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Psychiatric Emergency Services for the U.S. Elderly: 2008 and Beyond

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Abstract

In 2011 the oldest baby boomers will turn age 65. Although healthcare researchers have started to examine the future preparedness of the healthcare system for the elderly, psychiatric emergency services (PES) have been widely overlooked. Research is needed to address PES need and demand by older patients, assess the consequences of this need/demand, and establish recommendations to guide PES planning and practice. The authors examined journal articles, review papers, textbooks, and electronic databases related to these topics. We outline the current PES environment in terms of facilities, characteristics, and visits, and discuss current geriatric patient PES use. Factors expected to impact future use are examined, including sociodemographic characteristics, psychiatric illness prevalence, cohort effects, medical comorbidity, mental healthcare resources and utilization, and stigma. Consequences of these on future psychiatric care and well-being of the elderly are then explored, specifically, greater acute services need, more suicide, strained delivery systems, increased hospitalization, and greater costs. The following are proposed to address likely future PES shortcomings: enhance service delivery, increase training, standardize and improve PES, prioritize finances, and promote research. The degree to which the geriatric mental healthcare “crisis” develops will be inversely related to the current system's response to predictable future needs.

Keywords

aged; psychiatric; emergency department

In three years the first of the baby boomers will qualify for Medicare by meeting its age criterion of 65 years. As this milestone approaches there has been increased study on the degree of preparedness of the healthcare system in caring for the aged. However, published studies lack sufficient attention to emergency mental health services. In 2006 the Institute of Medicine

published three reports that offer recommendations for the most pressing emergency service issues.¹ Unfortunately, these reports did not consider emergency psychiatry, describe how emergency department (ED) services may be impacted by the aging American population, or address specific elderly patient needs.² Furthermore, concern has been expressed that the “current healthcare system serves mentally ill older adults poorly and is unprepared to meet the upcoming crisis in geriatric mental health.”³ Older adult psychiatric care needs remain overlooked even though the future holds a dramatic increase in the number of elderly with psychiatric disorders.^{3,4,5} Since the psychiatric emergency service (PES) has emerged as a main gateway to inpatient mental healthcare and an important referral location,⁶ and because EDs cannot deny access to care,⁷ it is critical that they be included in discussions of future geriatric care.

In recent years older adults have presented to EDs for psychiatric reasons at increased rates and represent an increasing proportion of total older adult ED presentations.^{8,9} Also, for overall ED use, elderly persons have higher visit rates and longer ED stays, are more likely to be repeat ED users, and, if admitted from the ED, have longer hospital stays than younger adults.^{10,11} In this paper we explore the impact of patient and system factors that threaten the future provision of geriatric emergency psychiatric care. We do so by asking three questions:

- What are the relevant issues for anticipating the demand for geriatric psychiatric emergency services?
- What consequences will this demand impose on the provision, management, and organization of psychiatric emergency services?
- What recommendations can help guide the planning and practice of psychiatric emergency services for the elderly?

CURRENT PSYCHIATRIC EMERGENCY SERVICES ENVIRONMENT

Psychiatric emergency services (PES) has come to refer to freestanding acute mental healthcare units.¹² For this review we use the terms *designated PES* or *psychiatric ED* when referring specifically to this service. When we use the term *PES* or *emergency psychiatric care* we refer to mental health treatment within the ED environment, whether or not the treatment location is in a designated PES or a general ED (also referred to as simply *ED*).

Facilities

In 2004 there were approximately 4,500 U.S. EDs,⁷ a decrease of 425 from ten years earlier.¹ The number of psychiatric EDs increased substantially from the early 1960's to an estimated 3,000 by 1991,¹³ the latest year for which data are available. Hospitals with at least 3,000 emergency mental health visits a year are likely to have a psychiatric ED.¹² The increasing number of psychiatric EDs has been attributed to deinstitutionalization of patients, legislation mandating emergency psychiatric provision, and decreases in both average length of hospitalization and number of inpatient beds.¹³

Characteristics

Typically, psychiatric EDs provide diagnostic assessments, medication and therapeutic treatments, hospital admission when appropriate, outpatient referrals, and follow-up appointments. Frequent users are a consistent concern and a relatively small proportion of patients may account for a significant proportion of visits.¹⁴ Table 1 includes key findings on patient and program characteristics from a 1998 survey of psychiatric ED directors⁶ as well as ED visit statistics.

Visits

EDs are experiencing rapid increases in volume.^{1,6,7,14} In 2004 there were 110 million ED visits in the U.S, an 18% increase from 1994.¹⁵ Older adults accounted for 14.3% of these visits.¹⁵ EDs serve as important providers for nursing home residents, with almost a fourth of residents visiting EDs annually.¹⁶ The rates of psychiatric related ED visits have increased for all age groups with the highest increases occurring in the elderly.⁸

RELEVANT ISSUES FOR ESTIMATING ELDERLY NEED FOR PSYCHIATRIC EMERGENCY SERVICES

Important issues underlying future demand for older adult PES include sociodemographic characteristics, psychiatric illness prevalence, medical comorbidity, cohort effects, mental healthcare resources and utilization, and stigma (Table 2).

A sociodemographic imperative

Between 2000 and 2030 the number of U.S. adults age 65+ will more than double to over 70 million, increasing from 12.4% of the population to 19.7%.¹⁷ Approximately 4.2% (1.5 million) of the elderly reside in nursing homes,¹⁸ a proportion that has been decreasing in recent years.¹⁹ The elderly population will be more racially and ethnically diverse in the future.¹⁹ The proportions of African Americans, Asians, and Hispanics will all increase in the next several decades, with elderly Hispanics almost quadrupling between 2003 and 2030, from two to nearly 8 million (Table 3).

The mental health needs of future older adult cohorts will be impacted by individual, family, and societal changes. Poor social support and being unmarried are related to high PES utilization.¹⁴ The proportion of divorced elderly women increased substantially in recent decades and is expected to be even higher in the future.¹⁹ Access to resources must evolve as 65% of non-institutionalized older adults rely primarily on unpaid assistance for personal care needs.²⁰ Community resources will be challenged by the escalating dependency ratio for older persons (i.e. the number of persons age 65+ per 100 working age persons [ages 20-64]).¹⁸ Education and employment factors also influence mental healthcare demand. The next generation of older adults will be the most highly educated geriatric population thus far and obtaining at least some college has been linked to greater outpatient psychiatric care use.²¹ Shifting role expectations and integration of women into the employment market have been suggested as potential factors for the higher depression rates among more recent cohorts of women.²²

Psychiatric illness prevalence

The overall prevalence of psychiatric disorders for older U.S. adults is estimated at 20-25%.^{3,23} Specific prevalence estimates include 6% with diagnosable depressive disorder,²⁴ 0.6% with schizophrenia,²⁴ and 0.6-3.7% with alcohol abuse and dependence.⁵ A growing percentage of older adults misuse prescriptions and illicit drugs, and medication and alcohol misuse together impact close to 20%.²³ The 4.5 million older adults with Alzheimer's Disease in 2000 is projected to increase to 7.2-8.6 million in 2030.²⁵ Dementia rates for community dwelling adults age 65+, including Alzheimer's disease, have been approximated at 4.5-16.8%.²⁶ Rates escalate with age reaching 30%+ for people age 85+. ^{24,27} Elderly persons in nursing homes have even a higher prevalence of mental health conditions with overall psychiatric disorders, including dementia, at 51-94%.²⁸ Geriatric patients presenting to EDs have depression rates greater than 20%,²⁹ rates of delirium of 10%, and cognitive impairment or delirium rates of 26-40%.^{30,31,32} At the time of the ED presentation two thirds of nursing home patients are chronically or acutely cognitively impaired.¹⁶

Cohort effects

There is evidence of cohort effects with regard to psychiatric conditions.³³ Increases in the rates of psychiatric disorders for younger age groups imply that compared to the current elderly the lifetime prevalence of mental disorders of the next generations of elderly will be greater.⁴ Depression rates have been demonstrated to be higher for birth cohorts born since the 1940's.³³ Birth cohorts have also been linked to suicide³⁴ and it has been suggested that newer cohorts of people entering old age have increased risks for suicide.^{35,36} Perceived need may also differentiate contemporary elderly from younger people. In one study older adults who met criteria for mental health disorders were less likely than younger patients to perceive the need for mental healthcare, receive specialty mental healthcare or counseling, or obtain referrals to mental health specialty care.²¹ This study concluded that the "lack of perceived need for mental healthcare may contribute to low rates of mental health service use among older adults."²¹ However, the baby-boomer generation likely will seek specialist psychiatric care more frequently.³⁶ Cohort effects could reverse the current psychiatric care underutilization, including PES, of older adults in coming years, especially if commonly held negative attitudes by providers and patients toward mental illness and the elderly improve.^{23,37}

Medical comorbidity

The overall health of the elderly is improving with declining death rates from heart disease and decreasing disability rates.¹⁹ Still, 80% of people age 65+ have at least one chronic medical condition.¹⁹ Medical comorbidity in older adults with psychiatric disorders represents a serious concern for PES that will likely increase as the population ages.³⁸ Medical conditions' "masking" of psychiatric symptoms is an inherent complication in geriatric mental health presentations. For example, geriatric depression can be difficult to assess due to frequent comorbid physical conditions,³⁹ and emergency physicians frequently do not recognize geriatric patients' depression.²⁹ Older adults with many different medical conditions such as metabolic disorders or infections may present with delirium.³⁸ While mental status impairment in elderly ED patients is common, it is poorly recognized by emergency physicians.³² Poor recognition of delirium in the ED environment is evident in that a significant portion of delirious patients are discharged.^{32,40,41} Further, ED patients with undetected delirium have higher mortality rates within 6 months of discharge than ED patients whose delirium was recognized.⁴⁰ Overall, the assessment of cognitive impairment is not performed appropriately in the ED.¹¹ ED providers may incorrectly assume primary care physicians are aware of the patient's mental status.³² Moreover, inadequate addressing of psychiatric concerns may reflect overwork of ED staff and their preoccupation with coexistent life threatening medical conditions.¹¹

Polypharmacy is a growing concern among geriatric providers as frail elderly are at particular risk for adverse drug reactions (ADRs).^{42,43} ADRs in the elderly often lead to hospital admission, frequently occur during hospitalization, and are a significant cause of morbidity and death as well as healthcare cost. A 1997 study involving elderly outpatients taking 5+ medications found that 35% experienced an ADR with 29% of these patients requiring ED services or hospitalization.⁴² In a 4 year study 67% of elderly nursing home residents experienced ADRs and 16% had ADR related hospitalizations.⁴³ Polypharmacy has been noted as a leading cause of delirium among geriatric patients.⁴⁴ However, few (<1%) older adults' hospital admissions for psychiatric diagnoses through the ED are medication-induced and less than 5% of these are the result of psychotropic medications.⁴⁵

Mental healthcare resources and utilization

Older adults with psychiatric concerns currently underutilize mental health resources.³⁵ It is estimated that only half of elderly persons that acknowledge mental health problems receive treatment from any provider and that a mere 3% of people age 65+ receive outpatient treatment

from a psychiatric professional - the smallest percentage of all adult age groups.³⁹ Older adults only account for 9% of private psychiatric care, 7% of inpatient mental health services, and 6% of community-based mental health services.²¹

Although older people are more likely to visit EDs for medical/surgical issues than younger adults,^{15,19} the geriatric population is underrepresented in PES, comprising only 5% to 6% of PES visits.⁴⁶ During 1997-2000, among ED patients that were given a primary diagnosis of depression, only 6.8% were age 65+.⁴⁷ However, it should not be assumed that the next cohort of the elderly will follow the same patterns. African Americans underutilize services and are more likely to present for emergency than scheduled care.⁴⁸ Elderly African Americans also are more likely to be diagnosed with dementia, secondary psychosis, and schizophrenia relative to elderly white adults who have higher rates of diagnosed anxiety and mood disorders.⁴⁸ Racial and ethnic minorities are less likely to seek mental health treatment. Mistrust is a barrier for minorities seeking care and some minority groups, such as Asians and Hispanics, hold more severe stigmatizing beliefs regarding mental health.⁴⁹

Stigma

Stigma plays a part in elderly mental healthcare by “hindering diagnosis, preventing adequate treatment, and impeding individuals and their families from acknowledging mood disorders and seeking help.”³⁷ This influence is felt in different types of geriatric care utilization, including emergency services,²⁹ and can interfere with older adults' continuation of care,³⁷ resulting in their return to the ED. However, mental healthcare stigma has been diminishing, albeit slowly, in American society.⁵⁰ Ageism, though, still seems to dull concerns for older adults challenged by cognitive impairment, depression, and loss of independence.⁵¹

CONSEQUENCES AND IMPLICATIONS

Potential consequences of the preceding issues include greater acute mental health services need, more suicide, strained delivery systems, increased hospitalization, and greater costs.

Greater need for acute mental health services

The “prevalence of psychiatric illness in older adults and the subsequent demand for health services are likewise expected to increase.”⁴ Patients age 70+ experienced a dramatic 55.3 % increase from 20.6 mental health related ED visits per 1000 persons in 1992 to 32.0 in 2001. We expect a substantial future increase in the number and proportion of geriatric patients needing emergency mental healthcare.

More suicide

On average more than 13 people age 65+ kill themselves in the U.S. every day.⁵² In 2000, people age 65+ comprised 12.4% of the total population and committed 18.1% of U.S. suicides, a rate of 15.2 suicides per 100,000 older adults.^{17,52} The suicide rate of 57.5 per 100,000 men age 85+ was more than five times the national suicide rate of 10.4.⁵² Age and gender trends will escalate the problem of older adult suicide. Furthermore, the baby boom generation historically has had higher suicide rates³⁴ and suicide rates appear to be increasing in the newest population cohort entering old age.³⁵ Still, the approximately 5000 suicide deaths by elderly persons annually⁵² amounts to a small fraction of the older population. Thus managing older adult suicidality at the individual treatment site level is difficult due to the overall infrequency of older adult suicide and related potential for reduced staff attention and awareness.

Strained delivery systems

The increased prevalence of psychiatric disorders and heightened perceived need of mental healthcare will strain mental healthcare delivery systems. Weakened effects of both stigma and ageism will also influence treatment-seeking behavior in years to come. Reduced stigma will increase ED self-referrals and psychiatric symptoms reporting to other healthcare providers. This increased reporting in turn could lead to increased referrals to PES. Already 6 in 10 emergency physicians note that the increase in psychiatric patients negatively impacts access to emergency medical care.⁵³

Increased hospitalization

Inpatient hospitalization rates will be affected by the increase of psychiatric emergency cases. Psychiatric presentations by elderly patients relative to younger patients are medically complex and more likely to result in hospitalization.^{8,9,10,12} Adult patients diagnosed with a psychiatric disorder are admitted more frequently from the ED than patients without a psychiatric diagnosis. During 1992-2000, ED patients with a mental health related condition were hospitalized at a rate about 50% higher than were those with all conditions, 22% as compared with 15%.⁹ As the overall need for geriatric mental healthcare increases and the effectiveness of the mental health system is lacking, patient need for PES will increase.⁵⁴ This will translate into more hospital use. Also, without outpatient mental healthcare that is adequate and acceptable to the next generation of older adults, the use of inpatient care will rise.⁵⁵

Greater costs

In 2001 U.S. mental health spending totaled \$85 billion, 6.2% of national healthcare spending.⁵⁶ Between 1991 and 2001 psychiatric inpatient expenditures as a proportion of mental health spending decreased by almost half, from 38% to 22%.⁵⁶ ED visits by elderly patients typically cost more than visits by younger patients, and visits by patients with a psychiatric condition cost more than visits by patients without such a condition.^{57,58} Future healthcare financing will have to accommodate an increased geriatric PES presence and a likely increase in inpatient admissions. These increases will be driven in part by higher admission rates for elderly patient ED visits due to more of these visits being psychiatric related. The failure to prepare for this likely development will potentially lead to greater societal healthcare costs.

RECOMMENDATIONS

1. Enhance Service Delivery

Promoting the establishment of designated PESs and improvement of PES will help enhance psychiatric care delivery. Little attention has been given to PES. Geriatric populations requiring psychiatric care would be particularly well served by adequate PES availability due to their multiple and intensive needs and the broad services accessible through PES. Apart from the creation of designated PESs, healthcare organizations should adopt new procedures and regulations that encourage delivery systems that treat emergency psychiatric care as a central component. The service delivery system for older adults in particular must also be coordinated among specialties and levels of care.

A major challenge for providers will be to “create a healthcare system that integrates primary healthcare and mental healthcare for older persons.”³⁵ Current managed care practices possibly deter healthcare sector cooperation and point to the need for enhanced relationships between psychiatric providers and primary care practitioners.³⁵ Adequate PES that affords better access to and treatment of psychiatric illness must collaborate with primary care providers to ensure effective geriatric mental healthcare. Psychiatric symptom recognition by primary care physicians is often poor and treatments inadequate,^{36,38} depression is underdiagnosed and undertreated,²⁴ and older adult substance abuse and dependence is often

unrecognized by healthcare providers.⁵ Studies have shown suicides by older adults occur despite recent primary care visits.^{36,59} PES communication with primary care must encourage parallel treatment objectives, ongoing mental health assessments, and early detection. Collaboration could also encourage primary care providers to adopt more comprehensive and effective psychiatric screening and assessment processes. Incorporating the practices of mental healthcare professionals within the primary care setting has been shown to be more effective than a referral approach in engaging elderly primary patients with psychiatric services.⁶⁰

The establishment of designated PESs has shown success in integrating psychiatric care with the management of patients' overall hospital care and psychiatric care post discharge.⁶ Upon the determination of psychiatric care need and triage, a designated PES also affords the opportunity to effectively treat patients with severe psychiatric conditions presenting in the context of comorbid medical illnesses.¹² Ideally new designated PESs will be co-located within general medical facilities. General ED and PES staff must work in concert to address the mental health needs of older adults as serious medical concerns may prevent the elderly patient from visiting the designated PES. PES psychiatrists often provide consultation to medical EDs, are responsible for medical assessments, and are well positioned to treat geriatric emergency patients with psychiatric concerns. The training of PES staff in medical assessments alongside emergency medicine clinicians can provide the PES with a large role in the medical care of emergency patients.⁶ This may not only enhance geriatric patient care but assist in reducing the strain on general ED services. Whether associated with a designated PES or not, ED services should accept responsibility for minimizing the fragmentation of mental and physical care as well as for hospital based and community based treatment for the geriatric populations they serve. This includes ensuring referral and continuity of care plans for patients that reflect site specific pathways to care. The availability of specialized psychogeriatric units is limited and PES patients in need of mental healthcare beyond ambulatory care may be treated in general psychiatric units, medical and surgical units, and long term care facilities. PES staff must be cognizant of the resources available and maintain a collaborative relationship with each treatment location. Representing the frontline of patient care, the role of general ED staff is critical in screening and assessing potential patients requiring PES. Cross-training and collaboration between mental health and non-specialized staff is essential to promote service efficiency.

2. Increase Training

Prospective educational and training programs in psychiatry and emergency medicine must address the need for adequate PES for older adults and the present lack of geriatric mental health practitioners. "The numbers of healthcare professionals currently available to treat elderly mentally ill persons in the United States are inadequate"³ and the number of geriatric mental health specialists has been declining.⁵¹ During 1991-2006 a total of 2,823 psychiatrists were board certified in geriatrics.⁶¹ The estimated need nationally is for a minimum of 5,000.³ Although research is limited, geriatric psychiatry services compared to general psychiatric services have demonstrated advantages in the thoroughness of diagnostic evaluations, psychiatric medication monitoring, cognitive assessments and standardized testing, and higher referral rate to geriatric mental health providers.⁶²

Better financial incentives (increased stipends, salaries, and loans) for higher levels of professional psychiatric training should be implemented.³ The PES programs in existence must encourage further training of current staff and enhance qualifications for new clinicians. As PES clinicians are involved in medical and psychiatric assessments of patients and face a likely increase in the number of geriatric patients with complex medical presentations, training must include more attention to differential psychiatric diagnosis and maintenance of their medical skill base.¹² PES educational and training models should include representatives from

emergency medicine, inpatient psychiatry, geriatrics, geriatric psychiatry, and primary care. The establishment of board recognized Emergency Psychiatry Fellowship training programs would also be valuable. Cross-fertilization of disciplines within training programs should be mandated and encouraged, even if for limited periods of time. This would promote ongoing communication that would be particularly helpful in coordinating PES aftercare for geriatric patients that may not otherwise occur. Curricula for psychiatry trainees, as well as for ED and geriatric medicine trainees, should include experience in geriatric psychiatry. Geriatric psychiatry trainees should likewise have experience in geriatric medicine and emergency mental health assessment and treatment. Further, medical student training should implement and enhance programs specifically on the psychiatric assessment and treatment of older adults within the emergency setting.^{60,63}

3. Standardize and Improve Psychiatric Emergency Services

The establishment of more structured PES care with advanced patient referral systems, provider communication, assessment tools, and treatment options in tandem with acute medical care will provide emergency patients better access to more appropriate specialty care. PES and ED service referral and linkage systems must be fostered and reformed to clearly include, initiate, or enhance geriatric-oriented mental health programs. Effective comprehensive geriatric assessment and multidisciplinary programs for elderly patients⁶⁴ offer models for psychiatric intervention programs to improve PES patient outcomes and reduce repeat use.

Comprehensive geriatric assessment is a multidisciplinary approach for evaluating frail elderly patients over several dimensions including psychiatric, medical, social, and functional. It can be performed in diverse clinical settings and generally aims to diagnose, establish a treatment plan, and guide long term care. A study of ED discharges age 75+ found that comprehensive geriatric assessment resulted in an 18% lower 18 month ED return rate, and increased time before the next ED presentation.⁶⁴ A recent review demonstrated that geriatric outpatient and home care based programs decreased ED presentations.⁶⁵

Communication between geriatric providers and PES should be standardized whenever possible, particularly for cognitively impaired patients and for patient transfers. Despite the high rate of nursing home patients seen in EDs and the high prevalence of cognitive impairment among these patients, nursing home and ED clinicians often treat the same patient without sharing information.² Patient transfers between nursing homes and EDs routinely are incomplete although simplified, standard forms have demonstrated improved quality control and communication.^{16,66} ED and psychiatric ED documentation procedures should be uniform, comprehensive, efficient, and described in written protocol.

PES access, increased training, and better communication among geriatric providers will aid identification of older adults in need of psychiatric care. In the future the younger elderly (ages 65-69) may be in better overall physical and mental health and less in need of acute mental healthcare, while the older elderly and nursing home population may have greater psychiatric and medical needs. In the context of varied healthcare concerns, the patient's more urgent clinical demands may get priority in limited visit time. This competing demands model may explain the underdetection of psychiatric problems and how the elderly with psychiatric concerns are viewed during the ED encounter,⁶⁷ as well as poor symptom recognition by patients and caregivers,^{28,31,68} somatization of symptoms, and ageism.²⁴ Mental status examinations often are not done in EDs, even for patients diagnosed with depression,⁴⁷ and elderly ED encounters have not routinely included psychosocial evaluations.⁶⁹ Future general ED and designated PES protocols for elderly patients should incorporate mental status examinations which include documented assessments of alertness, appearance, behavior, mood, affect, language, thought process, thought content, and a basic cognitive exam.³⁸ Brief

screening tools that take only a few minutes to administer have been developed for depression, 29,70 delirium, and cognitive impairment.^{11,31,38,41,71}

4. Prioritize Finances

Existing funding mechanisms must be revamped to ensure sufficient financing for PES programs facing escalating older adult needs, specifically including community and mental health system components that link psychiatric patients to PES. Currently the largest portion of acute hospital mental healthcare resources is spent on inpatient care. Healthcare innovations continue to divert patients to outpatient care,⁷² and evidence exists for cost effective approaches to older adult care.

Hospitalized frail patients age 65+ from 11 Veterans Affairs medical centers were randomized to either geriatric outpatient evaluation and management or to usual care. Outpatient evaluation and management had a significant positive effect on mental health at one year when compared to baseline and discharge. Neither inpatient nor outpatient geriatric services experienced increased costs over the year of the study.⁷³

There are also opportunities to prevent acute hospitalization within the nursing home population. When nursing home staff are overwhelmed, typically by acute problems, and have little or no specialized or other support, they often refer residents to PES, thus using the ED as a last resort. Evercare, a Medicare HMO serving nursing home patients, has demonstrated that intensive primary care for the elderly can reduce hospitalizations. Medical service utilization data for nursing home residents over two years were analyzed for control nursing home residents versus Evercare nursing home residents with active primary care provided by nurse practitioners. Hospitalization rates were almost twice as high for the two control resident groups compared to the Evercare residents.⁷⁴ For preventive general medical care, an approach targeted to psychiatric symptoms could enhance efforts to minimize potentially avoidable elderly mental health presentations to EDs and PES. Funding of training programs to ensure the timely provision of necessary services in the nursing home would be beneficial.

An approach to mental health funding that will continue to impact PES utilization is capitated financing. Reducing potentially unnecessary treatment to contain costs drives the use of capitation versus fee-for-service reimbursement methods. Capitation may reduce PES utilization without an accompanying decline in quality of care.⁵⁴ Alleviating acute services for non-urgent cases may allow more effective and efficient psychiatric treatment.

Improving PES care for the elderly, increasing geriatric specific training for PES and general ED staff, and enhancing the assessment of geriatric patients in the emergency setting will involve greater expense and more time.

5. Promote Research

Research on the accessibility, utilization, and quality of elderly PES will become even more relevant in the future and should be promoted. A priority should be the effective linkage of psychiatric emergency, outpatient psychiatry, and primary care services for the elderly. Emergency clinicians have a unique opportunity to detect psychiatric symptoms and initiate treatment for older adults.⁵ PES should be studied with specific attention to older adults and the efficacy of symptom recognition methods in general EDs and designated PESs need to be evaluated for older adults of diverse age and medical complexity.

Psychiatric ED directors should collaborate with geriatric providers and health service researchers to analyze older adults' mental healthcare utilization post discharge. This can guide program evaluations, cost analysis, and prospective research and interventions at the local level. Older adult suicide by patients of geriatric psychiatric providers should also be a primary

research focus.³⁷ Research on providers' early detection and correlates of older adult suicide should be implemented and addressed as a quality control outcome for primary care, older adult clinics, and hospital based services. Newer technology may be more assessable and applicable to the next generation of older adults and providers, and access to care and information through the Internet, email, and video should be studied as well as the potential benefits of electronic health records. Telemental health offers bidirectional video communication between patients and providers⁷⁵ and could be particularly useful for the elderly population in need of mental healthcare with low social supports or low access to specialty psychiatric providers. Furthermore, the function of the geriatric psychiatrist in the PES should be studied. The future high demand for this specialty makes analysis of their effectiveness an important objective for research.

CONCLUSION

The degree to which the geriatric healthcare “crisis” develops in coming years will be inversely related to the current system's response to predictable future patient needs and evolving healthcare environments. Present overall healthcare trends toward more outpatient care and cost-effective treatments could be jeopardized by more geriatric hospitalizations and misallocation of resources unless PES and outpatient psychiatric programs can compensate for the expected increasing demand for mental healthcare by elderly patients. If healthcare and sociodemographics trends are not appreciated, the crisis for elderly patients in need of psychiatric emergency services will be realized through inadequate treatment options and less effective and efficient service delivery. Psychiatric emergency care, by virtue of its accessibility, gatekeeper role, and increasing patient utilization, will serve as a central component of the mission to address these challenges.

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Table 1
Service and Patient Characteristics of Psychiatric Emergency Departments^a

PES characteristics: ^a	
Open 24 hours, 7 days/week:	92%
Attending psychiatrist present at least 8 hours/day:	96%
Attending psychiatrist present 24 hours/day:	26%
Follow up care provided by PES:	51%
Patient mean length of stay:	9.0 hours
% of patients presented involuntarily:	37%
% of patients admitted to inpatient services:	34%
% of patients with Medicare:	14%
Prevalence of patient PES psychiatric diagnoses (all ages):	
Psychotic disorder	29%
Primary substance abuse	25%
Major Depression	23%
Dementia	5%
ED Visit Data: ^{b c d e}	
Psychiatric admitting diagnosis from ED, 65 years +: ^b	
Dementia	38.8%
Mood disorder	29.5%
Schizophrenia/psychosis	19.8%
Substance-related	8.9%
Anxiety disorder	2.3%
Medication-induced	0.7%
ED visits, all ages, 2004:	110.2 million ^c
% of ED visits by patients 65 years +, 2004:	14.3 ^c
ED visits per 100 older adults, 2004:	45.4 ^c
% of ED visits due to mental health condition, 2001:	6.3 ^d
% of ED visits by institutionalized patients, including NH residents, 2003: * 2.6 ^e	
Psychiatric related ED visits, per 1000 pop., 2001 (1992): ^d	
All ages	23.6 (17.1)
70 years +	32.0 (20.6)
Psychiatric related ED visits, per 1000 ED visits, 2001 (1992): ^d	
All ages	62.5 (48.7)
70 years +	64.1 (46.4)

Sources:

* While "institutions" from this source includes prisons, the average age of patients from institutions is clearly elderly: 71 years.

^aCurrier and Allen, 2003⁶

^bChapman et al., 2003⁴⁵

^cMcCaig and Nawar, 2006¹⁵

^dLarkin et al., 2005⁸

^eMcCaig and Burt, 2005¹⁸

Table 2**Central Issues in Predicting Future Elderly Psychiatric Emergency Service Need**

Sociodemographic Imperative	Growing elderly population/ elderly as proportion of population Decreased rates of nursing home residency Marital status changes Changing support systems, family and gender roles Higher education
Psychiatric Illness Prevalence	Increased prevalence of mental health conditions Decreased mortality for serious mental disorder
Cohort effects	Increased depression Suicide rate changes More mental health care utilization
Medical Comorbidity	Improved overall health Lower disability rates More elderly with chronic medical conditions Greater prescription use “Masking” of psychiatric symptoms Increased utilization of ED services
Mental Health Care Resources and Utilization	Psychiatric underutilization by elderly Primary care use for mental health treatment Increased utilization of ED services
Stigma	Lessening mental health stigma

Table 3**Older Adult Population Characteristics (2003)^a**

	<u>2000</u>	<u>2030</u>	<u>% increase</u>
U.S. population age (% of total pop.): ^b			
65 years +	35.1 mil (12.4)	71.5 mil (19.7)	103.8
85 years +	4.3 mil (1.5)	9.6 mil (2.6)	125.1
Under 65 years	247.1 mil (87.6)	292.1 mil (80.3)	18.2
Male 65 years + (% of 65+ pop.): ^b	14.5 mil (41.2)	31.3 mil (43.9)	116.9
Male 85 years + (% of 85+ pop.): ^b	1.2 mil (29.1)	3.3 mil (34.8)	169.4
Percent of elderly: Non-Hispanic White:	83	72	-13.2
Hispanic:	6	11	83.3
African American:	8	10	20.0
Dependency ratio for older adults [*]	21.1	36.2	71.6
Older adults residing in nursing homes (%): ^c	1.5 million (4.2)		
Life expectancy:	76.9 years		
Older adults with 1+ chronic condition:	80%		
2+ chronic conditions:	50%		
Number of victims of elderly abuse:	2.1 million		

Sources:

* Dependency Ratio = Persons 65 years and older/100 working age persons 20- 64 years old. Note: reference year is 2003, source is (a), and variables pertain to population 65 years old and older unless indicated otherwise.

^a He et al., 2005¹⁹

^b Projected Population of the United States, by Age and Sex: 2000 to 2050, 2004¹⁷

^c McCaig and Burt, 2005¹⁸