# older adults + mental health:
# a time for reform

## a guide for mental health planning + advisory councils

**US Department of Health and Human Services**
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

This guide will help state mental health planning and advisory council members and others advocate for the implementation of evidence-based and innovative services to advance the quality of care for older persons with mental illnesses.

2007

## Substance Abuse and Mental Health Services Administration

The Substance Abuse and Mental Health Services Administration (SAMHSA) within the Department of Health and Human Services is comprised of three Centers that carry out the Agency's mission of improving the quality and availablility of prevention, treatment, and rehabilitation services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

The Center for Mental Health Services (CMHS) is the agency of SAMHSA that leads Federal efforts to treat mental illnesses by promoting mental health and by preventing the development or worsening of mental illness when possible. Congress created SAMHSA's CMHS to bring new hope to adults who have serious mental illnesses and to children with serious emotional disorders.

## The National Association of Mental Health Planning and Advisory Councils

The state mental health planning and advisory councils have joined together to form the National Association of Mental Health Planning and Advisory Councils (NAMHPAC). Federal law requires the establishment of mental health planning councils to review state applications for block grant funding, to serve as advocates for adults with serious mental illnesses and children with serious emotional disturbances, and to monitor and evaluate state mental health planning systems. Although these activities are mandated, many states do not provide funding to support them. In many cases, this lack of funding combined with council members' often short tenures prevents these organizations from making their full impact on service delivery and consumer empowerment. NAMHPAC provides technical assistance to these organizations in the areas of exemplary practices, organizational development, and information sharing. In addition, NAMHPAC provides a national presence on mental health policy issues on behalf of the state planning and advisory councils.

We hope that each planning and advisory council member will closely read this document and use its information to develop the state plan for year 2006 and beyond. In addition, NAMHPAC will contact members of state councils to encourage them to use these materials, to evaluate how the materials were used, to identify topics for future pamphlets, and to gather suggestions for dissemination of such pamphlets.

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**Acknowledgements**
This publication was prepared by the National Association of Mental Health Planning and Advisory Councils (NAMHPAC) under Contract 03M00011801D with the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS). Fran Randolph provided support for the development of the project. Pamela Fischer, Ph.D., and Deborah Stone, Ph.D., served as the Government Project Officers. Stephanie Townsend, M.A., of NAMHPAC, drafted and edited this publication.

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**Recommended Citation**
National Association of Mental Health Planning and Advisory Councils. Older Adults and Mental Health: A Time for Reform. DHHS Pub. No. SMA XXXXX. Rockville, MD. Center for Mental Health Services, Substance Abuse and Mental Health

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## Older Adults and Mental Health: The Background

Although a majority of older adults enjoy good mental health, one in five has a significant mental health disorder for which he or she receives no help.[1] Even for those older adults with mental illnesses who do receive help, the quality and availability of the services they receive are lacking. As a result, older adults who have mental illnesses may spend a significant amount of time in state psychiatric hospitals, be placed in nursing homes earlier than they would have otherwise, have frequent general hospital stays, or experience a combination of all of these outcomes.

Contributing to this gap between the need for mental health services and the availability and quality of those services have been misconceptions about aging, stigma, and the mental health system in general. Assuming that the number of older Americans doubles as expected to nearly 70 million by 2040, addressing these issues takes on added importance.[2]

The goal of this publication is to help state planning and advisory council members understand the needs of this growing segment of our population. The information provided here will help members and others to close the gap between the need, availability, and quality of services through the implementation of evidence-based and innovative services designed to advance the quality of care for older people with mental illnesses.

### *The Consequences*

Most people know that a lack of access to mental health care can have profound consequences on an individual's mental health—ranging from a decline in quality of life to suicide. What's less well-known but has become increasingly clear in recent years is the impact that not having access to adequate—or any—mental health care has on physical health. For example, in one study, older adults with depression who were otherwise physically healthy were twice as likely to die within a given time period than their counterparts who didn't have depression. The study's researchers

also found that older adults' depression is as likely a cause of death as is a history of heart attacks.[3] Other studies indicate that older adults who have depression are also more likely than their peers to:

- heal more slowly from hip fractures
- suffer heart attacks
- succumb to cancer[4]

Beyond the impact of mental illnesses on physical heath are the societal costs, financial and otherwise, required to treat these physical conditions. Because the physical conditions mentioned above often require extensive – and expensive – health care, many older adults are forced to rely on care provided in nursing homes in order to receive treatment. This can lead to older adults being placed in nursing homes at younger ages than they would have been otherwise, which disrupts families and places added strains on public health-care systems.

## *Demographics and Prevalence Rates*

There are three subgroups of older adults who are in need of specialized mental health services: (1) those with serious and persistent mental illnesses, (2) those with mental health problems that develop later in life, such as dementia, late onset schizophrenia, alcohol and prescription drug abuse, anxiety, and depression; and (3) those facing the developmental challenges of old age, such as role changes, loss of friends and relatives, and declining functional abilities.

Among older adults in these three subgroups, the most common type of mental illnesses are anxiety disorders, such as obsessive compulsive disorder or generalized anxiety disorder, with depressive disorders following at a close second. Severe cognitive impairment (e.g., dementia and its associated psychiatric problems) and schizophrenia are the third and fourth most common mental health problems among older adults, respectively.[5]

Depression, in particular, can have profound consequences for the nation's 35 million adults older than 65. Although depression is not an inevitable part of aging, 2 million people are estimated to have depressive illnesses and another 5 million may have "subsyndromal" depression, which means that they may have many, but not all, of the symptoms of a depressive illness.[6]

The worst consequence of depression, which is made more likely if the depression goes untreated, is suicide. In 2003, adults age 65 and older constituted 12 percent of the population[7] but represented a staggering 16.7 percent of suicides.[8] Adults age 75 and older have the highest suicide rates of any other age group – about 1.5 times the national average.[9] Contributing to this high suicide rate are late-life challenges such as physical health problems, caring for a spouse with dementia or physical illness, and bereavement. These challenges can exacerbate existing depression, which, in turn, increases the risk of suicide.

With 17 percent of older adults abusing or misusing alcohol and/or medications, substance abuse is also a significant problem.[10] In addition, 10 percent of older adults suffer from dementia, a disorder that is commonly accompanied by depression or anxiety, or both. Unfortunately, these disorders often go unaddressed due to the misconception that individuals with dementia can't benefit from treatment for mental health disorders. Less than half of older adults with mental illnesses receive any mental health services.[11]

## *Barriers to Service*

To effectively advocate for improved services for older adults, planning council members need to have a full understanding of the barriers older adults face in obtaining quality care.

## *General Barriers*

Adults age 65 and older face a myriad of barriers in obtaining mental health services. Among these challenges are stigma, discrimination, poverty, and isolation, all of which are the unfortunate realities for many older adults.

**Stigma and Discrimination**: Older adults who have mental illnesses often face a tougher battle than their younger counterparts in obtaining services. In addition to the universal stigma surrounding mental illnesses, older adults also face discrimination due to their age. This bias, labeled

"ageism" by some, promotes many damaging attitudes about older adults. These include the false beliefs that depression is a normal part of aging, that older adults cannot recover from mental illnesses or substance abuse disorders, and that older adults are no longer productive members of society. Such destructive attitudes may be internalized by older adults who could otherwise benefit from mental health services but refuse to seek help out of fear of being labeled "insane" or of losing their independence; feeling shame; or assuming that nothing much can be done for them due to their age.

Members of the 65+ age group also grew up at a time when misconceptions about mental illnesses—specifically the disorders' causes and treatments—were even more prevalent than they are today.[12] Racial and ethnic discrimination throughout history also make it difficult for millions of older adults who belong to diverse communities to seek help from a system that in the past has overlooked their needs.

**Poverty**: About one in 10 older adults were living below or just above the poverty level in 2003.[13] Untreated mental illnesses can exacerbate poverty, in part, by making it more difficult to maintain employment. Without a steady income beyond Social Security payments, being able to afford medications and other treatments often becomes too difficult, which exacerbates their mental health problems. As their mental health problems worsen, it becomes even more difficult to maintain employment, which only perpetuates a vicious circle.

**Isolation**: Among members of all age groups, older adults are the most likely to live alone and have transportation problems, which heighten their isolation from friends, family members, and neighbors.[14] They're also likely to be isolated from others due to stigma, ageism, and poverty. As a result, they are less likely than others to seek help, to have means of obtaining help, and to have people in their lives to help them. Because older adults often live alone, they are less likely to interact with others, which leads to further isolation and creates a reinforcing pattern that is challenging to overcome.



### *Systemic Barriers*

While discrimination, poverty, and isolation are general barriers for older adults who need mental health care, our mental health system's infrastructure also significantly contributes to the difficulties older adults experience accessing services.

**Fragmented System of Mental Health Care**: Due to the complex needs of this population and the decentralized nature of our system, older adults must obtain help from multiple services and multiple providers (e.g., medical, housing, nursing homes, aging network, criminal justice, and others). However, there's often poor coordination – if any – among the providers of these services, which makes the system difficult for many people to understand and access.[15] For example, although each state has a mental health agency as well as a separate agency that focuses on aging issues, the agencies in many states don't coordinate their services. Each agency within a state operates under the assumption that the other agency is providing services. Due to this disconnect, many older consumers fall through the cracks.

Those that do seek mental health care often do so through their primary care providers, a setting where they often feel most comfortable. However, due to stigma, they often don't seek help for the mental health problem itself but instead make an appointment under the pretext of a physical health problem. In addition, many mental illnesses can produce physical symptoms, such as headaches, backaches, and digestive problems. Because primary care physicians aren't necessarily trained to spot mental health problems, many mental health disorders often go undiagnosed. Also playing a role in the inability of primary care physicians in diagnosing mental health problems is the limited amount of time physicians are able to spend with patients due to managed care restrictions and an inconsistent use of evidence-based screening methods. In fact, one study showed that up to 75 percent of older adults who die as a result of suicide had visited their primary care physicians within a month of the suicide.[16]

**Mismatch Between Care and Needs**: In 2003, the President's New Freedom Commission Subcommittee on

Older Adults and Mental Health identified a fundamental problem in the way the mental health community provides treatment: a "mismatch between the current system of care and the needs and preferences of older adults."[17] Although research points to the effectiveness of home- and community-based treatments (see page 13), most mental health services are offered only in settings older adults may not have access to or may feel uncomfortable in, such as hospitals, mental health clinics, and psychiatrists' offices. Because older adults are often unable to access care in these settings, their only alternative may be to receive care, especially long-term care, through nursing homes. Estimates indicate that up to 75 percent of nursing home residents have mental illnesses, and quality mental health care in that setting is often scarce.[18]

Contributing to the mismatch between the settings in which older adults may feel most comfortable receiving services and the settings that actually offer the services they need are the policies of Medicare and Medicaid, the two primary funding sources for mental health services. These policies often limit the funding available for mental health services to hospital- or long-term care-based settings. Funding for home-based services, for example, isn't usually covered. Other Medicaid and Medicare policies only exacerbate barriers to mental health care by requiring copayments, limiting prescription coverage, and implementing rate adjustments that are designed to support acute, hospital-based care of medical disorders.[19] For example, Medicare policy requires a 50 percent copayment for mental health-related services compared to a 20 percent copayment for physical health services.

In addition, Medicare reimbursements to providers for both physical and mental health care are often lower than the costs of the actual services, which causes many healthcare professionals to refuse to accept Medicare patients. Also limiting Medicare beneficiaries' access to mental health services are financing policies that are not designed to provide for continuity or coordination of services. For example, Medicare will typically not pay for an individual to make two separate visits to a mental health professional during the same day, and Medicare doesn't provide adequate coverage for community-based services, such as case management and psychosocial rehabilitation. Finally, although Medicaid is the largest payer of institutional care for older adults with mental illnesses, the program's funding policies discourage the use of specialty mental health services in nursing homes (this issue and possible solutions are explored later in this publication).

**Gap Between Research and Practice**: In the final report of the full President's New Freedom Commission on Mental Health, the commission highlighted the gap that exists between the interventions and treatments shown to be effective in research and those implemented in practice. Although this gap exists in all mental health services, it's especially pronounced for those services aimed at older adults.[20] Contributing to this gap is the lack of funding and other resources that are devoted to spurring research on model programs that can deliver mental health services to older adults.[21] An example of this is the 2001 National Institute of Mental Health's budget, which devoted only 6 percent of the agency's grants to studies focused on the older adult population.[22]

**Workforce and Caregiver Capacity**: There is a shortage of professional providers with adequate expertise and training in the fields of mental health and aging, a problem that reduces the availability of services. A 2003 Alliance for Aging research report, "Ageism: How Health Care Fails the Elderly," states that the gap between the need for providers and the supply is widening.[23] Those in the aging field often are not properly trained in mental health issues, and those in the mental health field often lack proper training in aging issues. In 2003, there were 2,285 American psychiatrists with a subspecialty certification in geriatric psychiatry, and between 200 and 700 geropsychologists. It is estimated, however, that at least 5,000 professionals sin these subspecialties are needed to meet the needs of older adults in America.[24]

There is also little emphasis on geriatric training in medical school and graduate programs, which partly stems from the lack of professionals in schools to teach these issues. There

are less than 600 such teaching professionals in the United States, though it is estimated that there is a need for about 2,400.[25] Economics also contributes to this problem. Many aspiring medical and mental health professionals have less of an incentive to specialize in older adult issues because geriatric professionals depend on Medicare and Medicaid for payments. As discussed, these programs reimburse care at rates that often don't even cover the cost of the services delivered.

Family, spouses, and friends are most often the "workforce" caring for their older loved ones who have mental illnesses. A majority of older adults with mental illnesses actually live at home, with relatives or friends, contrary to the popular belief that American families do not care for their aging family members. In fact, 13 million individuals in this country provide unpaid care to older relatives, and 75 percent of individuals with dementia are cared for in the home by family members.[26] Advantages of using family and peer caregivers include lower rates of costly services for the older adults with mental illnesses and delayed nursing home placement. However, caretaking exerts an extreme physical and emotional toll on the caregiver, leading to high rates of physical illnesses, substance abuse, and depression, which affect more than one-half of family caregivers.[27] Counseling, support groups, respite services, skills training, family-directed treatment, and other enhanced support services are needed to help caregivers with their own mental health and to enable them to provide care to their loved ones (see page 17).

**Cultural Competence**: The population of adults who are at least 65 and who are from ethnic and racial minority groups will increase from approximately 5.7 million to 19.7 million in the next 30 years (from 16.5 percent of the total population of older adults to 25.6 percent).[28]

People who are African American represent the largest group of older adults, followed by Latinos/Hispanics, Asian Americans and Pacific Islanders, and then American Indians. Our current system's infrastructure is inadequately designed to provide effective services to these populations due in part to the lack of mental health providers who come from diverse ethnic and racial backgrounds, and because providers rarely receive training in cultural issues separate from their own.[29] Such issues range from providing educational and other materials in languages other than English to the more complex, systemic issues of stereotype and prejudice. Separately, research of evidence-based practices for older adults rarely includes ethnic and racial minorities, which makes it impossible to know whether recommended treatments are applicable to populations other than those involved in the studies. All of these issues have lead to a system in which ethnic and racial minorities with mental illnesses are grappling not only with the challenges of aging but also with a mental health system that has not fully taken into account their needs.

## Evidence-based Solutions for Providing Exemplary Care to Our Aging Population

Evidence-based health care should be the foundation for building exemplary care for our aging population. At its core, evidence-based health care:

- supports individualized care based on individuals' unique needs, histories and other factors, and does not dictate "one-size-fits-all" treatment.
- develops through research, the results of which should be clearly stated and flexible in nature, and includes consumer representation.
- develops through research that is not limited to randomized clinical studies but also includes other forms of research to ensure that all racial and ethnic groups are represented.
- emphasizes safety and finding the right treatment for the individual as the top goal.
- supports doctor and consumer decision-making, not dictated treatment.

Built on this foundation are services and programs that include:

- outreach services, including community education and training, prevention and intervention efforts, and screening and early identification.
- comprehensive home- and community-based services, including integration with primary care, case management, peer- and consumer-run services, caregiver supports, crisis services, and long-term care.
- policy and legislative changes that address the problems of workforce development, funding, research, coalition building, and integrated service systems.

## *Outreach*

Outreach consists of components such as community education and provider training, case finding, assessment, referral, and consultation. Outreach is central to addressing the barriers of isolation, stigma, and discrimination. Several effective outreach efforts are highlighted in sidebars in this section.

**Community Education and Provider Training**: Outreach begins with campaigns to educate consumers, family members, providers, and the public on healthy aging and mental wellness, mental illness, substance abuse, and effective treatments. Educational campaigns can increase public and professional awareness that mental illnesses in older adults are a public health problem that can be both prevented and successfully treated.[30] In addition to encouraging older adults to

**Pennsylvania Statewide Depression Education and Awareness Campaign:**

- Depression awareness packets distributed for Older Americans Month and May Is Mental Health Month
- Depression screenings during local events
- Web-based series developed on mental health and aging issues

For more information on this and other Pennsylvania initiatives, visit the Pennsylvania Department of Aging at www.aging.state.pa.us.

seek help, such campaigns have additional benefits, including reducing stigma and providing consumers with a sense of empowerment.[31] Outreach efforts should include disseminating research findings as they are made available to promote effective treatments for older adults.

Consumers, family members, and providers aren't the only audiences for outreach efforts. There's great value in including state legislators and their staff in such efforts.[32] The outreach sessions help to educate policymakers about the condition of older adults with mental health and substance abuse problems and can raise awareness about many of the policy barriers discussed earlier.

**Prevention and Early Intervention**: Integral to outreach efforts are prevention and early intervention strategies that can circumvent mental health problems before they become serious, or even before they arise. Prevention and early intervention involves understanding the risk factors that make older adults vulnerable to mental illnesses, such as loss and bereavement, chronic illnesses, and social isolation. It also includes understanding the protective factors that foster resiliency, such as social supports and opportunities for productive social roles.[33] Prevention efforts should seek to minimize risk factors and maximize protective factors.

An example of these prevention efforts includes health and wellness programs, which promote mental health by normalizing the aging process, teaching coping skills, fostering peer support, and addressing the transitions of aging, such as the loss of a loved one. These programs should take place in the community where the individual is most comfortable (e.g., healthcare clinics, senior centers, libraries, religious institutions).[34]

Due to the high rates of suicide among older adults, particularly men, suicide is an especially prime target for prevention and early intervention efforts. Following the model of prevention and early intervention efforts described above, states need to address the risk factors associated with suicide, such as psychiatric and physical illnesses, functional impairment, and social isolation. Substance abuse is also a risk factor should be addressed in suicide prevention; the risk of suicide is up to 70 percent greater in people who are dependent on alcohol than the general population.[35] States also should educate caregivers about the warning signs of suicide and serious mental health or substance abuse problems.

**Alert and Alive** is a mental wellness program that addresses issues such as stress, memory, depression, loss, community resources, and many other pertinent issues. The program has four components:

- 12-session mental wellness education course
- 6-session volunteer training in leadership skills
- 3 volunteer-led mental wellness activities
- Program implementation through in-services training and supervisory monitoring

For more information, visit New York City's Department for the Aging website, under "Health Promotion," at www.nyc.gov/aging.

Former U.S. Surgeon General David Satcher outlined one model of suicide prevention in the "Surgeon General's Call to Action to Prevent Suicide." The model, called A.I.M., includes:[36]

- Awareness: Broaden the public's awareness of suicide and its risk factors
- Intervention: Enhance services and programs
- Methodology: Advance the science of suicide prevention

Many states and local governments are incorporating each of the A.I.M. components into their suicide prevention plans. It should be noted that some states' plans are initiated, designed, and carried out by staff outside of the department responsible for mental health, which again emphasizes the need for agency coordination.

Screening and Identification: Accurate assessments and diagnoses of mental health disorders are the cornerstone of effective treatment. The first step in this process is a screening. A screening is a preliminary determination about whether certain features of substance abuse or mental

health disorders are present in an individual and, if so, whether a more comprehensive assessment is warranted, which could lead to a diagnosis and treatment. Due to the important role that screening plays in early identification and intervention of substance abuse and mental health disorders, new advances in screening and assessment tools need to be disseminated to physicians and other providers as soon as they are available. One useful tool in doing this is th standardized geropsychiatric assessment and treatment planning toolkit, "The Outcomes-based Treatment Planning Toolkit for Geriatric Mental Health Services."[37]

Screenings should be a common component of physical examinations, and those in regular contact with older adults through housing, social, and other aging services, should be trained, or least made aware of, the symptoms of substance use and mental health disorders, and know how to connect older adults to services.

In fact, this was one of the recommendations of the New Freedom Commission's Subcommittee on Older Adults and Mental Health. The subcommittee recommended that mental health screening and outreach efforts be integrated into routine senior social services to improve older adults' access to care. This integration would involve training for clergy, senior center staff, and other professionals who are in frequent contact with older Americans.

A popular model that exemplifies the commission's recommendation for reaching isolated and at-risk older adults is the "Gatekeeper" model, which originated in Spokane, Wash. This model involves teaching community workers who come into contact with older people on a daily basis (e.g., postal service workers, delivery persons, first responders) to identify those who may be in need of mental health or substance abuse services and how to connect people to those services. This model gives mental health workers at least indirect and often daily contact with older adults who they probably would not otherwise have access to because the consumers would not self-refer and remain isolated.



To be effective, the Gatekeeper Model needs a designated organization to accept referrals, conduct screenings, arrange for assessments when needed, and provide information, referral, and assistance in securing services. Research on the Gatekeeper Model confirmed that this approach identified people who were likely to fall through the cracks, such as older adults who were widowed, divorced, or lived alone. In addition, research has demonstrated that there is no difference in service use or out-of-home placement between Gatekeeper-referred clients and traditionally referred clients. This finding indicates that this model does not place an undue tax on an already short-staffed and budget-pinched system.[38]

**HEROS – Helping Elders through Referral and Outreach Services:** Originated in 1996 by a mental health and aging coalition in Pierce County, Wash.

- Based on gatekeeper model
- Staff receive phone referrals and do initial screening
- If warranted, referrals are passed to Geriatric Evaluation Specialist, who makes phone contact and home visit to do comprehensive assessment
- Connects person with appropriate community services, including, but not limited to, mental health services

For more information about gatekeeper case finding models, visit ww.wiche.edu/MentalHealth/ExemplaryPractices/gatekeeper.asp.

One special screening tool requires special consideration. Medicaid law requires that states have a Pre-Admission Screening and Resident Review (PASRR), which is a screening process for individuals with mental illnesses who are applying for admission into Medicaid-certified nursing homes. Considerable controversy has surrounded the PASRR mandate. The original purpose of the law was to prevent the inappropriate admission and retention of those with mental illnesses in nursing homes. Despite the original intent, critics question the practical effects of PASRR. Proponents of the provision argue that it has given providers the opportunity to

identify nursing home residents who have serious mental illnesses, determine their needs, establish treatment plans, and connect them with appropriate services. Opponents are concerned that many nursing homes turn away individuals who are identified as having mental illnesses based on the PASRR screening results, which only further decreases their access to services. States need to carefully examine their PASRR process and policies to ensure the screening process is helping older adults who have been diagnosed with mental illnesses and not cutting them off from services.

### *Home- and Community-based Services*

In reviewing past research examining what types of interventions and treatments were most effective in helping older adults, researchers found the greatest empirical support for community-based, multidisciplinary, geriatric mental health services.[39] Such home- and community-based settings can include private homes, group homes, and retirement and assisted living communities.

The importance of sound home- and community-based services was underscored by the U.S. Supreme Court's 1999 Olmstead v. L.C. decision. The court held that the institutionalization of people who have disabilities violates the federal Americans With Disabilities Act if those people can live in communities when given appropriate supports. As a result, there has been a growing "de-institutionalization" of many people who have mental illnesses (among people with other disabilities), including consumers older than 65. To provide efficacious services within communities to older adults, certain program components must be in place.

**Case Management**: Case management is essential to providing effective services to older adults. This is particularly true within our fragmented service systems, which are often divided between health, mental health, substance abuse, social, and other services. To expect older adults, who may have multiple physical and emotional problems, to navigate the systems on their own to coordinate their care – along with their transportation, housing, and other needs – is not realistic. Including case management services as a component of community services, along with residential support, crisis services and other programs, can help older consumers avoid hospitalization in some cases and meet the needs of this population.

One model of providing case management services to older adults is based on one often used in the children's sector—wrap-around services. An example of this is Elder Wrap-Around, which is an emerging, promising practice that emphasizes the building of collaborative relationships between agencies and ensures that no person slips through the cracks.[40] This collaboration is done through an Elder-Wrap team, which includes representatives from mental health, health, aging, housing, social services, and other state agencies. With clients' permission, these teams review cases with a focus on older adults' wellness and in maintaining their independent living in communities for as long as possible. They also provide education to consumers, families, caregivers, and professionals, and provide trainings to professionals in screening, assessment, and treatment techniques.

Elder-Wrap teams have an additional benefit: helping older adults overcome stigma. The Elder-Wrap teams are the con-

**Interac Geriatric Counseling Service**: Interac, a Philadelphia-based program, provides accessible and appropriate behavioral health services. Its success lies in its mobility as a community-based service that can be provided in the home, senior centers, or senior housing sites. Staffed by clinical social workers with aging expertise, the program reaches out to and identifies older adults who would not otherwise receive services. There is a strong focus on decreasing stigma by maintaining a constant presence, and providing education at senior centers and housing sites. Treatment is customized to the needs of older adults and involves an "attitude of respect," extensive psycho-education, extended session times, and a focus on spirituality and cultural issues.

For additional information: visit www.intercommunityaction.org, call 215-487-1750 or e-mail administration@intercommunityaction.org.

sumer's primary contact rather than a traditional mental health professional. Health and other service agency providers offer older adults access to mental health services.

One state that has successfully implemented an Elder-Wrap program is New Hampshire, information on which can be found on the New Hampshire Department of Health and Human Services' website at www.dhhs.nh.gov/DHHS/BBH. Other states have similar successful programs based on the Elder-Wrap model, including Vermont, which has implemented the Elder Care Clinician Program. The goal of the program is to improve the well-being of older adults by sending clinicians to the homes of older adults who are in need of services. The clinicians' work includes case management services and is performed in conjunction with both local community mental health centers and area agencies on aging (for additional information on Vermont's ElderCare Clinician Program, visit the state Department of Disabilities, Aging and Independent Living at http://dail.vermont.gov). The keys to these and other successful programs are the availability of home- and community-based services, and the coordination of care among different agencies with the goal of helping individuals live outside institutions as long as possible.

**Integration With Primary Care – Mental Health Treatment Centers:** The most common community contact older adults have is with their primary care physicians. The American Psychological Association estimates that 50 percent to 70 percent of primary care medical visits are related to psychological factors, such as stress, anxiety, or depression.[41] Thirty-seven percent of older adults being treated by their primary care providers suffer from symptoms of depression.[42]

Primary care physicians are often not knowledgeable enough in behavioral health care to make an accurate diagnosis, or may mistakenly attribute psychiatric symptoms to aging or a physical illness. Currently, studies indicate that when primary care physicians do provide mental health care to older adults, the patients are more likely to receive inappropriate pharmacological treatment and less likely to be treated with psychotherapeutic interventions than younger primary care patients.[43] Even when trained, many physicians have difficulty inquiring about mental health issues because they think mental health or substance abuse questions are too intrusive. When physicians are educated about mental health and are comfortable in broaching the subject with their patients, the time constraints imposed by managed care practices on visits make it difficult to delve into such complicated issues. So it is not surprising that integration of mental health services and primary care is shown to reduce healthcare utilization.[44] In fact, such integration is essential.

According the federal Administration on Aging, there are three models for integrating primary care and mental health:

- **Attached mental health professional**: Within this model, the primary care office has an affiliation with a mental health professional that provides screenings, therapy sessions, and medication compliance monitoring.
- **Consultation-liaison**: Within this model, there is a high degree of collaboration between mental health professionals and primary care staff. This is a team approach that treats milder mental disorders and enhances the primary care doctor's ability to identify and manage mental illnesses. In more severe cases, the person is referred to the mental health specialist for more intensive face-to-face meetings; however, the medical team is still consistently brought in on the treatment.
- **Community mental health teams**: Within this model, there is a multidisciplinary team that serves within the community and is often based within psychiatric hospital services. This model provides a single point of referral for multidisciplinary care and assessments, education, and consultation with primary care and other community agencies.[45]

States have also used informal models of training primary care physicians such as utilizing an outreach psychiatrist to visit physicians and educate them on current issues and interventions catered to older adults. The model used can vary, but the goal should always be the same – identifying and effectively treating older adults with mental health problems.

**IMPACT** is a novel research project designed to help primary care physicians (PCPs) detect and treat depression. A mental health professional, such as a social worker, mental health nurse or psychologist, is added to the medical team, and treatment is stepped up to a psychiatrist if improvement in symptoms is not achieved. Preliminary results show promising outcomes with reduced symptoms and complete remission in many patients.

For additional information on this and related research projects, visit The John A. Hartford Foundation, www.jhartfound.org/program/impact.htm

**Peer Support and Consumer-Run Services**: Older adult consumers should be involved in the planning and implementation of the services that they receive. One method of doing this is the development of peer support and consumer-run services.

The basic characteristics of these services are *choice and self-determination*, which enable older consumers to feel – and be – a part of their treatment and recovery. Older adults are therefore integrally involved in their own care and are provided with information to make informed choices about their treatment options. Wellness Recovery Action Plans (WRAP), advance directives, and the inclusion of consumers on treatment teams are critical components of quality community care. They can also be woven into mental health services provided to older adults in nursing homes and other institutional settings.

Peer services serve a normalizing function and educate older adults on normal aging and mental health needs. Peer-run support groups are often effective preventative measures and provide psychosocial support during times of transition, crisis, or bereavement.

These and similar services can also supplement traditional treatment by mental health professionals, are cost-effective and help improve access to care. Many older consumers may find this type of service more acceptable.



**Caregiver Supports**: As discussed earlier, approximately 13 million caregivers provide care for older relatives, which results in higher than average levels of depression and anxiety among them.[46, 47] While most families express the desire to keep their loved ones home with them and in the community, the strain of providing for the needs of an older adult, particularly when mental illness is involved, is tremendous and can affect the quality and length of care well-meaning loved ones can give. Communities must therefore ensure that appropriate supports are in place to provide a safety net and strong support network for these families and the older adults for whom they provide care. Such community-based services are cost-effective because they allow older adults to remain in their homes longer than they otherwise would and avoid more costly institutional services.

Components of an effective community support system for caregivers include in-home and out-of-home respite to provide temporary relief. Another component is adult day centers, which provide older adults with social interaction and recreation services, and allow caregivers some time off. Some adult day centers also provide health services. In addition, caregivers need specialized information, referral, family consultation, care planning, education, training, and caregiver assessment.[48] Such proactive measures can prevent problems, such as caregiver abuse, which estimates show affects 5 percent of all older adults.[49] In addition, emergency response teams can prevent unnecessary hospitalizations and head off crises before they escalate.

The 2000 National Family Caregiver Support Program was established as part of reauthorization of the Older Americans Act (see Appendix A). This program called for state offices on aging to work with the local area aging agencies, community services providers, and consumer-run organizations to provide available resources to families; assist families in locating services; and provide caregiver counseling, training, peer support, respite care, and other supplemental services. These resources have been prevalent in Alzheimer's programs with the advent of Alzheimer's Disease Demonstration Grants for states, but also need to be available to families caring for older adults with mental illnesses.

As communities plan for caregiver and family support, it is important that they keep in mind the racial, ethnic, religious, and socio-economic diversity of older adults and their care-givers. Programs need to be tailored to fit with older adults' and caregivers' cultural backgrounds, and consider different cultures' varying levels of openness to services as well as unique family dynamics. It may be effective to engage the faith community and other non-traditional providers of service.

**Crisis Services**: Arguably the most important component of comprehensive community-based care are crisis services. As mentioned earlier, people older than 75 have the highest sui-cide rate among all age groups. Although most states have crisis personnel who are trained in general mental health issues and can be dispatched to individuals' homes in case of suicide attempts, issues specific to older adults who have mental illnesses are usually not included in training curricula.

State first responder curricula need to include material about aging issues and the services available for older adults. Such training can be done inexpensively through local area aging agencies, community mental health centers, mental health advocacy groups, and older adult and mental health coali-tions and consumer groups.

**PACE (Program of All-Inclusive Care for the Elderly)** is a national, innovative, long-term care model that pro-vides community-based care for elderly individuals with mental health diagnoses that qualify them for nursing home placement under Medicare. It provides all Medicare and Medicaid services, including home care, medications, rehab services, environmental modification, respite care, and non-traditional services. The key to the program's success is an interdisciplinary team that inte-grates primary care, adult day care, medication manage-ment, and social work support. In 2005, 18 states were implementing PACE programs and showing marked improvement in areas such as stable housing, functional independence, and decreased psychiatric admissions.

For additional information, visit www.cms.hhs.gov/PACE.

Some states, such as Florida and California, do have well-trained, designated Geriatric Crisis Response Teams, which specialize in interventions for older adults who might be at high risk for suicide. These programs include in-home assess-ment, crisis intervention counseling, psychiatric evaluation, follow-up, and case management.

When designing crisis services, policymakers also shouldn't forget about caregivers, who are at high risk for developing depression and anxiety disorders, which puts them at risk for suicidal behavior.

**Long-Term Care**: Some older adults diagnosed with mental illnesses are unable to live in the community due to the severity of their disorders. Although some of these older adults receive long-term care in hospitals, state psychiatric hospitals or federal Veterans' Health Administration facilities, the de-institutionalization of the state psychiatric hospitals has meant that these older consumers increasingly rely on nursing homes for care. Incentives built into the Medicaid program, which encourage the use of nursing home care over the care provided through hospitals and other long-term care facilities, have also contributed to the increasing reliance on nursing homes. The impact of de-institutionaliza-tion and Medicaid incentives can be seen among nursing home residents who have mental health disorders. According to former U.S. Surgeon General David Satcher, about two-thirds of these residents have some type of mental disor-der—the most prevalent being dementia, depression, and schizophrenia.[50]

Due to the prevalence of mental health disorder among nursing home residents, there is a clear need to provide accessible, quality care. However, there are several barriers in providing such care, including a shortage of mental health specialists willing to work in nursing homes, a lack of train-ing available for nursing home staff, and a lack of Medicaid and Medicare reimbursements to cover mental health servic-es. Solutions to these challenges include the implementation of mental health consultation services in nursing homes, which preliminary research indicates may be associated with

improved outcomes for patients. Also, training staff in assessment and management of behavioral problems leads to lower rates of staff turnover, one of the biggest problems in nursing homes.[51]

Services can be implemented in a variety of ways.

- Mental health services can be implemented through psycho-geriatric teams that cover certain geographic areas and focus on prevention of crises and acute hospitalization.
- Some nursing homes have onsite mental health departments that provide an array of interventions, such as interpersonal skills training, psychotherapy, education, group therapy, social hours, and in-service sessions for staff and family members.
- Some states provide mental health services in nursing homes through a collaborative relationship between the agency responsible for coordinating PASRR evaluations and the state's mental health agency.[52]

### *Policy Changes*

The government must be ready to address the mental health challenges of the "elder boom." Policy changes are needed to support the types of services outlined above to improve access to services, the overall quality of services, research on aging and mental health, and workforce capacity.

### *Cross Collaboration Among Agencies*

Before the 2005 White House Conference on Aging, the National Coalition on Mental Health and Aging conducted a briefing session for conference organizers. It delivered this message to policymakers: "There needs to be an increased collaboration among aging, health, mental health and substance abuse consumer organizations, advocacy groups, professional associations, academic institutions, research entities, and all relevant government agencies to promote more effective use of resources and to reduce fragmentation of services."[53] Seamless service systems are needed to ensure that no matter where an older adult enters the system – such as through a housing agency, transportation agency or healthcare provider – the mental health needs of the older adults are identified and appropriately addressed.

**Collaborative Case Review Model**: To address the lack of coordination among aging and behavioral health services, Pennsylvania is piloting a Collaborative Case Review Model. Within this model, local multidisciplinary teams discuss and resolve complex cases in a collaborative, community-based, family-focused, and culturally competent manner and using the least intrusive approach possible. When the local team is unable to remedy the problem, it is sent to a state level multi-disciplinary team to be addressed. Acting within these teams produces an effective and coordinated action, and identifies barriers and a means to address them with all players at the table (AAA director, MH/MR director, case managers, crisis workers, protective services and other pertinent systems). There is ongoing education for team members on cross-system issues, physiology of aging, pharmacology, and effective behavioral approaches.

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But to accomplish the goal of creating such a seamless system, there must be staff devoted to issues of aging. Most states' mental health agencies do not have full-time employees who are dedicated to addressing the needs of older adults due to a lack of resources, funds, and training. By comparison, most states' mental health agencies have established, separate divisions that focus on the unique needs of children and adolescents. Logically, older adults, who also have unique needs, should have staff devoted to them.

Underscoring this idea is the Older Adults Consumer Mental Health Alliance (OACMHA), which stresses the importance of state and local mental health authorities to have at least one full-time staff person responsible for developing and implementing a coordinated system of care. Such a system should address the total health needs of older adults who have mental health problems, including those with degenerative brain

disorders.[54] Other state agencies also should have staff devoted to coordinating older adults' programs and assistance with the mental health agency. Such an interagency team would be tasked to develop and foster collaboration among the agencies with the goal of developing a framework for responsive referral systems and service coordination.

Such collaboration should include interagency training where staff from a state's mental health agency train other human services agencies in the mental health-related issues facing older adults. In turn, staff from another agency, such as the state agency responsible for aging issues, train the other agencies in aging issues. It is important to note that in states where these collaborative relationships are being forged, advocates, usually older adult consumers, have often initiated the process of interagency collaboration and educate state employees about the needs of older adults who have mental illnesses.

Once the staff is properly trained, a process should be set in place to ensure that older adults are screened for mental health problems upon entry to any of the human services agencies. Modeled after the successful children's system of care paradigm,[55] all doors into the system must lead to help for mental health problems with an integrated process of screening, education, and referral.

### *Workforce Development*

Workforce development was another key issue identified by the President's New Freedom Commission on Mental Health, which called for a strategic plan to improve workforce recruitment, retention, diversity, and skills training.[56]

As noted in the "Barriers" section (see page 3), the workforce needed to provide services to older adults who have mental illness far outweigh what is currently available. To solve this in the long term, states need to focus recruitment campaigns beginning at the university level but also eventually to include graduate and post-graduate medical educational programs. Loan forgiveness programs, continuing education funding, and other financial incentives can also enhance recruitment. A more important recruitment effort would be to tackle the issue of low reimbursement rates among public and private health plans for rendered medical and other services. If students can expect to make a decent living and professionals are making a decent living, the field of geriatric psychiatric care might be more enticing.

In the short term, states must train health professionals. Some states have addressed this issue by revising licensing and continuing education requirements to include mental health, behavioral health, and substance abuse training for social services professionals. Maryland, for example, addressed this issue by instituting a cross-training effort that includes a list of training partnerships and targets a broad audience, as illustrated on the next page.

## Cross Training Efforts in Maryland

**TRAINING PARTNERSHIPS***

- Hospitals
- Universities
- Department of Aging (area Agencies on Aging)
- Department of Health (state and local)
- Department of Social Services/Human Resources
- Industry/Trade Associations
- Professional Associations (NASW, APA)
- Consumer Organizations
- Other Health Advocacy Organizations (e.g. Alzheimer's Association)
- Cultural and religious based organizations

**TARGETED AUDIENCES***

- Nursing home and assisted living staff and administrators
- Psychiatric rehabilitation programs
- Information and referral providers
- Senior center/adult day program staff
- Caregiver support coordinators
- University students in nursing/gerontology
- University gerontology faculty
- County Directors of Aging Services
- Public policy advocates
- Housing providers

The listed organizations came together in conference planning committees to create training conferences for certain target audiences. In addition to training these audiences, the partners had the added benefit of being able to exchange information and expertise with each other as a part of their planning meetings.[57]

In recruiting and training efforts, states must be creative in targeting non-traditional providers such as clergy, faith healers, and others to address the lack of diversity in the provider realm.

Educational institutions should actively recruit ethnic minorities to better serve the growing minority older adult population. Cross-training efforts should also target ethnic minorities. Geriatric specialists are few, but geriatric specialists with cultural competence training or who belong to ethnic or racial minorities are rare. Universities, training programs, and current provider settings should require cultural competence education for all staff.

**Research/Evidence-Based Treatments**: Although building workforce capacity is critical, professionals need information on the best practices available for the treatment of mental illness in older adults. As previously stated (see "Mismatch Between Care and Needs" on page 5), the chasm between the treatments that research has shown to be effective and what is actually be implemented is widening. Policies must be in place that promote research and implementation of emerging and evidence-based practices to decrease the gap between research and service delivery.

One such policy would be to include older adult consumers in all stages of research, from planning and design of studies to application of research results in programs. This policy should also include consumer input regarding which services work and which don't. In addition, increased funding is needed for research grants on programs addressing the mental health needs of older adults. This research should also include people who are from diverse racial and ethnic groups to measure the applicability of current and potential future practices on these populations. This means ensuring

that there are diverse, well-trained researchers representing population diversity.

The recently published Federal Action Agenda listed older adults as a topic of an upcoming evidence-based practice toolkit.[58] While the publication of this document is a good start to addressing the gap between research and service delivery, many other issues need to be addressed—and most important among them are funding streams. Initial research demonstrates that community-based treatment is the most efficacious type of treatment for older adult consumers,[59] but many funding policies don't allow the implementation of this research.

**Funding Methods**: Many state mental health policies are involved in determining the extent and availability of mental health services. Of these, policies related to funding are probably the most important. Therefore, reform in older adults' mental health services must begin with how those services are funded.

As discussed previously, most mental health services for older adults in the United States are funded through Medicare and Medicaid.[60] Despite the dependence of older adults on these two government programs in obtaining mental health services, there are some stringent restrictions on the types of services for which these program will pay.

Under Medicare, beneficiaries:

- receive only a 50 percent reimbursement for mental health services.
- have restrictions placed on the types of medications the providers can prescribe to them (through drug formularies).
- have trouble scheduling appointments with psychiatrists, who often opt out of the program due to low reimbursement rates.
- face problems in obtaining case management services due to inadequate coverage from the Medicare program, and often cannot obtain wrap-around, outreach, and other non-traditional services due to a lack of coverage in that area.
- have limited access to in-home mental health services.
- face limited coverage for transportation costs.
- face the prospect that, at some point, Medicare will stop paying for services due to a lifetime cap.[61]

Policies in the Medicaid program that limit enrollees' access to mental health services include:

- No special rates for home visits by mental health providers.
- Nursing home care is a mandated service while community-based mental health care is not.
- Cost neutrality requirements make obtaining Home and Community-Based Services (HCBS) waivers difficult. This has been a particular problem for states that seek federal approval of changes to their Medicaid programs to fund home- and community-based services. To receive federal approval for a waiver, a state must demonstrate cost savings, or neutrality, of the noninstitutionalized care versus care provided through institutionalization.[62]

To address these problems in general, Medicare, Medicaid, and other programs through which older adults receive mental health services need to use finance models that support best practices and innovative services that promote integrated services delivery, community-based treatment, and workforce development. For example, federal policymakers could redefine the cost-neutrality requirement in the Medicaid HCBS waiver so that the costs of providing care to a Medicaid enrollee in any setting, not just an institutional setting, is used as a basis for comparing the costs of providing services to an individual if a waiver were approved.[63]

Policymakers could also ensure that the health plans that participate in these programs provide mental health benefits on par, or at parity, with the benefits that they provide for physical health problems. Also, policymakers can find creative solutions for using funding that is already available, including allowing the blending of funding among state agencies responsible for aging, mental health, long-term care, and general health sectors.[64] States can also share

resources among agencies in part to prevent redundancy in services. This can be done by incorporating older adults' mental health programs into other existing programs. For example, states may incorporate mental health promotion and wellness programs into current disease prevention and health promotion services provided by state and area aging agencies that receive funding through the federal Older Americans Act (see Appendix A).

Another possible solution to funding problems would be to use the various grants available to states, including the federal Community Mental Health Block Grant, to provide specialized services to older adults. Although states are not required to allocate block grant funds to older adults, they are required to report on what services are available for this population in the Uniform Reporting System (URS) tables.[65] Another source of grants is the Substance Abuse and Mental Health Services Administration (SAMHSA), which has awarded Older Adults Mental Health Targeted Capacity Expansion Grants to provide funding to states to develop infrastructure for the mental health needs of older adults, as well as direct outreach, treatment and prevention services.[66] States may also utilize Nursing Home Transition Grants (when available)[67] and/or the state PASRR program.[68] These funds allow states identify those in need of services and appropriately refer and arrange wraparound services that allow individuals to remain in the community when appropriate.

**Coalition Building**: Coalitions allow groups to reach a broad audience that may not have traditionally been involved in the issue the coalition was formed to address. As a result, coalitions improve the capacity for educating policymakers and other key players.

As of 2006, there were 39 state mental health and aging coalitions that work toward improving mental health care for older adults, according to the National Coalition of Mental Health and the Aging. A strong coalition provides a base for excellent advocacy by involving multiple agencies and organizations. Finding resources to build a coalition can be challenging, particularly during times of fiscal crisis. Tapping into existing resources and being creative with partnerships can solve this problem. Some states, like Kentucky, have used Block Grant funding to create coalitions.[69] Other have partnered with Olmstead state coordinators who train consumers to be self- advocates and provide support in the creation of mental health and aging coalitions. Current state coalitions have focused on educating policymakers on the issues of mental health and aging, forging anti-stigma campaigns, working to coordinate services and agencies in their state that deal with older adults who are diagnosed with mental illnesses, and acting as advocates to monitor the system and identify gaps and areas of need.[70]

## Recommendations for Planning Councils

State Mental Health Planning and Advisory Councils (PACs) can play a central role in addressing the system and policy reforms needed to effectively serve older adults with mental health problems. Councils active in aging issues have initiated a number of efforts, some of which are listed below, to ensure maximum focus on older adults' needs within the mental health system:

- Ensure older adult consumer involvement in the council. Some state PACs have altered state-level requirements and bylaws to create designated seats on the council for older adults.
- Involve older adult consumer/advocacy groups from the state.
- Involve caregivers of older adults on the council.
- Create a designated seat for the administrator or deputy administrator of the state agency on aging to ensure collaboration between the mental health commissioner, administrator on aging, and planning council.
- Involve the state representative to National Association of State Mental Health Program Directors' Older Persons' Division (every state must have one) in planning council meetings and activities.

- Create an older adults committee/sub-committee to address issues of aging and mental health. Some state councils have taken a "lifespan" approach to committees and have structured their councils to have child, adult, and older adult committees. Others choose to use sub-committees or ad-hoc committees to tackle older adults' issues as they arise. For example, one state PAC formed an older adults' data workgroup to define the problems surrounding older adults with mental health disorders in their state, and gathered and analyzed related data. These analyses were used to advance advocacy efforts.

As the state mental health PAC, it is the council's responsibility to educate itself on the pertinent mental health issues for their states. As the population of older adults continues to increase, the issue of appropriate services for this population will become more critical. Planning councils can do some of the following to educate themselves on the core issues facing older adults:

- Gather resources from the organizations listed in this publication and distribute the materials to council members.
- Host an educational conference for planning council members, and invite experts from the aging and mental health agencies, geriatric providers (e.g., psychiatrists, social workers), advocates, caregivers, consumers, organizations, and stakeholder groups involved in older adult care.

Three Essential Roles: The Mental Health Block Grant legislation mandates that planning councils fulfill three essential roles: (1) review and comment on the Block Grant plan submitted by the state, (2) advocate for adults with serious mental illnesses and children with serious emotional disturbances, and (3) monitor and evaluate the state's mental health system.[71] The following are a list of recommendations that correspond with these three responsibilities:

## *Review the Block Grant*

- Review the Mental Health Block Grant application sections on services for older adults and provide recommendations based on information provided in this publication and associated resources. Ensure that the Block Grant application has specific goals/objectives for older adults.

## *Advocate*

- Educate legislators on the issues facing older adults with mental illnesses. This education can be done by distributing fact sheets or coordinating a Legislative Day when council members visit the capitol and meet with state legislators. Some states have created briefing books for legislators that provide pertinent prevalence and demographic data, and succinctly summarize the problem and the council's recommended solutions.
- Given the multiple agencies represented on the council, members can educate state human service agencies on the critical need for collaboration of services for this population.
- Advocate for adequate staff resources in mental health and aging agencies for older adults. This advocacy could include advocating for a full-time administrator of older adults services in the state mental health agency and associated staff.
- Use block grant money to hold a statewide conference to educate stakeholders about the unique mental health needs of older adults. Use proceeds from registration costs for continued education.
- Advocate for cross-systems training. The planning council can take the lead in promoting and implementing cross-systems training efforts to educate human services professionals on mental health and aging.
- Coordinate public education projects during Older Americans Month, which coincides with May Is Mental Health Month, to highlight the unique needs of older adults with mental illnesses, dispel stigma, and underscore the problems within the system that limit access to quality care for this population. Public education projects can also be done in conjunction with other national campaigns, such as Depression Awareness Week, which takes place every October.

- Educate council members on national-level issues that affect older adults and advocate for appropriate change. Some possible issues include parity for mental health coverage and access to effective prescription drugs for mental illnesses. Advocates must carefully monitor preferred drug lists because limiting medications for older adults can be dangerous.

### *Monitor and Evaluate*

- Assess the needs of the older adult community in your state. Council members can create ad-hoc committees to do needs assessments. For example, council members may want to survey nursing homes and other long-term care facilities to ascertain the training needs of the staff. This data can then be used to advocate for funding.
- Strategize and support means of attracting and retaining a workforce of professionals and paraprofessionals trained in geriatric specialties.
- Monitor state plans other than the Block Grant, such as the state plan on aging and the state plan on mental health, to ensure the mental health needs of older adults are being addressed.
- Use block grant dollars provided to the planning council for special projects to fund pilot projects. One successful state planning council was involved in a project to implement the Gatekeeper model using this mechanism.[72]
- Monitor and evaluate the capacity and competency of state providers and human services personnel to provide high-quality, culturally competent services to older adults with mental health problems.

Through advocacy, education, interagency collaboration and policy and programmatic change, we can create a seamless service system in which mental health problems in the elderly are identified early and addressed with evidence-based solutions. We can create a system in which recovery and resiliency is the norm and not the exception.



# Appendix A: Legislative Efforts

## Current Federal Legislation

### Older Americans Act

The Older Americans Act was originally signed into law by President Lyndon B. Johnson on July 14, 1965. In addition to creating the Administration on Aging, it authorized grants to states for community planning and services programs, research, and demonstration and training projects in the field of aging. Later amendments to the Act added grants to Area Agencies on Aging for local needs identification, planning, and funding of services, including but not limited to nutrition programs in the community as well as for those who are homebound; programs that serve Native American elders; services targeted at low-income minority elders; health promotion and disease prevention activities; in-home services for frail older adults; and services that protect older adults' rights, such as the long-term care ombudsman program.

The Act was reauthorized in 2000, and again in Oct. 2006. When it was reauthorized in 2000, Congress included a new program, the National Family Caregiver Support Program, to help hundreds of thousands of family members who are struggling to care for older loved ones who are ill or who have disabilities.

Under the National Family Caregiver Support Program, state agencies on aging work with area agencies on aging, and community and service provider organizations, to provide support services, including information and assistance to caregivers, counseling, support groups, respite and other home- and community-based services to families caring for their frail older family members. The National Family Caregiver Support Program also recognizes the needs of grandparents who are caregivers of grandchildren, and other

older family members who are caregivers of children who are 18 and under.

*For more information, visit the Administration on Aging website at http://www.aoa.dhhs.gov.*

## Proposed Federal Legislation

### Positive Aging Act

The Positive Aging Act was re-introduced in 2005 and seeks to make a number of reforms to improve the care of older adults, such as making mental health services for older adults an integral part of primary care services in community settings, and extending these services to other settings where seniors reside and receive services. The legislation would authorize the creation of an Office of Older Adults Mental Health Services within the Administration on Aging to spearhead initiatives designed to address the mental health needs of older adults.

The legislation would create a number of state grants for the development and testing of model mental health services for the elderly, and screening and treatment referrals for older adults living in rural settings, and for older adults in naturally occurring retirement communities (NORCs) in urban areas. Other demonstration projects created by this legislation would address mental health care in primary care settings and treatment outreach teams specifically designed for the elderly. Other key components of the legislation include the following:

- Create a new position of deputy director for Older Adult Mental Health Services in the Center for Mental Health Services at SAMHSA.
- Require appointment of representatives of older Americans, their families, and geriatric mental health specialists to the Advisory Council for the Center for Mental Health Services.
- Target substance abuse issues in older adults as part of SAMHSA's Projects of National Significance.
- Require state plans under Community Mental Health Services Block Grants to include descriptions of the states' outreach to and services for older individuals.

*For additional information, visit the American Association of People with Disabilities website at http://www.aapd-dc.org/policies/positiveageact.html.*

## Current State Legislation

Landmark legislation was passed in New York state in August 2005 to advance the care of older adults diagnosed with mental illnesses. The Geriatric Mental Health Act of New Yor State (A.7672/S.4742) provided the following:

- Innovation through a service demonstration program: supports to remain in community; improved quality of care; integration of mental health, health and aging services; enhance cultural competence; family support; efficient use of professionals, paraprofessionals, volunteers, peers; and new finance models.
- Creation of Interagency Geriatric Mental Health Planning Council: co-chaired by the commissioner of Mental Health and director of the Office of Aging; provide recommendations to state department and offices, submit annual report to governor and legislature.

This bill was supported by the work of the Geriatric Mental Health Alliance, which has 700 members from various stakeholder groups—mental health, health, aging, providers, academic leaders, researchers, older adults, advocates, funders, and public officials. Their success lies in broad recruitment efforts of individuals rather than organizations, an extremely organized campaign, bipartisan advocacy at the state and local levels, and the building of strategic relationships with the executive branch and legislative branches.

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# Resources

**National Mental Health Information Center (NMHIC)**
Phone: 800-789-2647 or (TDD) 866-889-2647
http://mentalhealth.samhsa.gov

**National Clearinghouse for Alcohol and Drug Information (NCADI)**
Phone: 800-729-6686, (TDD) 800-487-4889 or (espanol) 877-767-8432
http://ncadi.samhsa.gov

**Older Americans Substance Abuse and Mental Health**
Technical Assistance
Phone: 888-281-8010
E-mail: OlderAmericansTAC@westat.com
www.samhsa.gov/aging/age_10_11_05.aspx

**Positive Aging Resource Center**
Brigham & Women's Hospital, Boston, MA 02215
www.positiveaging.org

**Administration on Aging**
Washington, DC 20201
Phone: 202-619-0724
www.aoa.dhhs.gov

**Mental Health America**
2000 N. Beauregard Street, 6th Floor, Alexandria, VA 22311
Phone: 800-969-6642
www.mentalhealthamerica.net

**NAMI**
Colonial Place Three
2107 Wilson Blvd., Suite 300, Arlington, VA 22201-3042
Phone: 800-950-NAMI (6264)
www.nami.org

**National Council on Aging**
300 D Street, SW, Suite 801, Washington, DC 20024
Phone: 202-479-1200
E-mail: info@ncoa.org
www.ncoa.org

**The National Institute on Aging**
Building 31, Room 5C27
31 Center Drive, MSC 2292, Bethesda, MD 20892
Phone: 301-496-1752
www.nia.nih.gov

**National Coalition on Mental Health and Aging**
www.ncmha.org