older—and then make policy and research recommendations for meeting those needs through a competent and well-trained mental health workforce, especially in light of the projected doubling of the aged population by 2030.

The committee will

- Provide a systematic and trend analysis of the current and projected mental and behavioral health care needs of the target population.
- Within the target population, consider the special needs of growing ethnic populations, of veterans with posttraumatic stress disorder, and of persons with chronic disease.
- Weigh the impact of improved diagnostic techniques, of addressing mental health issues as part of effective chronic disease management, and of the implementation of the federal mental health parity law on meeting the mental health needs of the target population.

When making recommendations, the committee will consider forces that shape the health care workforce, such as education, training, modes of practice, and the financing of public and private programs.

tobacco use (as a substance use condition), and workforce issues related to caregivers' needs.

A VULNERABLE AND UNDERSERVED POPULATION

Current and Future Prevalence of MH/SU Conditions Among Older Adults

MH/SU conditions in older people are associated with a wide range of negative effects, including emotional distress, functional disability,

reduced physical health, increased mortality, suicide, high rates of hospitalization and nursing home placement, and high costs. The committee identified 27 MH/SU conditions that can have substantial negative effects on a person's emotional well-being, functional and self-care abilities, and quality of life (Box S-2). Although available data do not support definitive prevalence estimates, the committee concluded that at least 5.6 million to 8 million older adults have one or more of these conditions—about 14 to 20 percent of the overall elderly population. Depressive disorders and dementia-related behavioral and psychiatric symptoms are the most prevalent. Serious mental illness—including schizophrenia and bipolar disorder—is less common, but has significant implications for the workforce and care delivery.

Many older adults who have MH/SU conditions also have acute and chronic physical health conditions, and some have cognitive and functional impairments. The interaction of physical health conditions, cognitive and functional impairments, and MH/SU conditions is a defining feature of the geriatric mental health and substance use fields and has critical implications for the workforce. The interaction of these conditions also results in difficult caregiving situations for families, physicians, and other health care professionals, and residential care and home- and community-based service providers. For example:

- Age-related changes in the metabolism of alcohol and drugs, including prescription drugs, can cause or exacerbate alcohol and drug use conditions and increase an older person's risk of dangerous overdoses, even for people who have used alcohol and drugs at the same dose and frequency for many years without serious negative effects.
- Loss and grief are common in old age. The death of a spouse, partner, close relative, or friend can trigger or exacerbate depression and lead to severe, debilitating symptoms. Providers may find it difficult to distinguish major depression and grief when a patient is in the midst of a significant loss.
- Medications to treat common acute and chronic physical health conditions in older people can cause and exacerbate MH/SU conditions and, conversely, medications to treat MH/SU conditions can cause or worsen their physical health conditions.
- Cognitive and functional impairments can complicate the detection and diagnosis of MH/SU conditions. Cognitive impairment can also reduce an older person's ability to comply with treatment recommendations, including medications prescribed for the person's MH/SU and physical health conditions.

BOX S-2
Geriatric Mental Health and Substance Use Conditions Addressed in This Report

DSM-IV-TR Mental Disorders

- Adjustment disorder
- Anxiety disorders (including posttraumatic stress disorder)
- Bipolar disorder
- Depressive disorders
- Personality disorders
- Schizophrenia
- Substance-related disorders (including alcohol dependence and abuse, drug dependence and abuse)

Other Conditions

- Anxiety symptoms
- At-risk drinking or drug use
- Behavioral and psychiatric symptoms of dementia
- Complicated grief
- Fear of falling
- Hoarding
- Minor depression (depressive symptoms)
- Severe domestic squalor
- Severe self-neglect
- Suicidal ideation, plans, or attempts

NOTE: DSM-IV-TR mental disorders are defined by explicit criteria in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition-Text Revision.

These unique characteristics of geriatric MH/SU create important requirements for workforce competencies, including the ability to detect possible MH/SU conditions in older people with coexisting physical health conditions and cognitive and functional impairments; ability to diagnose the conditions or knowledge about how to refer the person for a diagnostic evaluation; and ability to adapt treatments and ongoing management to accommodate the coexisting conditions.

Several demographic trends—growing population diversity, change in the makeup of the older population and characteristics of the baby boomer cohort—are likely to affect the prevalence of MH/SU conditions and the need for services in the coming decades. The U.S. Census Bureau projects that, from 2010 to 2030, the proportion of whites in the older population will decrease from about 80 to about 71 percent, reflecting sizable increases in the black and Hispanic/Latino older population. During the same period, the black older adult population is expected to increase by about 115 percent, and the Hispanic/Latino older adult population by more than 200 percent. By 2030, blacks will constitute about 10 percent of the older population, and Hispanic/Latinos about 12 percent.

Although there are only limited prevalence data for subgroups of older adults with MH/SU conditions, some analyses suggest important differences among racial and ethnic groups. The proportions of different age cohorts within the 65-and-older age group are also changing and are likely to have implications for the types of MH/SU services that are needed. For example, as the group ages 75-84 grows, dementia and associated psychiatric symptoms will become more prevalent.

As the baby boomers age, the rates of use of illicit drugs appear likely to increase. One recent report by the Substance Abuse and Mental Health Services Administration (SAMHSA), for example, found that illicit drug use nearly doubled among people ages 50-59 between 2002 and 2007, increasing from 5.1 percent in 2002 to 9.4 percent in 2007. This included an increase in marijuana use from 3.1 to 5.7 percent and nonmedical use of prescription drugs from 2.2 to 4 percent.

Adverse drug reactions may also be on the rise. According to SAMHSA, 61 percent of the 1.1 million emergency department visits for adverse drug reactions involved a person age 65 or older in 2008, and nearly a fourth of these emergency visits involved central nervous system drugs, including narcotic and nonnarcotic pain relievers.

Use of MH/SU Services

Older adults have been less likely to use MH/SU services compared with younger people with similar conditions. Older adults have also been less likely to use services provided in specialty settings, such as psychiatric hospitals, mental health clinics, and substance use treatment centers, and more likely to use MH/SU services provided in general medical care, residential care, and community-based service settings. In comparison with the current generation of older people, the baby boom generation has had higher average rates of mental health service use throughout their lives, and it is possible they will continue this pattern of service use as they grow older.

THE GERIATRIC MH/SU WORKFORCE: TOO FEW AND NOT PREPARED

Questions about the relationship between the demand for services and the supply emerge naturally in any discussion of workforce issues. It might seem straightforward to translate data on illness prevalence into estimates of service need and then, in turn, to estimates of required workforce supply. However, such efforts have always been fraught with methodological challenges and serious questions about the validity of the estimates that have been generated.

Data on the geriatric MH/SU workforce are even more elusive because the majority of workers who provide services to the geriatric population do not have recognized credentials in this specialty, and are thus more difficult to count, track, and analyze. Nevertheless, the committee finds that the sheer number of providers entering, working in, and remaining in the fields of primary care, geriatrics, mental health, substance use, and geriatric MH/SU is disconcertingly small.

Geriatric MH/SU specialists are an essential part of the interdisciplinary team because they are the most experienced and best equipped to consult and provide care for serious mental illnesses. With shifting models of care and the changing roles of different professions, it is not possible to estimate with great precision how many geriatric MH/SU specialists will be necessary to serve the geriatric population. However, the rate of specialized providers entering the workforce is dwarfed by the pace at which the population is growing. For example, the number of available fellowships in geriatric psychiatry has remained relatively stagnant since the 1990s, while the number of geriatric psychiatry fellows filling available slots decreased by half. This decline, juxtaposed with the predicted doubling of the geriatric population in the next 20 years, will make it increasingly difficult to rely solely on highly trained specialists to meet the MH/SU needs of older adults.

Training

General providers at all levels should be aware of the signs and symptoms of MH/SU conditions, and be able to respond appropriately within their level of training and scope of practice. However, few professions have mandated curricular standards related to MH/SU in geriatric patients. Where there is curriculum, it is unclear how and to what extent the concepts are applied in the classroom or in practical training. The prevalence of co-occurring conditions in the elderly and the shift toward collaborative models of care make interprofessional training essential to overall training in geriatric MH/SU care. The increasing racial, ethnic, and linguistic diversity of the geriatric population also makes cultural competence imperative. To what extent these aspects of care are being integrated into training and education is also unclear.

Barriers to Growing the Workforce

The barriers to growing and strengthening the geriatric MH/SU workforce are fundamental and entrenched in the systems and programs of numerous public and private entities—including multiple HHS and other federal agencies, professional organizations, medical and profes-

sional training institutions, credentialing and accreditation organizations, licensing bodies, service systems, payers, and research institutions (Box S-3). Recent efforts to augment training show that even when provided opportunities to specialize in geriatric MH/SU, students often do not choose to pursue it. This underscores the importance of simultaneously providing more training opportunities, guidance, mentorship, positive experiences, and financial incentives. Building up one of these

BOX S-3
Key Barriers and Issues Related to and Strengthening the Geriatric MH/SU Workforce

Defining the Geriatric MH/SU Workforce

- The geriatric MH/SU workforce is made up of many types of providers. Workforce roles are often poorly defined and overlapping.

Estimating Workforce Supply and Demand

- The standardized workforce data trended over time that are required to make accurate predictions of workforce supply and demand are not available.

Shortage of Geriatric MH/SU Providers

- The workforce prepared to care for geriatric MH/SU is inadequate in sheer numbers, with the growth of the population threatening to exacerbate this.

Recruiting Geriatric MH/SU Providers

- Across all health professions, relatively few opportunities for specialization in geriatric MH/SU exist. There is little support or mentorship available for those who do pursue specialization.
- Financial incentives are not in place to encourage geriatric MH/SU providers to enter and stay in this field.

Inadequate Preparation of the Geriatric MH/SU Workforce

- Professional training in geriatric MH/SU is inconsistent and not well documented because national standards and requirements in these areas are minimal and vague. MH/SU specialists have little required training in geriatrics; geriatric specialists have little

components without considering the others will not solve the workforce crisis at hand.

Training general health care professionals and DCWs is pivotal to improving the workforce because they are the most likely personnel to come into contact with older adults with MH/SU conditions. The extent to which training and education are provided for these groups is not well documented. Relatively few standards are in place to ensure that formal

required training in MH/SU; and most general providers do not have extensive requirements in either area.

Training the Geriatric MH/SU Workforce

- Many professions have made progress on geriatric MH/SU competency development and workforce development, though these efforts are often done in silos where their dissemination and impact are not easily measured.
- Innovations in geriatric MH/SU workforce development are often vulnerable to grant cuts, and many promising programs end without adequate documentation or evaluation to assist future development.

Strengthening the Role of Direct Care Workers (DCWs) in Geriatric MH/SU Care

- Complex factors, including poor working conditions, low wages, lack of training, and limited opportunities for advancement, deter the development of a stable DCW workforce.
- DCWs have the most contact with older adult patients, yet do not have adequate training in geriatrics or MH/SU, and virtually never receive training in both.

Empowering Older Adults and Their Families

- There is a growing emphasis on peer support and self-care, including for older adult populations.
- Family members play a major role as caregivers, but receive little support and training for caring for older adults with any medical conditions, including MH/SU conditions.

training programs include competencies in addressing MH/SU conditions in older adults. Also essential to training are skills in cultural competence and interprofessional collaboration to meet the complex needs of older adults. However, the evidence base to determine what modes of training are most effective in geriatric MH/SU is largely insufficient.

WORKFORCE IMPLICATIONS OF MODELS OF GERIATRIC MH/SU CARE

U.S. health care delivery remains in a mode of care with origins in the early 20th century, when health care problems were typically acute and life expectancy was significantly shorter than today. However, an acute care orientation is not appropriate for much of geriatric care. For the older adult, chronic illness is the norm, not the exception—for both mental and physical health conditions.

A persuasive body of evidence, drawn from two decades of research, indicates that two common MH/SU disorders among older adults—depression and at-risk drinking—are most effectively addressed when care is organized to include these essential ingredients: (1) systematic outreach and diagnosis; (2) patient education and self-management support; (3) provider accountability for outcomes; and (4) close follow-up and monitoring to prevent relapse. Moreover, these elements are best obtained when care is patient centered, in a location easily accessed by patients (e.g., in primary care, senior centers, or patients' homes), and coordinated by trained personnel with access to specialty consultation. This is not likely to be achieved, however, without practice redesign and change in Medicare payment rules. There is a fundamental mismatch between older adults' need for coordinated care and Medicare fee-for-service reimbursement, which precludes payment of trained care managers and psychiatry consultation.

The committee concluded, as have many other studies, that the delivery of and payment for health care services to older adults must be reorganized to reflect the chronic nature of MH/SU and other health conditions prevalent in the 21st-century geriatric population. The workforce implications are daunting. Registered nurses are particularly well suited to coordinate MH/SU and physical health care, but they need additional training to serve in this capacity. Primary care providers, such as physicians, advanced practice registered nurses, and physician assistants have not been trained in collaborative care and do not work in a practice or system supportive of comanagement, colocation, screening, and outcome monitoring required by these models.

Frontline workers within the aging provider network agencies may be a potential source of care managers. However, they will require inten-

sive training in evidence-based program treatment as they are likely to have limited knowledge of MH/SU. Moreover, training alone will not ensure the intended outcome of effectively meeting the MH/SU needs of older adults. Adequate supervision and coaching support of staff are also essential.

Finally, research on effective delivery of MH/SU care for certain older populations is urgently needed, especially for individuals residing in nursing homes and other residential settings, prisoners, rurally isolated elders, and older adults with serious mental illnesses.

RECOMMENDATIONS

There is a conspicuous lack of national attention either to preparing the health care workforce to care for older adults who have MH/SU conditions or to ensuring sufficient numbers of personnel for the rapidly growing elderly population. Many federal agencies, particularly within HHS, influence the makeup, competence, and capacity of the health care workforce to deliver MH/SU services to older adults. Yet, federal responsibility appears to be diffused across various agencies, bureaus, and departments. Moreover, the efforts of these agencies are minimal, lack specific focus on geriatric MH/SU, and, in some cases, are being discontinued. The Agency for Healthcare Research and Quality (AHRQ), for example, has initiated a noteworthy interagency effort—the Academy for Integrating Mental Health and Primary Care—to coordinate the collection, analysis, synthesis, and dissemination of research on integrating MH/SU services in primary care. But the program is underfunded.

The Centers for Medicare & Medicaid Services (CMS) has substantial potential to influence the delivery of geriatric MH/SU services. At present, Medicare and Medicaid reimbursement rules act to deter rather than to facilitate access to effective and efficient geriatric MH/SU services. The agency has numerous projects under way to evaluate new approaches—including payment reform—to improving the quality and effectiveness of services provided to Medicare and Medicaid beneficiaries. These innovation efforts may lead to MH/SU workforce improvements if eventually implemented on a wide scale.

The Health Resources and Services Administration (HRSA) is the central HHS agency tasked with promoting the production and training of key health personnel, but none of its geriatric training programs require exposure to MH/SU conditions.

Several institutes at the National Institutes of Health have missions related to aging and mental health or substance use, but none focus on geriatric MH/SU. The National Institute of Mental Health (NIMH), for example, has funded important research to inform the effective delivery

of MH/SU services to older adults, but NIMH is scaling back support for interventions and services research in favor of research in basic translational neuroscience.

SAMHSA is the federal government's lead agency charged with directing services and resources to people with MH/SU conditions, yet it has consistently devoted only a small fraction of its budget to older adults. It is particularly disconcerting that the agency is reducing its activities related to geriatric MH/SU, including the elimination of the Older Adults Targeted Capacity Expansion grants program.

BOX S-4
Recommendations

RECOMMENDATION 1: Congress should direct the Secretary 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 and 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 widescale 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,

Box S-4 presents the committee's recommendations. Congress and the HHS Secretary must act to establish a locus of responsibility for geriatric MH/SU, to invigorate investment in the human capital that is the geriatric MH/SU workforce, to catalyze basic system redesign to allow for effective deployment of geriatric MH/SU personnel, and to stimulate essential research to inform the education and training of personnel and workforce planning itself.

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 Administration on Aging (AoA), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare & Medicaid Services (CMS), Health Resources and Services Administration (HRSA), National Institute of Mental Health (NIMH), National Institute on Drug Abuse (NIDA), 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.

continued

BOX S-4 Continued

  - CMS should enforce and monitor implementation of the Pre-Admission Screening and Resident Review (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 in acute or 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, as well as 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 recredentialing and professional development for already licensed and certified personnel.

RECOMMENDATION 4: Congress should appropriate funds for the Patient Protection and Affordable Care Act (ACA) 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* (DSM)-defined disorders and other MH/SU conditions, including data on comorbidity of these conditions. Representative data on the following subgroups are essential:
  - Age within the 65+ population (65-74, 75-84, and 85 and older)

continued

BOX S-4 Continued

- Gender
- Race and ethnicity (including non–English speakers)
- Veteran status
- Living situation (private household, public housing or senior housing facility, group home, assisted living or other residential care facility, and nursing home)
- Coexisting physical health conditions
- Coexisting cognitive and functional impairments
- Geographic area

- Use of MH/SU services for the above subgroups.
- Comprehensive and comparable information on the full range of geriatric MH/SU personnel with sufficient detail to assess the workforce supply by race and ethnicity; language skills; geographic location and distribution; qualifications, training, and certification; areas of practice; and hours spent in the care of older adults.