



The Geriatric Mental Health Alliance of New York

GERIATRIC MENTAL HEALTH POLICY A BRIEFING BOOK

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TABLE OF CONTENTS

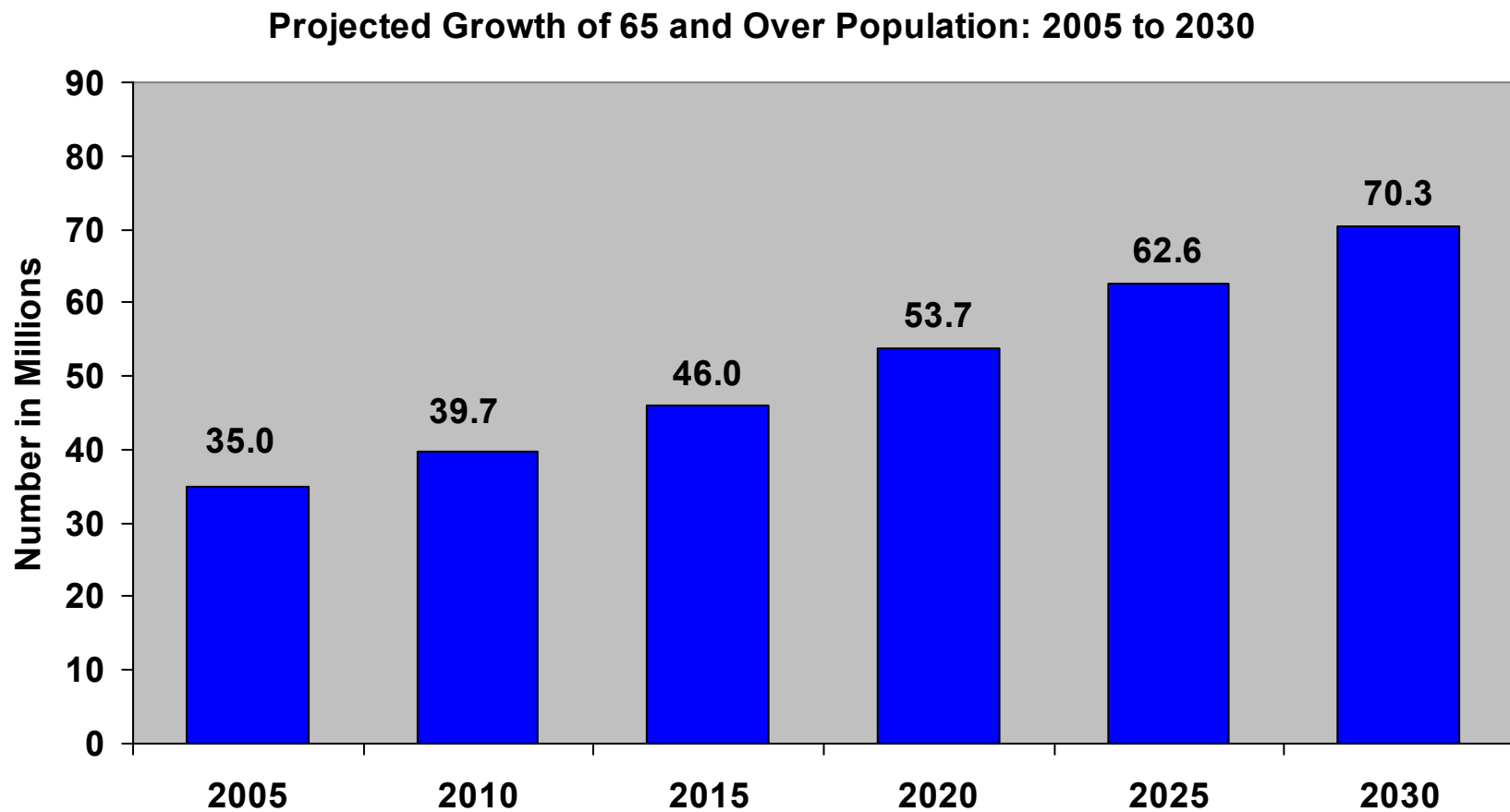
• Alliance	3
• Demographics	4-15
• 65 and Older Population	5-7
• Working-Age Adults	8-9
• Minority Population	10
• Females	11
• 85 and Older Population	12
• 65 and Older Disabled	13-14
• Housing	15
• Prevalence and Utilization	16-37
• Thirty-year Projections	18-20
• Heterogeneous Population	21
• Older Adults Function Differently	22
• Older Versus Younger Adults	23
• Depression	24
• Suicide Rates	25-27
• Schizophrenia	28-31
• Older Adults Increased Needs	32
• Substance Abuse	33
• Dementia	34-35
• Comorbidity	36-37
• Utilization of Mental Health Services	38-44
• Sources of Funding	45
• Commonly Identified Policy Problems	46-55
• Geriatric Mental Health Alliance Policy Recommendations	56-60

This document provides background information essential for the development of geriatric mental health policy. It was prepared by The Center for Policy, Advocacy and Education of the Mental Health Association of NYC (the Center), for the Geriatric Mental Health Alliance of New York (the “Alliance”), which was founded by The Center in 2004.

- The Alliance is an advocacy and educational organization that seeks to confront the mental health challenges of the elder boom and to promote critical changes in practice and policy. It is made up of over 3000 mental health, health, and aging service professionals and providers, researchers, academic leaders, consumers, older adults, advocates, family members, and public officials.
- The long-term goal of the Alliance is to promote improved geriatric mental health practice by identifying best and innovative practices, identifying barriers to their use, developing policy proposals to overcome these barriers, advocating for policy and practice changes, and providing training and technical assistance regarding state-of-the-art program models and funding.

Demographics

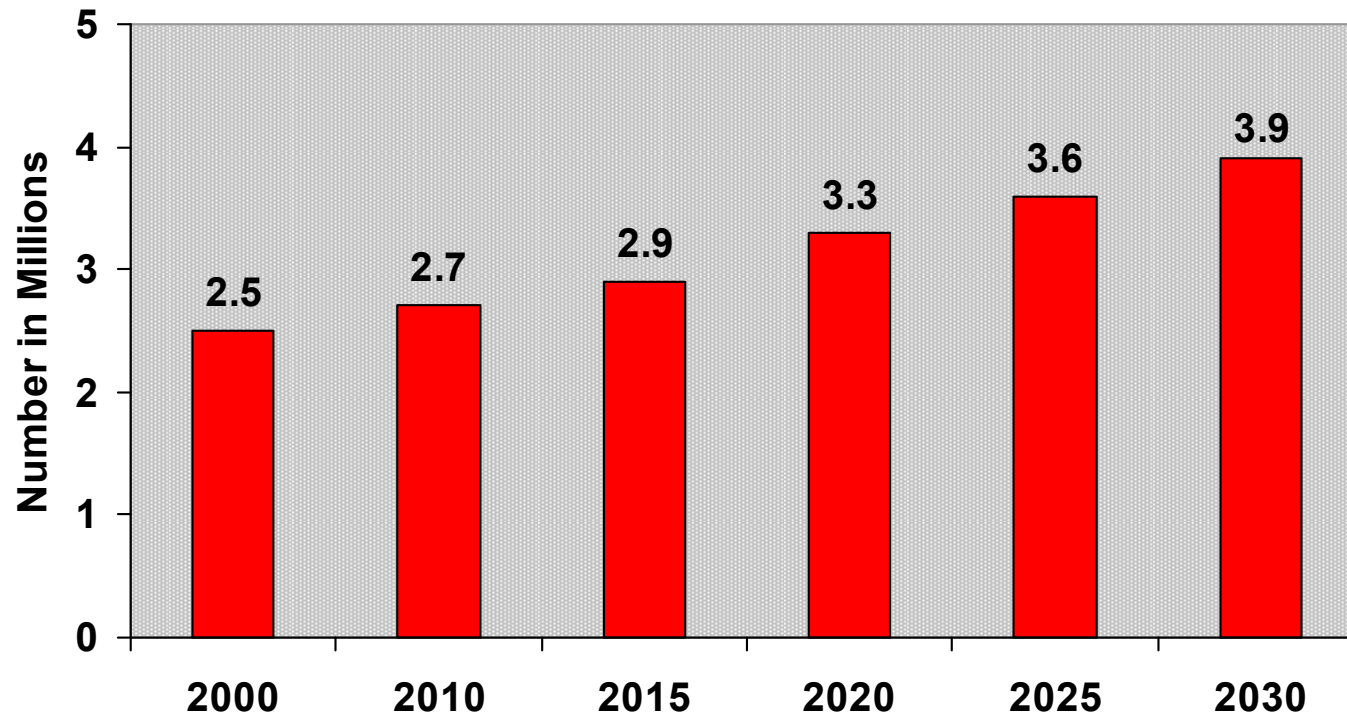
Nationally, The Number Of Older Adults Will Double Between 2005 And 2030.



Source: U.S. Bureau of the Census. (2000). Population projections of the United States by age, sex, race and hispanic origin: 1995-2050, *Current Population Reports*, P25-1130.

In NYS, The Number Of Older Adults Will Increase 50% From 2000-2030.

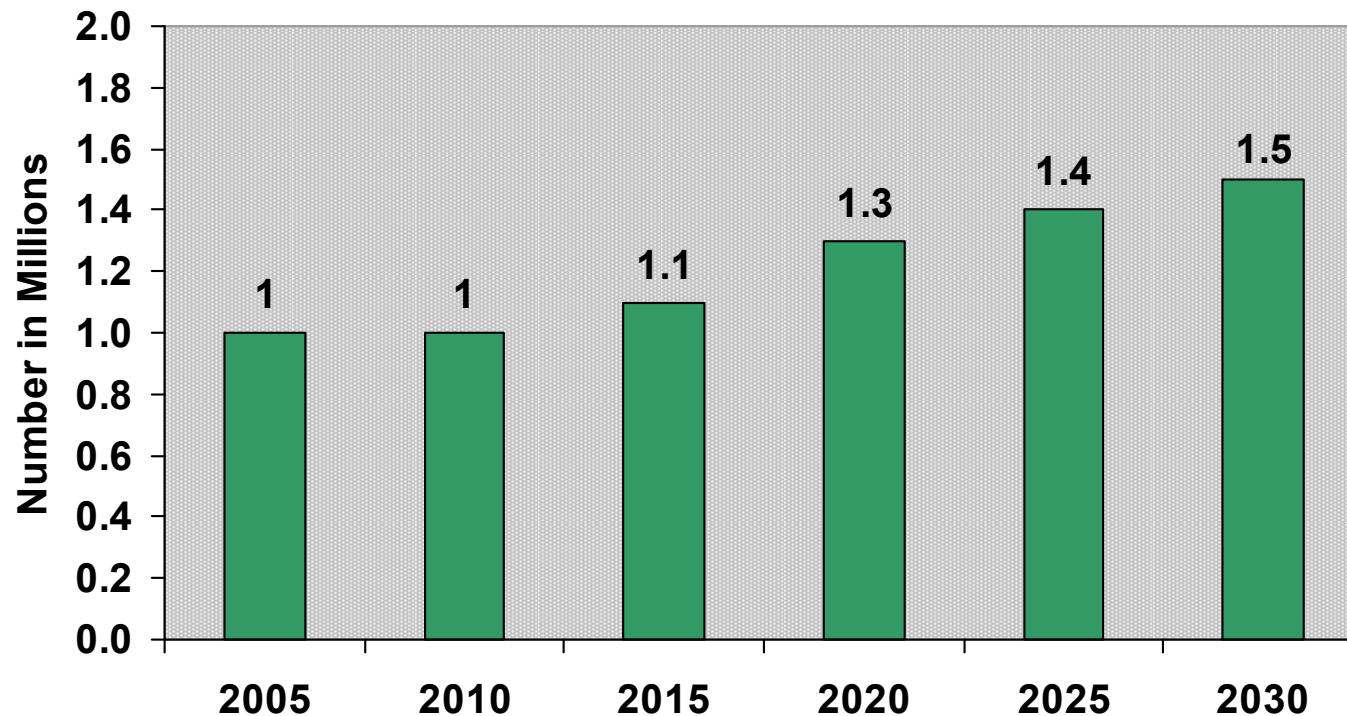
Projected Growth of 65 and Over Population
in New York State: 2000 to 2030



Source: Interim State Projections of Population by Single Year of Age: July 1, 2004 to 2030. U.S.Census Bureau, Population Division, Interim State Population Projections, 2005. <http://www.census.gov/population/projections/DownldFile3.xls>

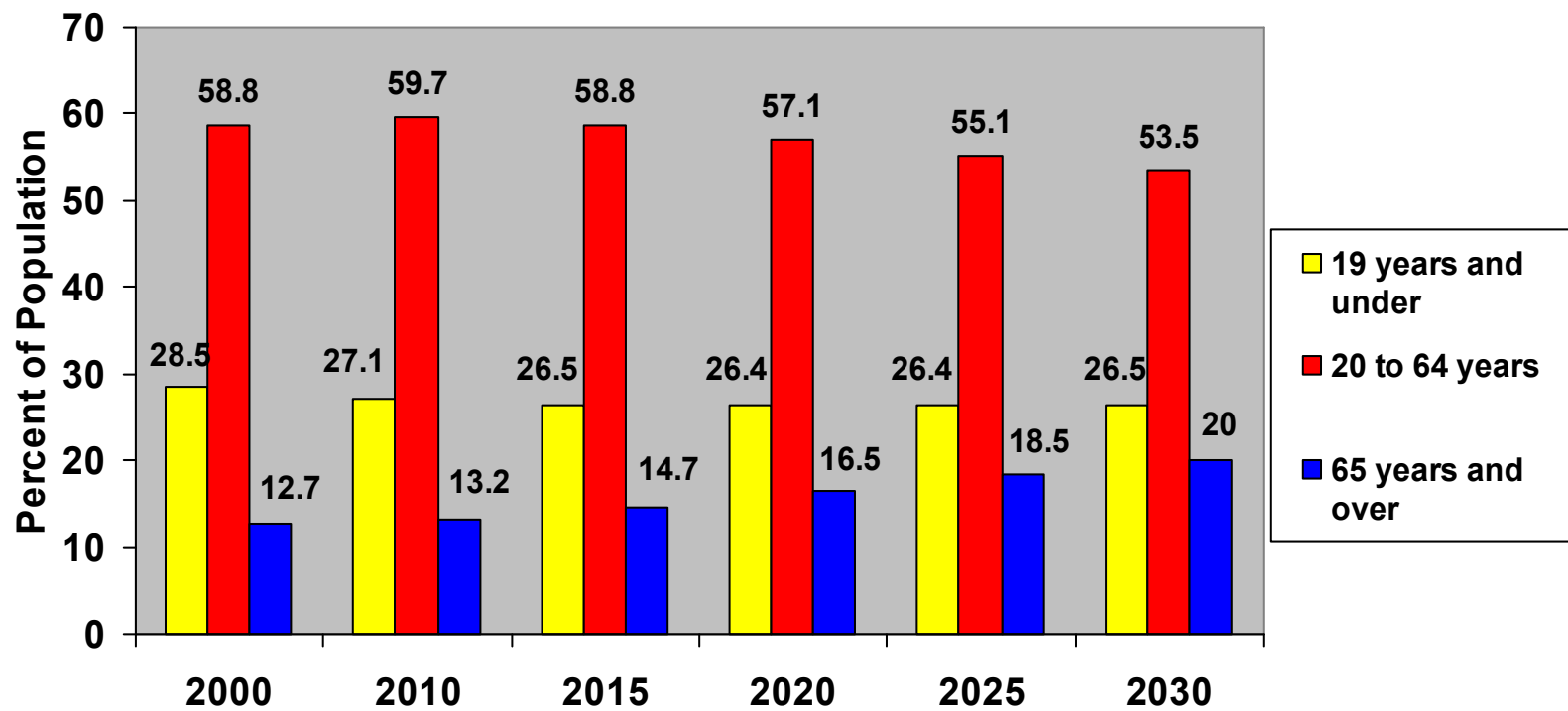
In NYC, The Number Of Older Adults Will Increase 50% From 2005-2030.

Projected Growth of 65 and Over Population
in New York City: 2000 to 2030



Older Adults Will Increase From 12.7% Of The U.S. Population To 20%. Working Age Adults Will Decrease Over 5%.

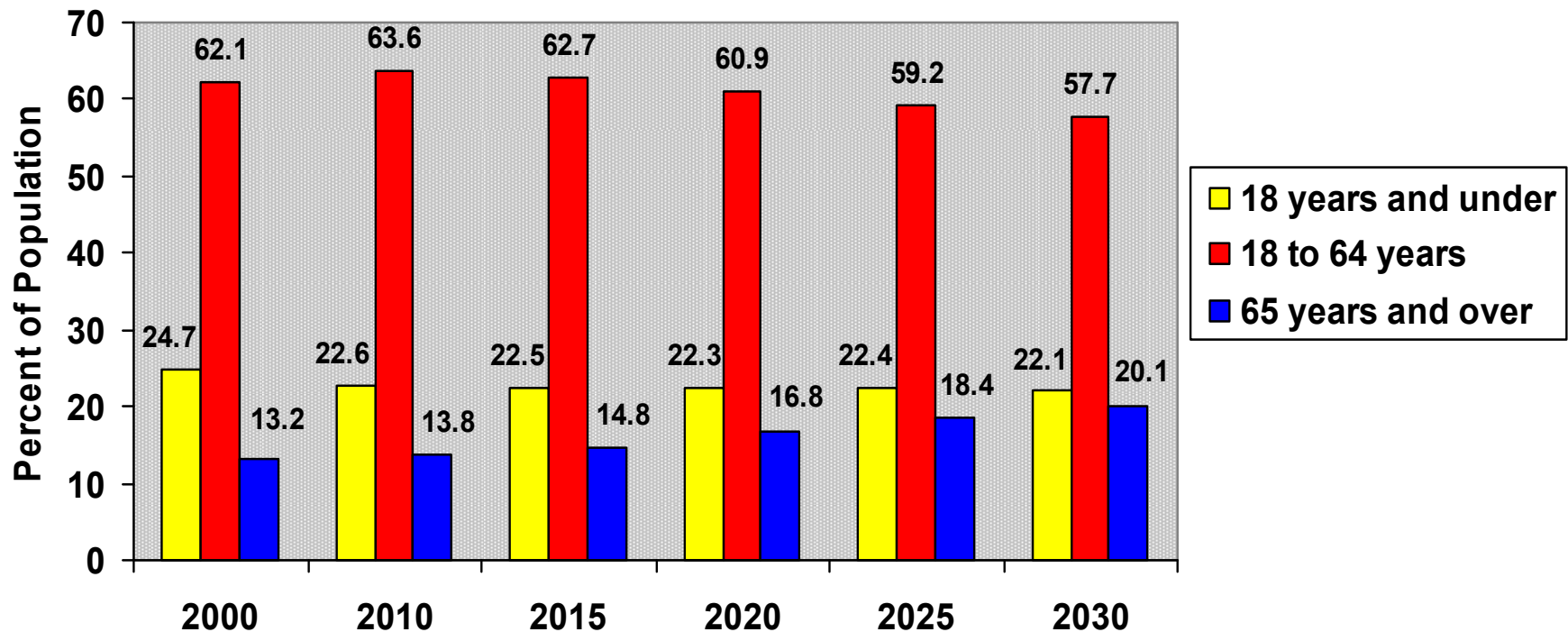
Projected Growth of Population by Age Cohort:
2000 to 2030



Source: U.S. Bureau of the Census. (2000). Population projections of the United States by age, sex, race and hispanic origin: 1995-2050, *Current Population Reports*, P25-1130.

In NYS, Older Adults Will Increase By 7%.
Working Age Adults Will Decrease By 4%.

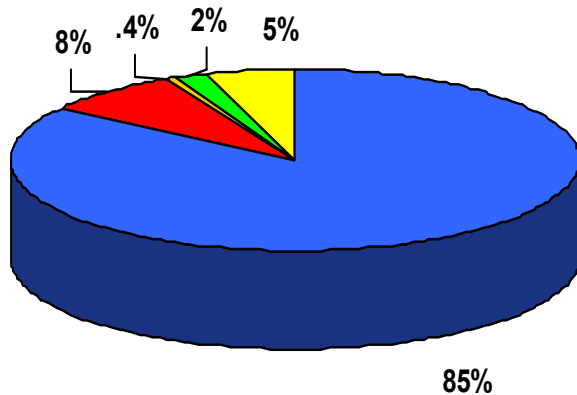
Projected Growth of Population by Age Cohort
in New York State: 2000 to 2030



Source: Interim State Projections of Population by Single Year of Age: July 1, 2004 to 2030. U.S.Census Bureau, Population Division, Interim State Population Projections, 2005. <http://www.census.gov/population/projections/DownldFile3.xls>

Nationally, The Minority Population Of Older Adults Will Increase From 15% To 25%.

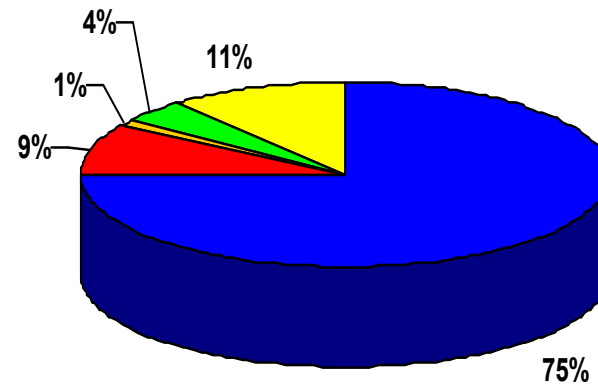
The 65 and Over Population by Race: 2000



Population (in millions)

White	29.1m
Black	2.8m
American Indian	0.2m
Asian/ Pac Islander	0.8m
Hispanic	1.9m

The 65 and Over Population by Race: 2030

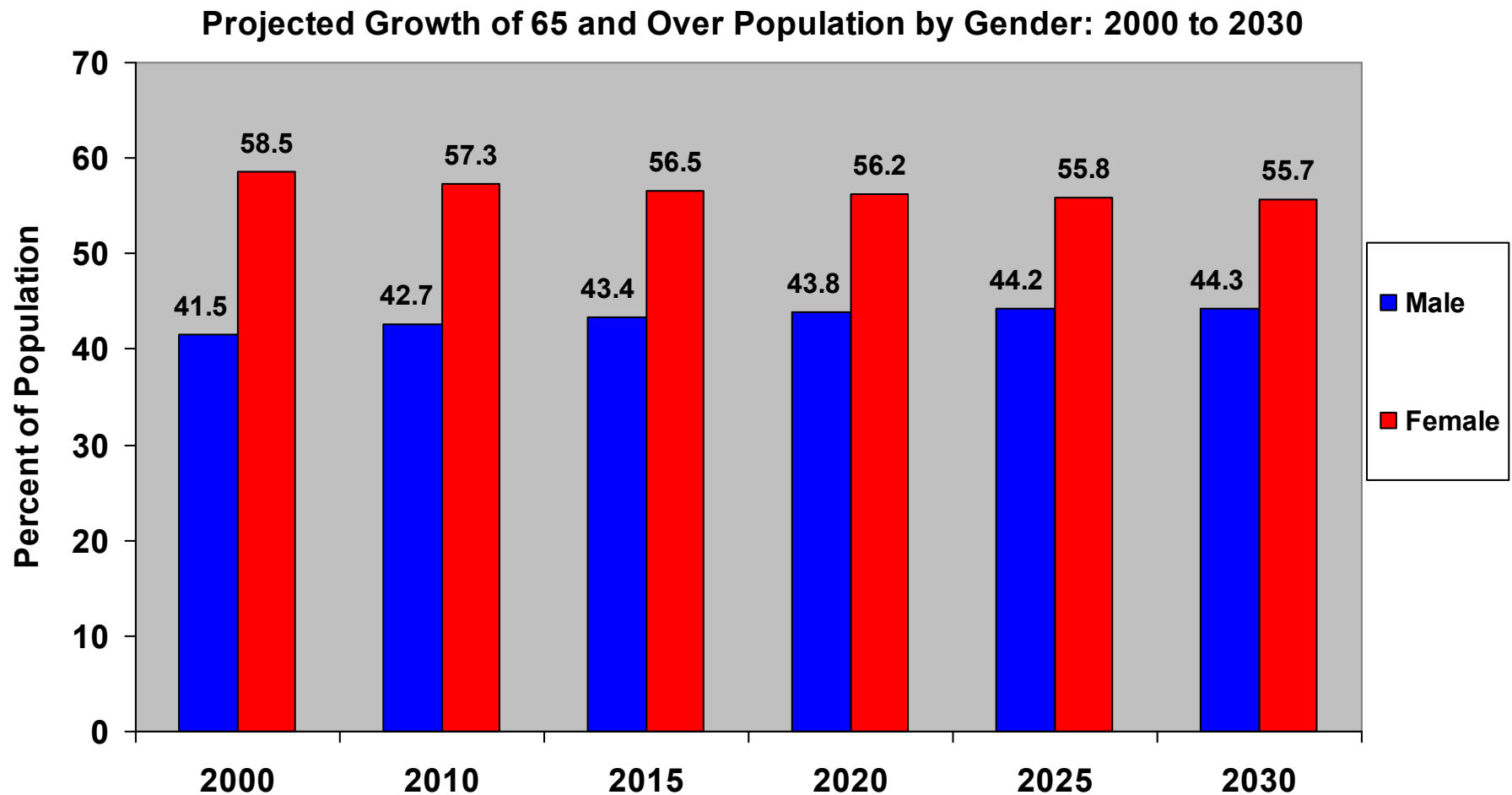


Population (in millions)

White	51.7m
Black	6.4m
American Indian	0.4m
Asian/Pac Islander	3.2m
Hispanic	7.7m

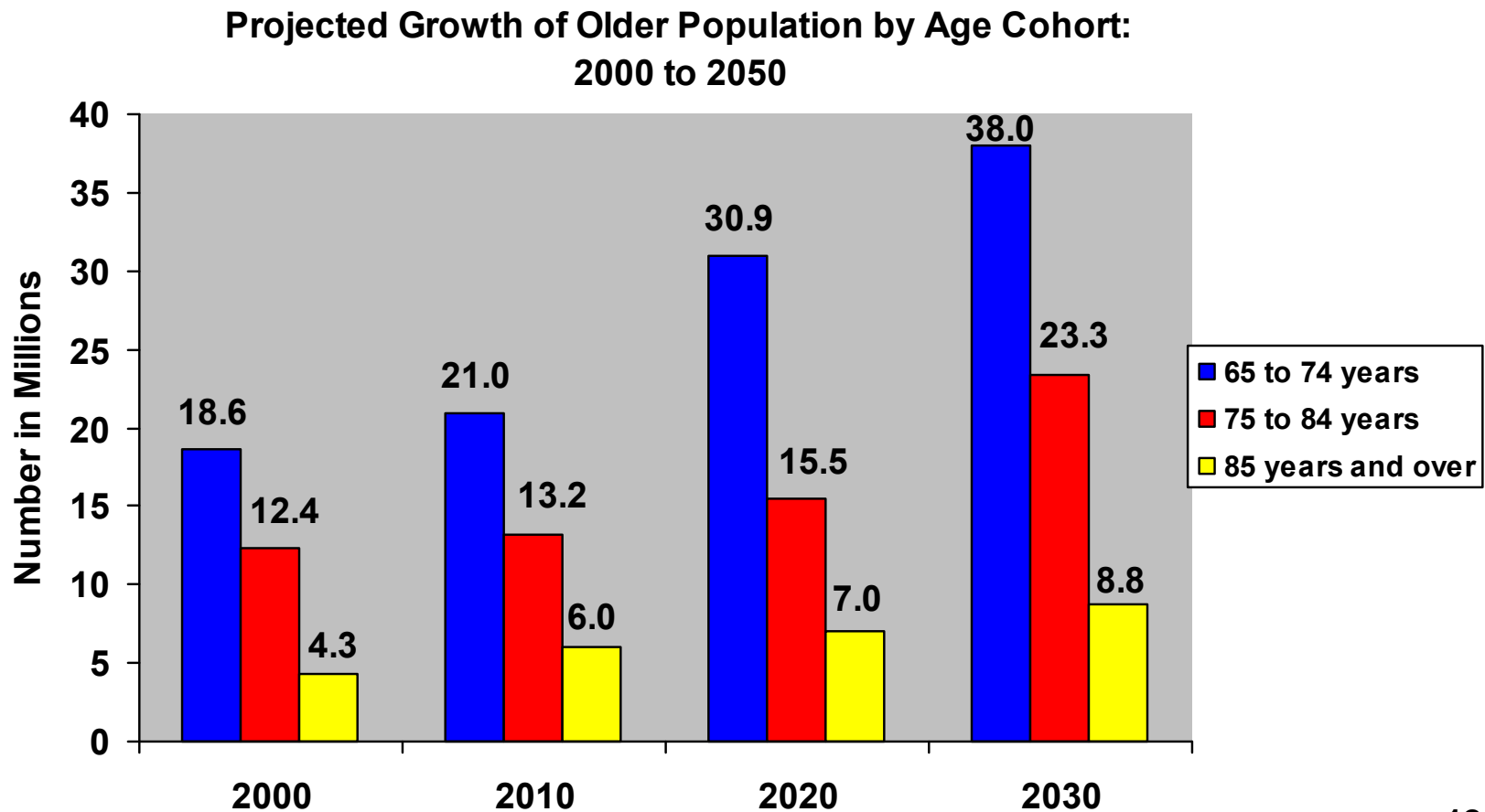


Nationally, The % Of Older Females Will Continue To Be Greater Than The % Of Males.



Source: U.S. Bureau of the Census. (2000). Population projections of the United States by age, sex, race and hispanic origin: 1995-2050, *Current Population Reports*, P25-1130.

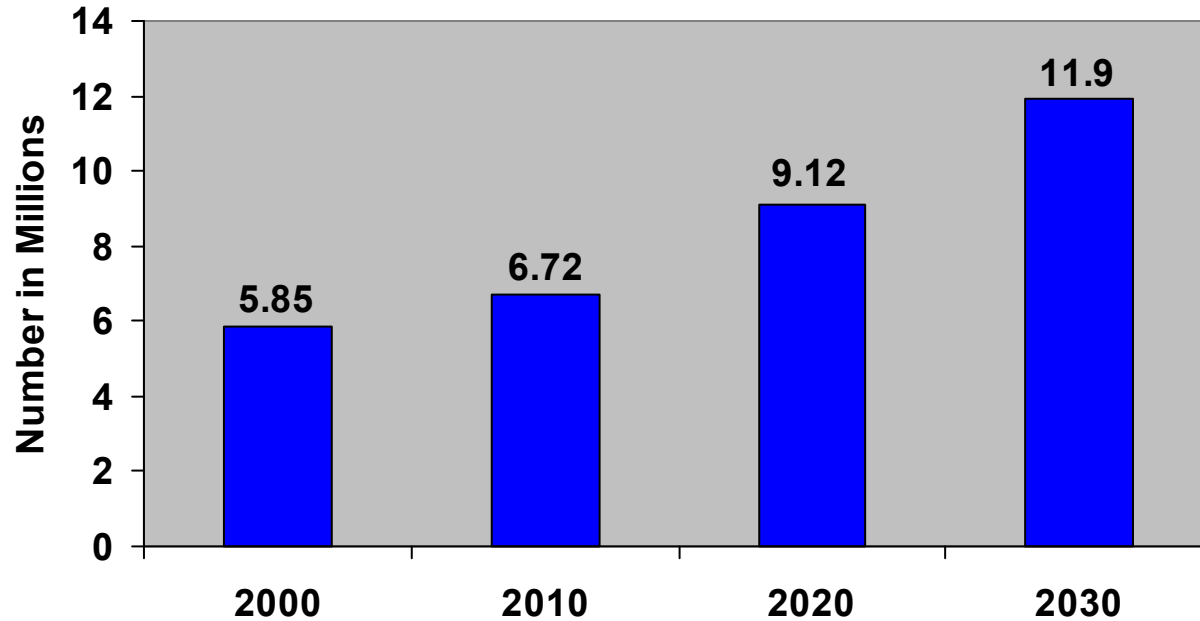
Those 85 And Older Will Double, But Those 65-74 Will Still Be The Largest Portion Of Older Adults.



Source: U.S. Bureau of the Census. (2000). Population projections of the United States by age, sex, race and Hispanic origin: 1995-2050, *Current Population Reports*, P25-1130.

Number Of Disabled Older Adults In Need Of Assistance Will Double.

Projected Growth of 65 and Over Population with Disability Who Need Assistance: 2000 to 2030



Disability is partially defined by the ADA as a physical or mental impairment that substantially limits one or more of the major life activities of an individual.

Needs Assistance is described in the study below as needing personal assistance with one or more ADLs or IADLs.

Sources: U.S. Bureau of the Census (2004): "U.S. Interim Projections by Age, Sex, Race, and Hispanic Origin," <http://www.census.gov/ipc/www/usinterimproj/natprojtab02a.pdf>

U.S. Bureau of the Census. (1997). Americans with Disabilities: Household Economic Studies, *Current Population Reports*, P70-73.

Families Are The Primary Caregivers For Older Adults With Disabilities.

- 80% of caregiving is provided by families.¹
- There are an estimated 34 million Americans providing care for older family members.²
- The average out-of-pocket cost of caring for an older adult is approximately \$5,500 per year. ³
- The national economic value of informal caregiving was \$196 billion in 1997, equivalent to \$375 billion in 2007.^{4,5}

¹ Spillman, B. and Pezzin, L. (2000). Potential and actual family caregivers: Changing networks and the “sandwich generation”. *Milbank Quarterly*, 78 (3), 347-374.

^{2,3} Evercare Study of Family Caregivers – What They Spend, What They Sacrifice, November, 2007: http://www.caregiving.org/data/Evercare_NAC_CaregiverCostStudyFINAL20111907.pdf

⁴ Arno, et al. (1999) The Economic Value of Informal Caregiving. *Health Affairs*.

⁵ Houser, A. & Gibson, M. (2008). Valuable the invaluable. The economic value of family caregiving, 2008 update. *AARP Public Policy Institute*.

In NYS The Vast Majority Of Older Adults Live In The Community.

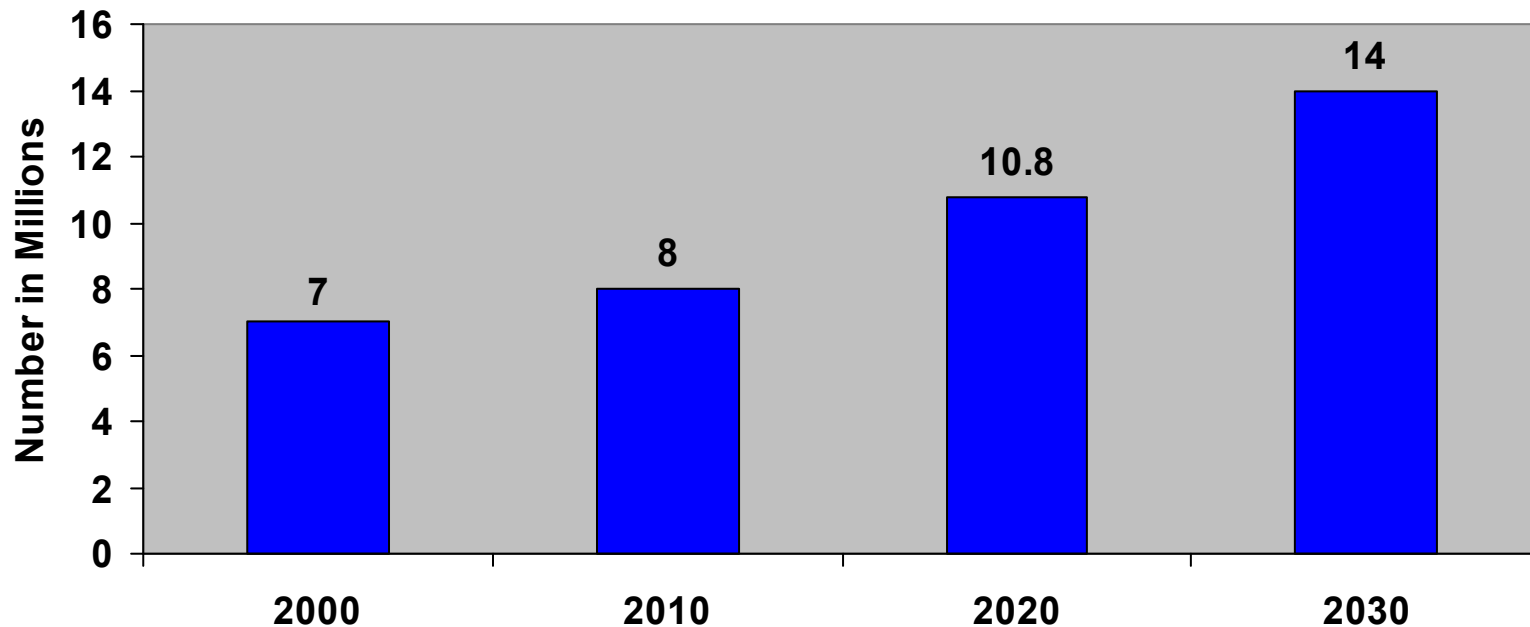
- 94.2% live in community settings, either alone (29.2%) or with family or friends.
 - Some settings are intergenerational; some primarily house older adults in naturally occurring retirement communities.
- Older adults also live in:
 - Lifecare communities
 - Assisted living facilities
 - Adult homes
 - Nursing homes
 - Psychiatric centers
 - Prisons

Mental Illness Among Older Adults: Prevalence and Utilization

Approximately 1 In 5
Older Adults Has A Diagnosable
Mental And/Or Substance Use Disorder.

In The U.S., The Number Of Older Adults With Mental Illness Will Double.

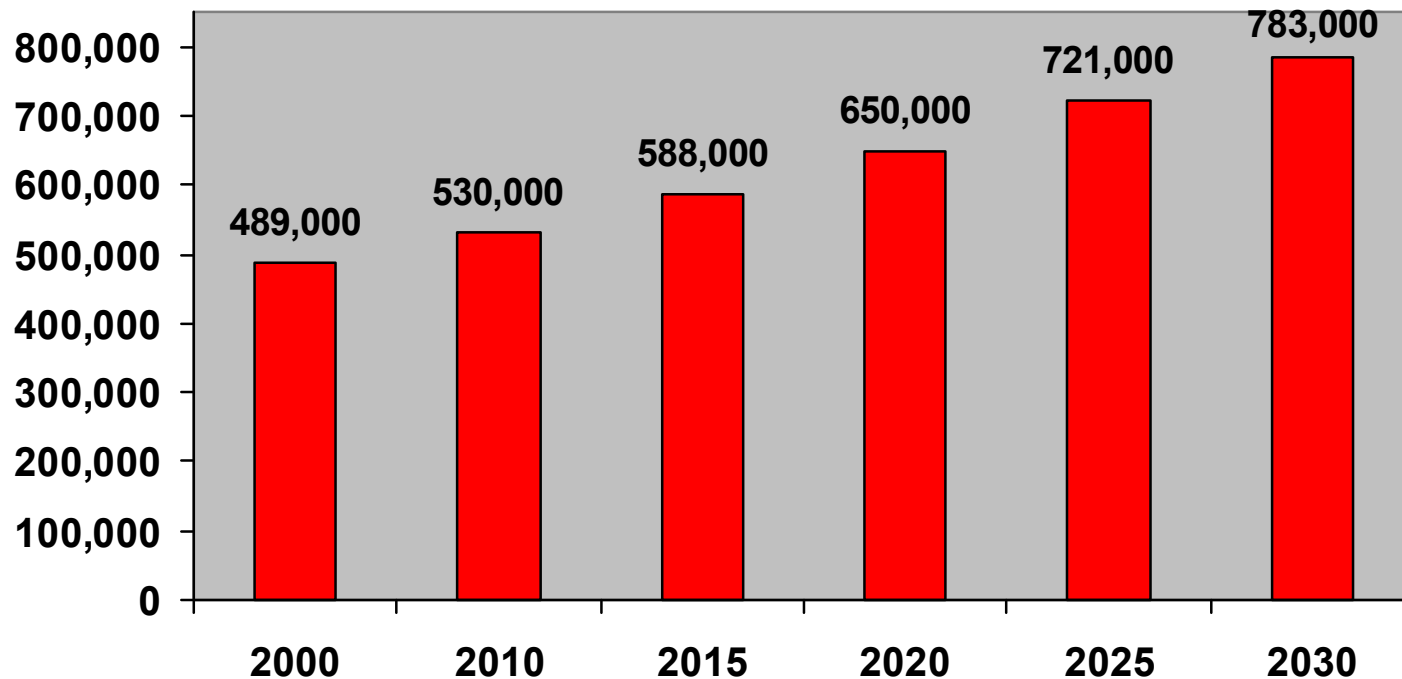
Projected Growth of 65 and Over Population with Mental Disorders:
2000 to 2030



Sources: U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: 1999). U.S. Bureau of the Census. (2000). Population projections of the United States by age, sex, race and Hispanic origin: 1995-2050, *Current Population Reports*, P25-1130.

In NYS, The Number Of Older Adults With Mental Disorders Will Increase Over 50%.

Estimated Number of Adults Aged 65 and Over with Mental Disorders in New York State

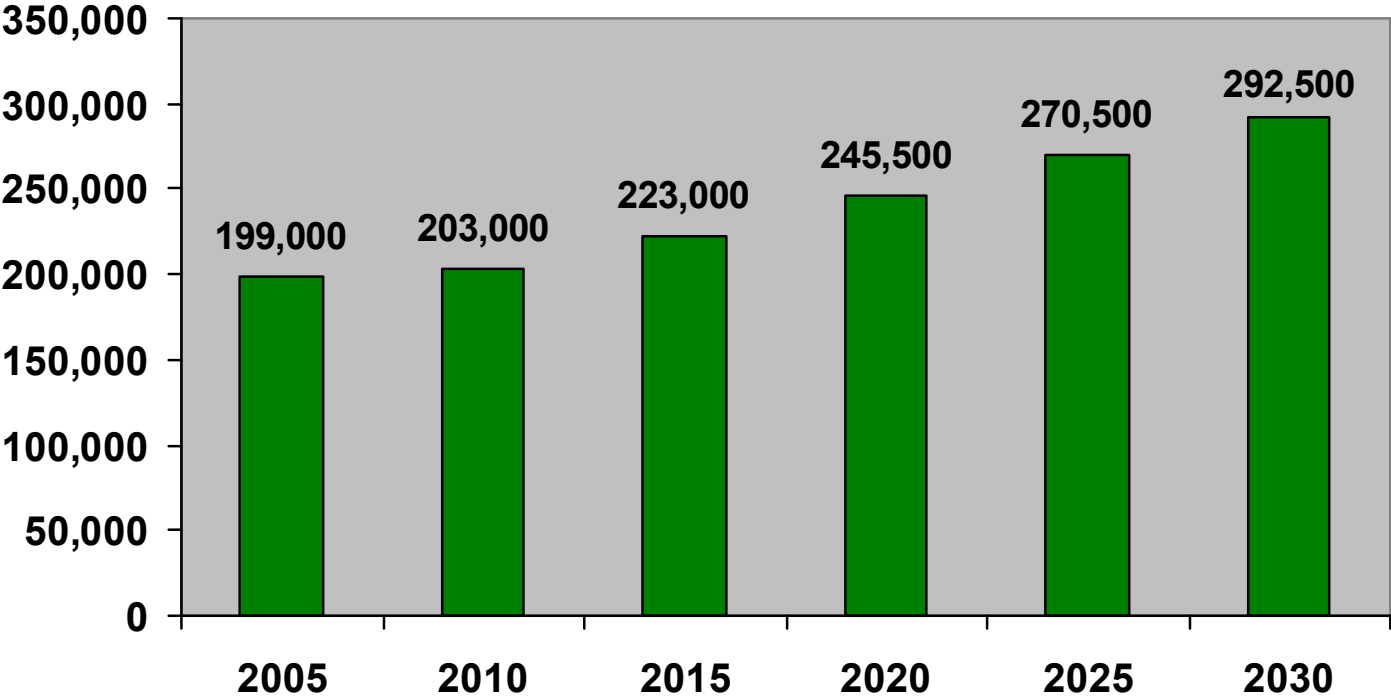


Sources: U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: 1999).

Interim State Projections of Population by Single Year of Age: July 1, 2004 to 2030. U.S.Census Bureau, Population Division, Interim State Population Projections, 2005. <http://www.census.gov/population/projections/DownldFile3.xls>

In NYC, The Number Of Older Adults With Mental Disorders Will Increase 50%.

Estimated Number of Adults Aged 65 and Over with Mental Disorders in New York City



Sources: U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: 1999).

Source: Cornell University – New York Statistical Information System Data. (2008). NYSIS County Population Projections By Sex And Age, 2000-2030. Retrieved from: <http://www.human.cornell.edu/che/BLCC/pad/data/projections.cfm>

Older Adults With Mental Health Problems Are a Heterogeneous Population

- Long-term psychiatric disabilities
- Late-life psychotic conditions
- Dementia
- Severe anxiety, depression, and paranoia
- Less severe anxiety and mood disorders
- Addictive disorders: lifelong and late life
 - Especially misuse of alcohol, prescriptions and over-the-counter medication
- Emotional problems related to aging

Not All Older Adults With Mental Illness Are Disabled. They Function At Many Different Levels.

- Severe psychiatric disability: long-term and recent disabling dementia
- Limited self-care skills and isolated
- Limited self-care skills with family/friends support
- Isolated with self care skills
- Relatively inactive and/or socially isolated but mobile
- Retired, active
- Working (the rate of employment is 26.1% for all people aged 65-69, declining to 5.1% for all people over 75)

The Types Of Mental Illnesses Experienced By Older Adults Are Somewhat Different From Those Experienced By Younger Adults.

Adults 18-54

Older Adults 55+

Any Disorder	21%
Any Anxiety Disorder	16.4%
Any Major Mood Disorder*	7.1%
Schizophrenia	1.3%
Severe Cognitive Impairment	1.2%
Anti-social Personality	2.1%

Any Disorder	19.8%
Any Anxiety Disorder	11.4%
Any Major Mood Disorder*	4.4%
Schizophrenia	0.6%
Severe Cognitive Impairment (Primarily Dementia)	6.6%

* This does not include minor depression. 27% of older adults have symptoms of depression.

NOTE: These figures represent the prevalence of mental disorders in a 1-year period.

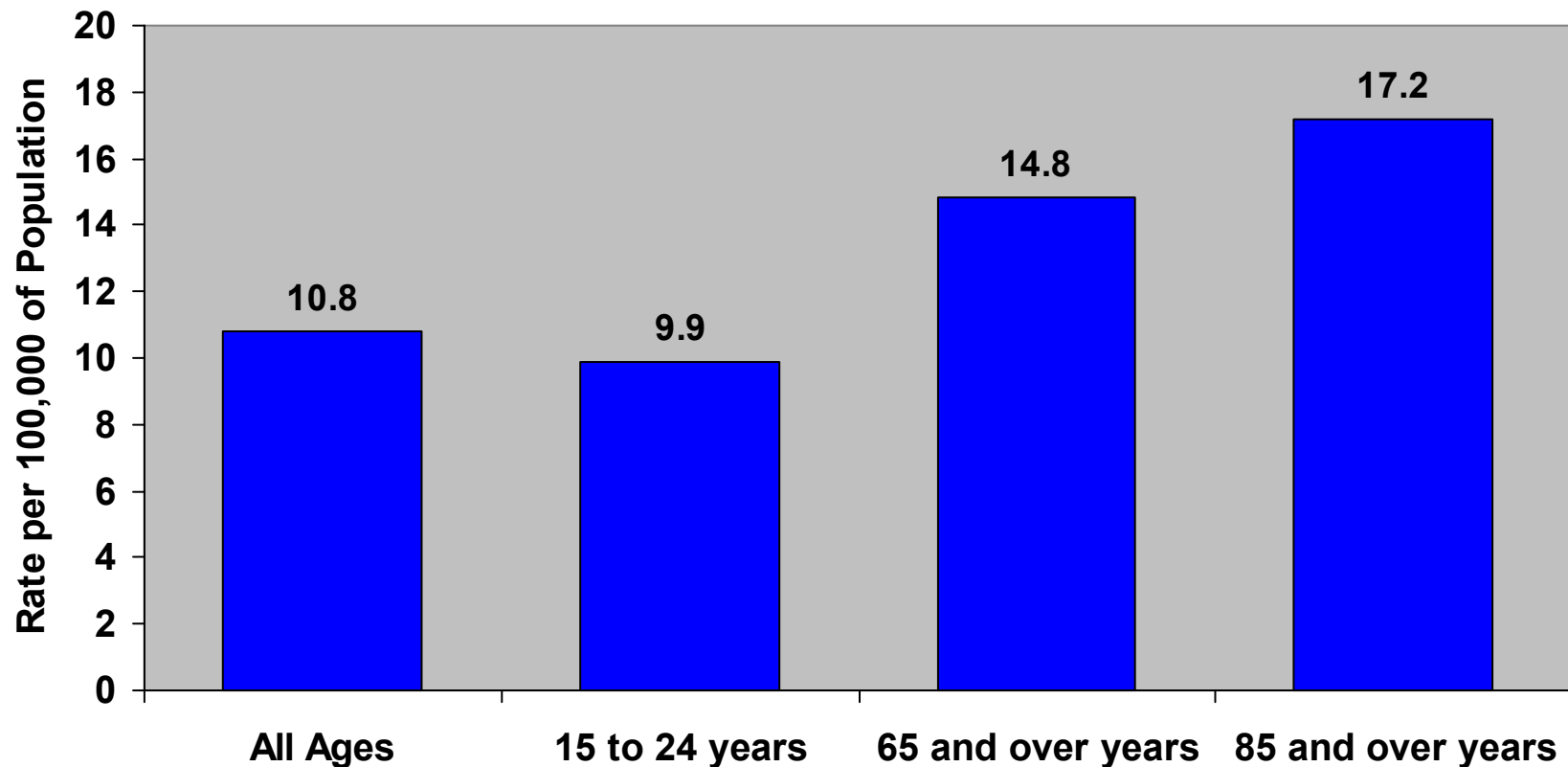
NOTE: The percentages do not add up to 100% due to co-occurring disorders.

Source: U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: 1999).

Depression Is Not Normal In Old Age

- Contrary to common belief, MAJOR depression appears to be less common in older adults than in younger adults.
- However, older adults are more likely to experience *symptoms of depression*, but often do not have enough symptoms to meet the criteria of a diagnosis of major depressive disorder.
- Younger generations appear to have higher prevalence of depression. Therefore, as younger populations age, the prevalence of depression among older adults may rise.

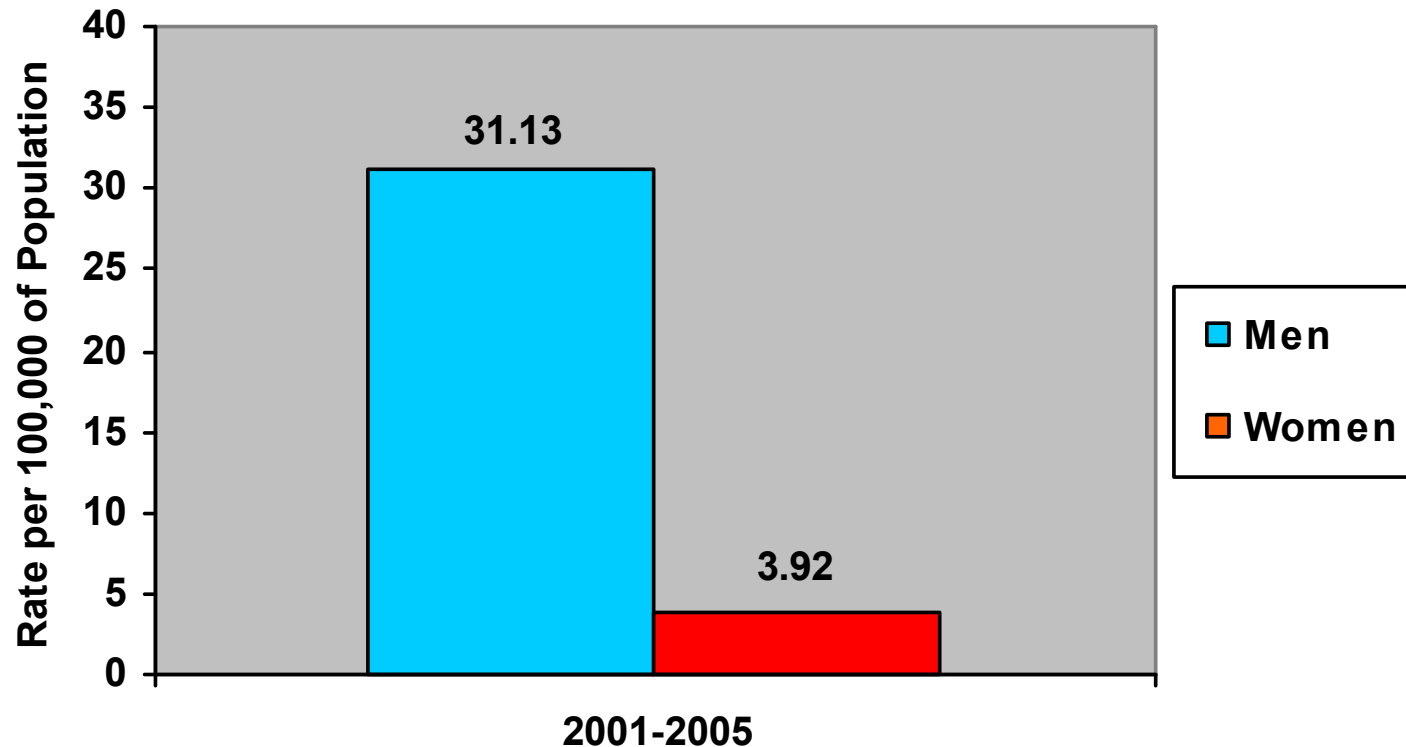
From 2001-2005 The Rate Of Suicide For Older Adults Was Nearly 50% Higher Than The General Population.



Source: Mortality Reports. National Center for Injury Prevention and Control. Centers for Disease Control and Prevention.
<http://www.cdc.gov/ncipc/wisqars/>

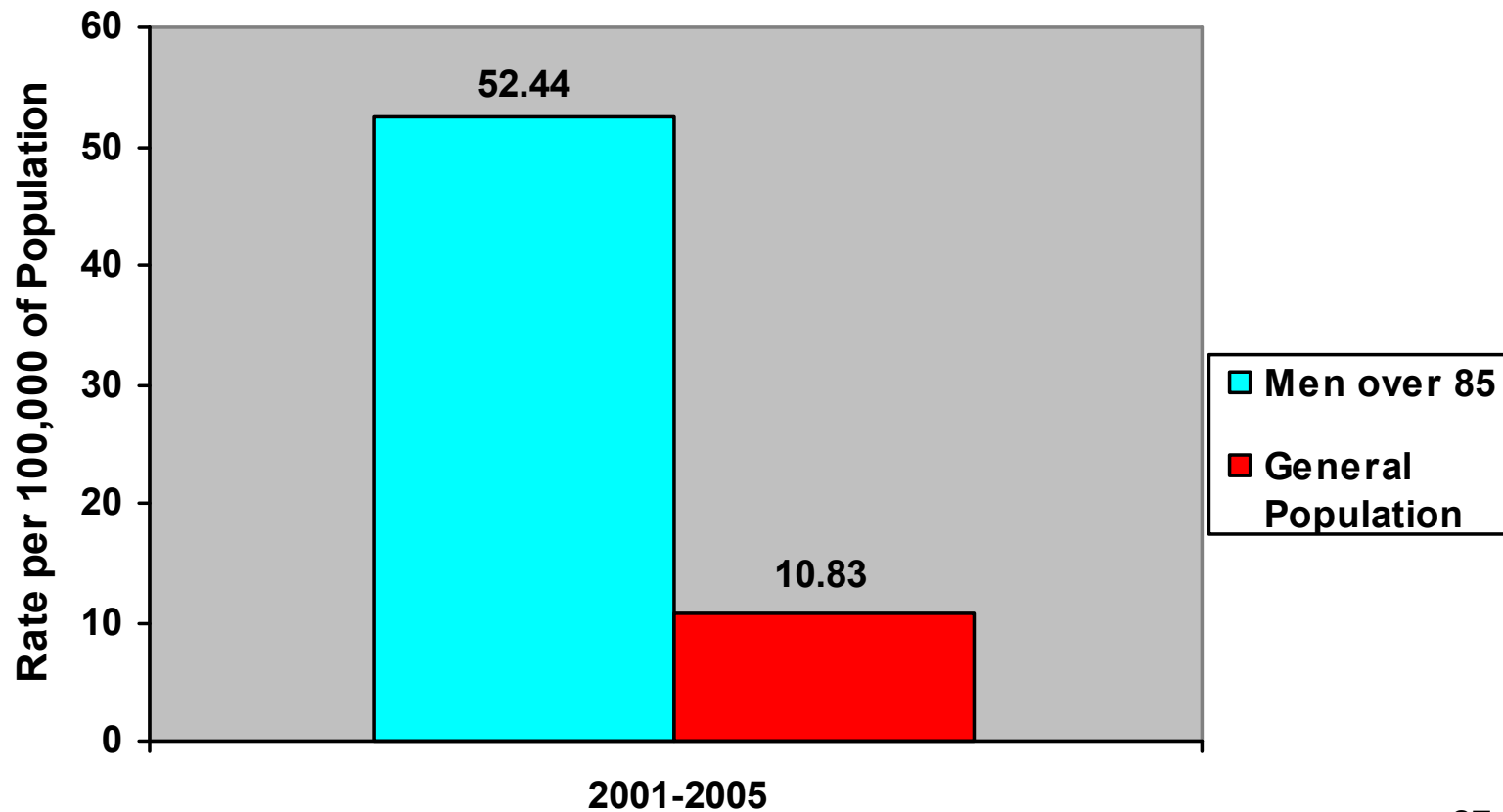
Older Men Are Much More Likely Than Women To Commit Suicide.

Suicide Rates Among 65 and Over Population by Gender per 100,000 of the Population



From 2001-2005, The Rate of Suicide For White Men 85 And Older Was Nearly 5 Times The General Population.

Suicide Rates Among Male 85 and Over Population vs. General Population per 100,000



The Prevalence of Schizophrenia Declines Somewhat In Old Age

- The Surgeon General estimated the prevalence of schizophrenia as less than .6% in older adults aged 55+.¹
- The prevalence is probably understated.
 - This estimate is from 1982.
 - Late onset schizophrenia was not counted in the 1982 estimate.
 - People in institutions were not counted in the 1982 or 2000 estimates.
- More recent estimates are about 1%.²

¹ U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: 1999).

² McAlpine, D. Patterns of care for persons 65 years and older with schizophrenia. In Cohen, C. (2003). *Schizophrenia Into Later Life*.

Why Might A Lower Proportion Of Older Adults Have Schizophrenia?

- Recovery over time
- Lower life expectancy (10-25 years less than general population)
 - Smoking, Obesity, Hypertension, Diabetes, Heart Disease, Pulmonary Disease
 - Limited Access to Quality Health Care
 - Suicide
 - Accidents and Injuries

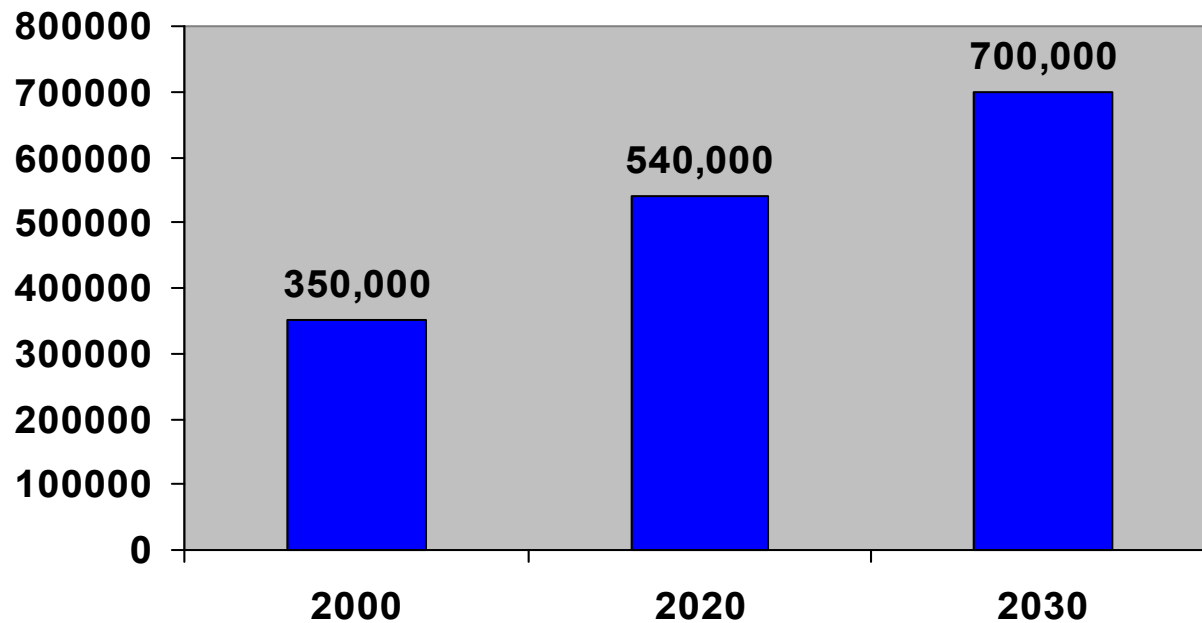
Despite The Possible Reduced Proportion Of People With Severe Psychiatric Disabilities, More Services Will Be Needed As They Age.

- Number of people with psychiatric disabilities will grow from at least 350,000 to 700,000.
- Number with co-occurring mental and physical disabilities will grow including
 - Dementia and Depression and/or Anxiety
 - Chronic Physical Illness and Mental and/or Substance Use Disorders

By 2020 There Will Be 540,000 Older Adults With Schizophrenia, Rising To 700,000 In 2030.

(N.B. Total Patients In State Hospitals At Peak Use: 550,000)

Projected Number of Older Adults with Severe and Persistent Mental Illness: 2000 to 2030



Source: McAlpine, D. Patterns of care for persons 65 years and older with schizophrenia. In Cohen, C. (2003). *Schizophrenia Into Later Life*.

Increasing Disability and Co-Morbid Physical And Mental Illness Result In Increased Needs.

- More safe and accessible housing.
- More supports for activities Of daily living.
- Increased integration of health and mental health care.
- Improved Oversight Of Medications.

Substance Use Problems Affects Up To 17% of Older Adults¹

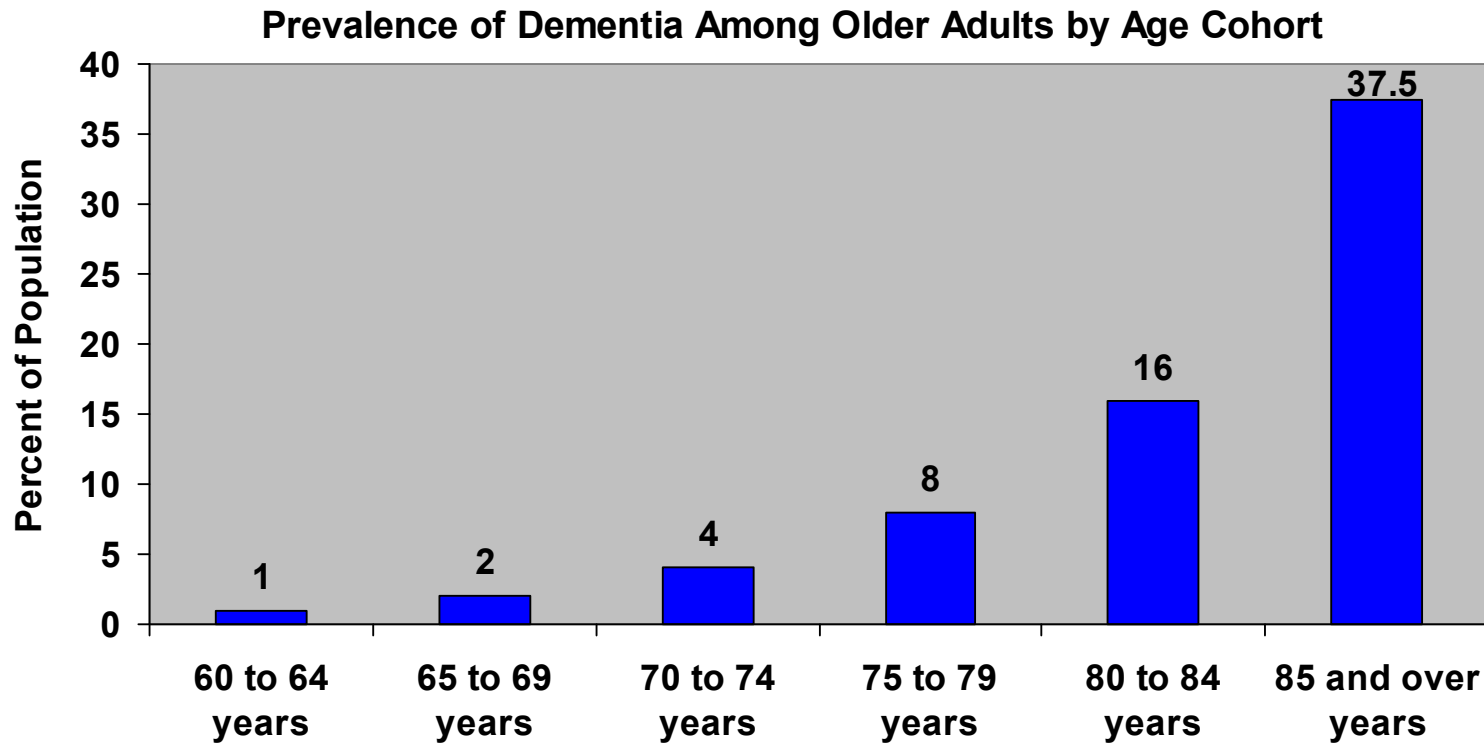
- 3-9% of older adults engage in heavy drinking.²
- In the current generation of older adults, 1.8% use illegal substances.³
- Since younger adults have higher rates of illegal drug use than current older adults did at their age, it is likely that there will be an increase in the use of illegal substances in the next generation of older adults.⁴

^{1,4} Blow, Frederic C. et al. (1998). *Substance Abuse Among Older Adults Treatment Improvement Protocol*. U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration. <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.section.48537>

² U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: 1999).

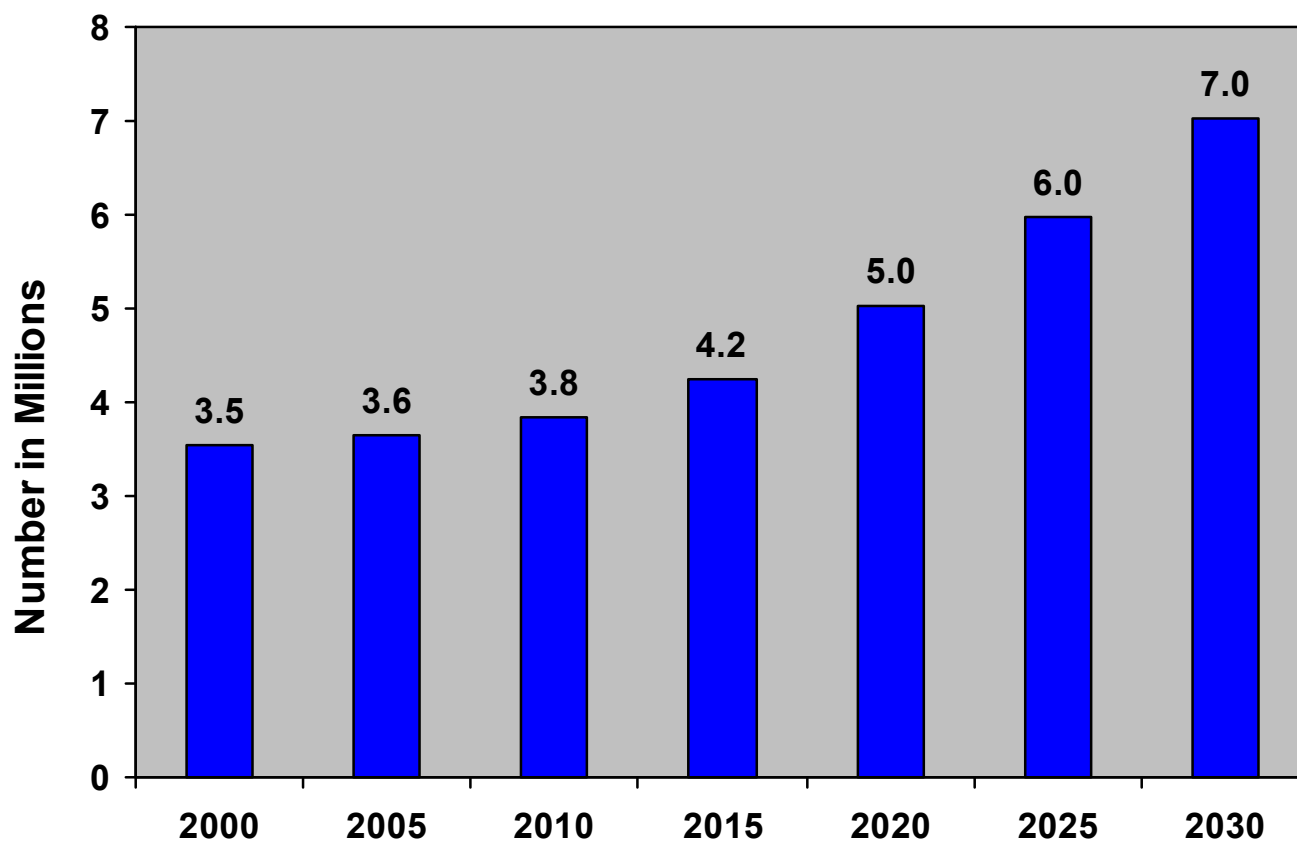
³ SAMHSA DASIS Reports, and SAMHSA National Survey on Drug Use and Health (2005): <http://www.oas.samhsa.gov/2k5/olderadults/olderadults.htm>

The Prevalence Of Dementia Doubles Every Five Years After The Age Of 60.



Sources: U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: 1999).
Cummings, Jeffrey L. and Jeste, Dilip V. (1999) Alzheimer's Disease and Its Management in the Year 2010. *Psychiatric Services*.
50:9, 1173-1177

The Number Of Americans 71 And Older With Dementia Will Double.



Plassman, B.L., et al. (2007) Prevalence of Dementia in the United States: The Aging, Demographics, and Memory Study.

<http://www.karger.com/ned>

US Census Bureau, Annual Projections of the Resident Population by Age, Sex, Race, and Hispanic Origin: Lowest, Middle, Highest Series and Zero International Migration Series, 1999 to 2100. <http://www.census.gov/population/www/projections/natdet-D1A.html>

For Older Adults With Mental Disorders, Co-occurring Physical Disorders Are Virtually Universal.

- Older schizophrenic, schizoaffective, and bipolar patients are more likely to be diagnosed with cardiovascular and pulmonary conditions than younger patients and have a greater burden of medical comorbidity overall.¹
- People with serious mental illnesses are at high risk for obesity, hypertension, diabetes, and cardiac and respiratory problems.
- Psychiatric disturbances affect as many as 90% of patients with dementias.²
- Older patients are more likely to be diagnosed with 3 or more medical conditions (aside from mental illness diagnosis) than younger patients.¹
- These conditions can lead to greater functional decline and premature mortality for mentally ill older adults. They also may affect the patient's treatment course and progress.

¹ Kilbourne, A.M., Cornelius, J.R., Han, X., Hass, G.L., Salloum, I., Conigliaro, J., Pinous, H.A. (2005). General-medical conditions in older patients with serious mental illness. *American Journal of Geriatric Psychiatry*, 13 (3), 250-254.

² Lyketsos, C.G. & Olin, J. (2002). Depression in Alzheimer's Disease: Overview and Treatment. *Biological Psychiatry*, 52, 243-252

Co-occurring Mental And Physical Disorders (Continued)

- 25% of older adults with chronic illness have clinically significant depression.²
- Depression is highest among older adults with heart disease, stroke, cancer, lung disease, arthritis, dementias, and neurodegenerative disorders.³
- 14% of individuals receiving Medicare home health care in Westchester and New York City suffer from major depression.⁴
- People with depression as well as serious physical illness are at higher risk for disability and premature death, and the costs of medical care increase, as much as 50%-100%.^{5, 6}
- Multiple large-scale studies have shown an increase in cardiovascular mortality for depressed older adults compared to non-depressed; a systematic analysis of 57 studies suggests that depression increases the risk of death by cardiovascular disease.⁶

^{2,3} U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: 1999).

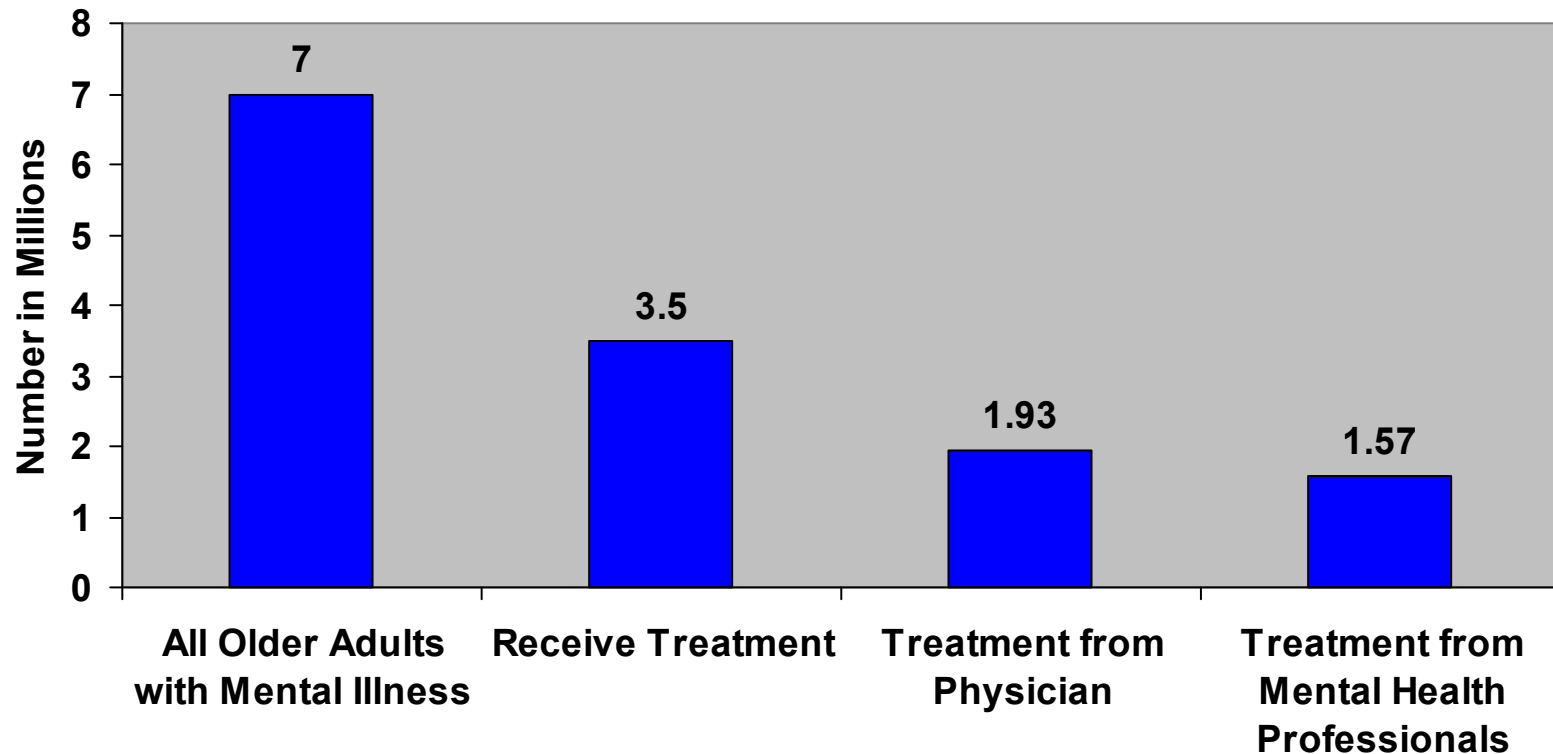
⁴ Bruce, M.L. (2002). Major depression in elderly home care patients. *American Journal of Psychiatry*, 159, 1367-1374.

⁵ Husaini, B.A, et. Al (2000). Prevalence and cost of treating mental disorders among elderly recipients of Medicare services. *Psychiatric Services*, 51, 1245-1247.

⁶ Katon, W., Ciechanowski, P. (2002). Impact of major depression on chronic medical illness. *Journal of Psychosomatic Research*, 53, 859-863.

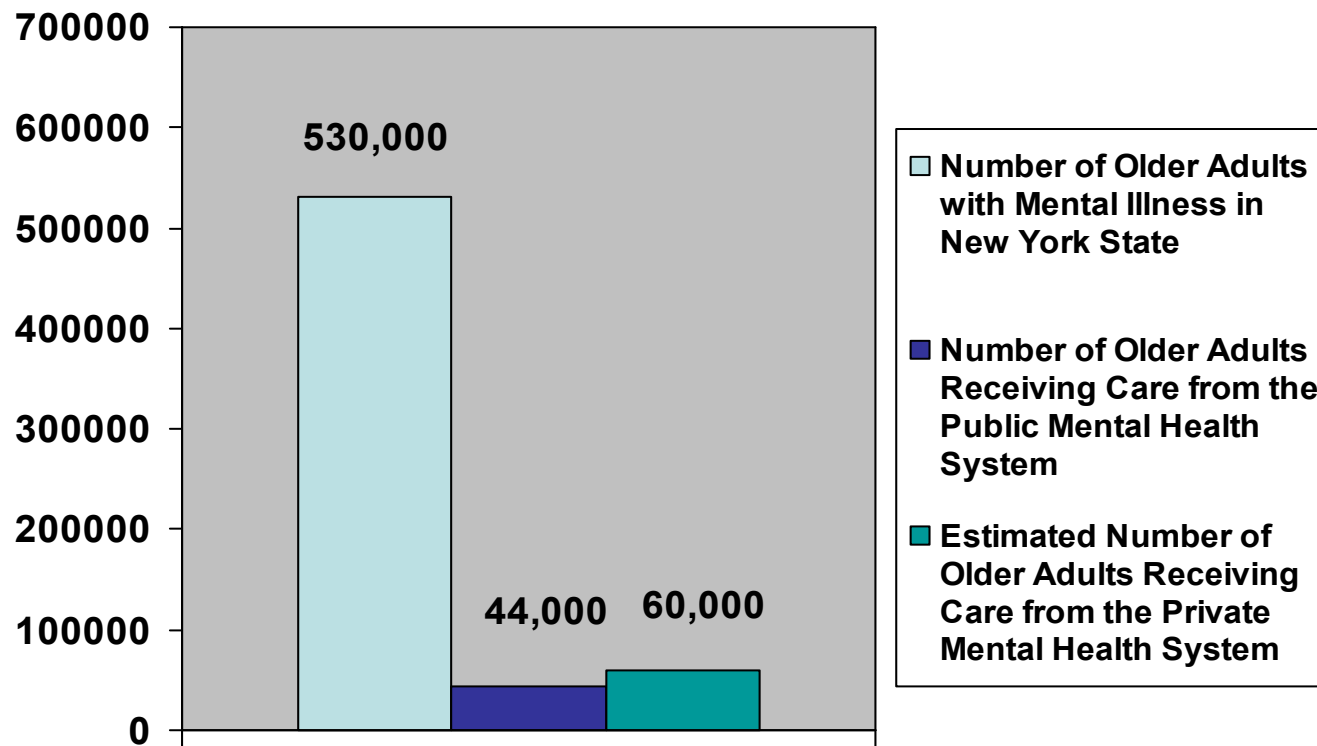
In The U.S., Only 22.5% Of Older Adults With Mental Illnesses Get Treatment From Mental Health Professionals. They Are More Likely To Go To Primary Care Physicians.

Treatment for Mental Illness Among Older Adults



Source: U.S. Department of Health and Human Services, *Older Adults and Mental Health: Issues and Opportunities* (Rockville, MD: 2001).

Approximately 25% Of Older Adults With Mental Illness In NYS Receive Care From Mental Health Professionals.



Source: New York State Office of Mental Health, *Patient Characteristics Survey* (2007), <http://www.omh.state.ny.us/omhweb/PCS/pcsMain.htm>

Source: U.S. Department of Health and Human Services, *Older Adults and Mental Health: Issues and Opportunities* (Rockville, MD: 2001).

The Majority Of Older Adults With Mental Illnesses Do Not Get Minimally Adequate Mental Health Services.

- Treatment by primary care physicians is minimally adequate only 12.7% of the time.¹
- Treatment by mental health professionals is minimally adequate more often but only 48.3% of the time.¹
- Older adults are less likely to get health care in mental health specialty settings than other age groups.¹
- In-home service providers, such as home health aides, are rarely trained to identify, let alone treat, mental disorders.
- Community service providers in senior centers, adult day care, etc. are rarely trained in identification or treatment.
- Mental health care in nursing and adult homes is also uneven. Overuse of anti-psychotic medications is common and dangerous.

¹ Wang, P.S., Lane, M., Olsson, M., Pincus, H.A., Wells, K., Kessler, R.C. (2005). Twelve-month use of mental health services in the U.S. *Archives of General Psychiatry*, 62, 629-640.

People With Long-term Psychiatric Disabilities Get Limited Physical Health Care

- People with severe mental disorders are less likely to be treated for physical conditions and less likely to receive preventive health care.¹
- There are many barriers to receiving health care for the severely mentally ill including
 - Lack of integration of mental and physical health care services¹
 - Socioeconomic disadvantage ²
 - Lack of health insurance ³
 - Cognitive limitations ³
 - Lack of motivation ³
 - Physician discomfort in treating the severely mentally ill ³

¹ Bazelon Center for Mental Health Law (2004). Get it together: How to integrate physical and mental health care for people with serious mental disorders. Washington, D.C.

² Blumenthal, D. et al. (1995). The efficacy of primary care for vulnerable groups. *Health Services Research*. 30, 253-273.

³ Druss, B.G. et al. (1998). Mental disorders and access to medical care in the U.S. *American Journal of Psychiatry*. 155, 1775-1777.

Primary Care Physicians Often Fail To Identify Or Treat Mental Illness In Older Adults

- Almost 90% of older adults with depression get no treatment or inadequate treatment in a primary care setting¹
- Older adults who meet diagnostic criteria for mental illness are less likely than young or middle-aged patients to receive specialty mental health care or to be referred from primary care to specialists.²
- 70% of older adults who complete suicide have seen their primary care physician within 30 days.³

¹ O'Neill, G., Patrick, M. (2002). State of aging and health in America. Merck Institute of Aging & Health, Washington, D.C. and Gerontological Society of America, Washington, D.C.

² Klap, R., Unroe, K.T., Unutzer, J. (2003). Caring for mental illness in the United States: A focus on older adults. *Am J Geriatr Psychiatry* 11 (5), 517-524.

³ Luoma, J., Martin, C., & Pearson J. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *Am J Psychiatry*. 159 (6), 909-916.

Mental Illness Is Highly Prevalent In Nursing Homes And Assisted Living Facilities.

- Nursing Homes
 - CMS data show 46% of nursing home residents in NYS have dementia, often with emotional and behavioral complications. 35% are clinically depressed. 17% have other psychiatric diagnoses. And 23% have behavior problems associated with mental illness.¹
 - These estimates may be low- other estimates suggest as much as 68% of nursing home residents have some mental illness.²
 - 16.4% of nursing home residents have a primary diagnosis of mental illness. This is second only to circulatory diseases.³
 - Nationally, there are approximately 43,000 people diagnosed with schizophrenia in nursing homes.³
- Assisted Living Facilities
 - 67.7% of those in assisted living have some dementia.⁴
 - 23.3% have some other mental illness.⁴

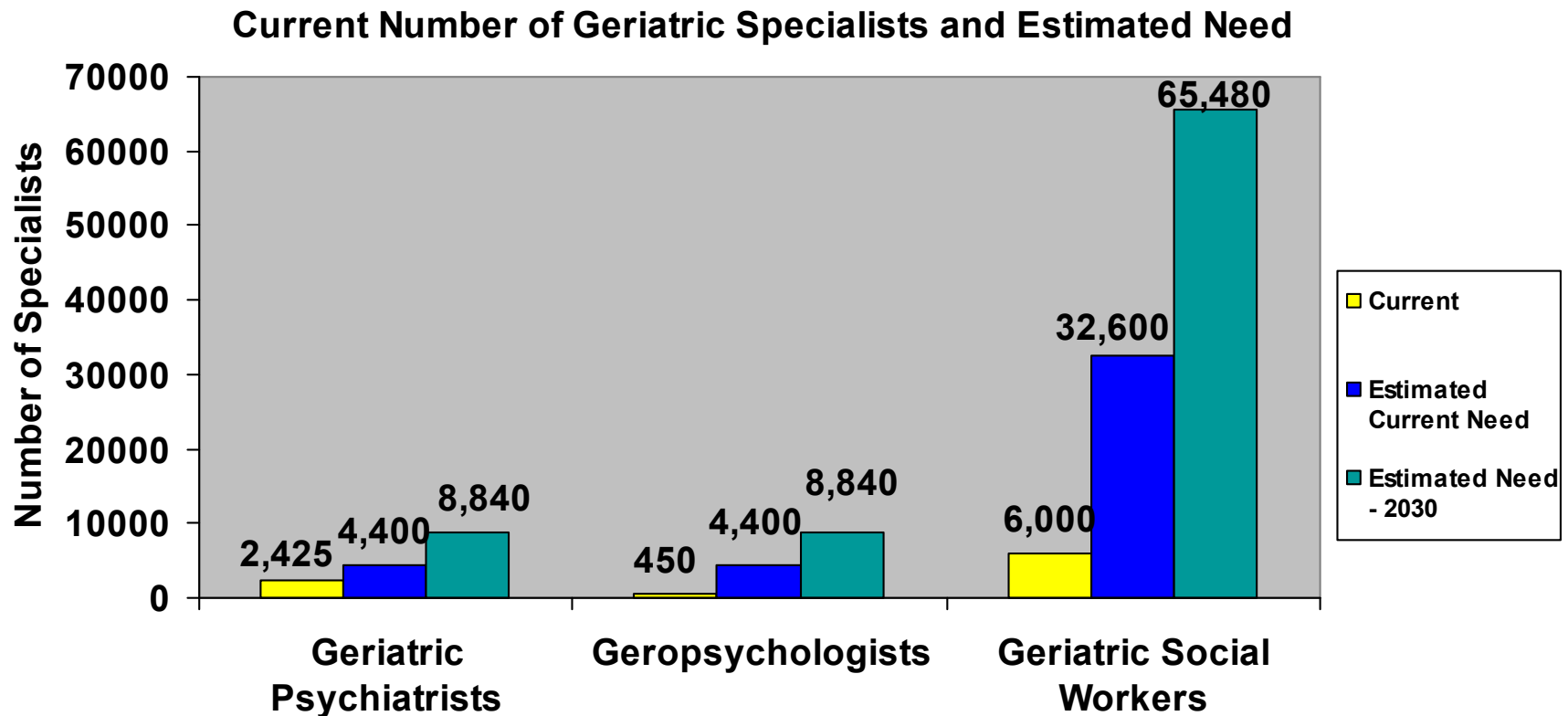
¹ Center for Medicare and Medicaid Services. (2007). *CMS OSCAR data current surveys: Medical condition-mental status*. Retrieved from http://www.ahcancal.org/research_data/oscar_data/NursingFacilityPatientCharacteristics/MC_mental_status_Jun2007.pdf

² Mechanic and McAlpine. "Use of Nursing Homes in the Care of Persons With Severe Mental Illness: 1985 to 1995." <http://ps.psychiatryonline.org/cgi/reprint/51/3/354>

³ CDC: 2004 National Nursing Home Survey. http://www.cdc.gov/nchs/data/nnhsd/Estimates/nnhs/Estimates_Diagnoses_Tables.pdf#Table38

⁴ Rosenblatt et. al. "The Maryland Assisted Living Study: Prevalence, Recognition, and Treatment of Dementia and Other Psychiatric Disorders in the Assisted Living Population of Central Maryland." http://www.hopkinsmedicine.org/Press_releases/2004/10_04c_04.html

There Are Too Few Geriatric Mental Health Professionals.



Sources Of Funding For Mental Health Services For Older Adults.

- **Medicare** – Almost all older adults have limited coverage for inpatient and outpatient mental health services and for prescription drugs.
- **Medigap** – Supplemental policies that provide additional coverage at varying prices depending extent of coverage.
- **Medicaid** – Covers poor older adults not eligible for Medicare and provides supplemental coverage for poor older adults with Medicare.
- **In Addition to Medicaid, New York State Can Provide Funding for:**
 - Mental health grants and contracts
 - Prescription drugs (EPIC)
- **In Addition to Medicaid and Medicare, the Federal Government Provides Funding for:**
 - Research
 - Training
 - Very Limited Services
- **Private Insurance** – Variable coverage depending on benefit plan
- **Self-Pay** – Some older adults pay out-of pocket for mental health services

Problems Meeting The Mental Health
Needs Of Older Adults
Now And During The Elder Boom

Problems

– **Aging Well**

- Failure to recognize that mental health is essential to aging well
- Shortage of efforts to maintain and promote mental health
- Shortage of efforts to prevent the development or exacerbation of mental disorders and suicide
- Failure to include services and supports regarding mental health in efforts to modernize the aging services system

– **Health**

- Failure to address the impact of mental illness on the prognosis for older people with chronic health conditions
- Failure to address vastly reduced life expectancy of people with serious mental illness

Problems (Continued)

- **Aging in the community**
 - Failure to provide adequate supports to help older adults with mental health problems to live in the community
 - Not enough home and community- based services, including crisis services
 - Not enough home health and case management service providers with competence in geriatric mental health
 - Not enough housing suitable for older adults with mental disabilities and for those with co-occurring serious physical and mental disorders
 - Not enough caregiver support for both informal and formal caregivers

Problems (Continued)

- **Limited access to mental health services** due to
 - Shortages of service
 - Cost of treatment
 - Shortage of mobile services and transportation
 - Limited access to psychiatric medications
 - Failure to reach out to and engage cultural minorities
- **Problems of integration**
 - Lack of integrated treatment of co-occurring disorders. This includes both co-occurring mental and physical disorders (e.g. heart disease and depression) and co-occurring mental disorders (e.g. dementia and depression or depression and substance abuse)
 - Lack of integration of health, mental health, and geriatric social services
 - Particularly, failure to develop networks of local service providers, whether formal or informal.

Problems (Continued)

- **Uneven quality of treatment in the community**
 - Limited ability of most primary care physicians to identify or treat mental and/or substance use disorders
 - Limited mental health competence of community-based long-term care providers, including home-health, case managers, and day programs, especially regarding behavior management
 -
 - Limited translation of research findings into practice
 - Inadequate attention to the addictive disorders common to older adults
 - Limited cultural competence

Problems (continued)

- **Uneven quality of treatment in, and poor transition from, nursing homes and adult homes**
 - Poor living conditions in some homes
 - Day-to-day structure that often is not responsive to the choices and abilities of residents
 - Limited ability of medical and other personnel to identify and treat mental disorders
 - Limited ability of institutional staff to manage behavioral problems and provide rehabilitative services

Problems (Continued)

- **Ignorance about mental health**

- Lack of knowledge about effectiveness of treatment and where to get it
- Stigma
- Ageism

- **Workforce limitations**

- Too few mental health, health, and aging services professionals and paraprofessionals now. This will get worse as the proportion of older adults increases and the proportion of working age adults decreases.
- Limited clinical and cultural competence regarding older adults with mental and/or substance use disorders
- Lack of use of older adults in professional, paraprofessional, volunteer, and peer roles

Problems (Continued)

- **Research**
 - Not enough research: epidemiological, biomedical, clinical, services, and systems
 - Failure to translate research findings into practice
- **Inadequate funding:** both structure and amount (See slides 54 and 55)
- **Lack of planning** at federal and state levels
- **Lack of political interest and will**

Funding Problems

Current funding models frequently do not support the use of best practices and innovative services and do not promote integrated service delivery. Problems include:

- **Medicare**

- Lack of knowledge about how to optimize Medicare funding
- Current lack of parity (will be phased in beginning in 2010)
- Restricted drug formularies; particular problems for dual-eligibles
- Psychiatrists can, and do, refuse to accept Medicare
- Lack of a special rate for in-home mental health services
- No coverage for wrap-around, outreach, and other non-traditional services
- Coverage only for emergency transportation
- Lifetime cap
- Limited mental health coverage under Medicare managed care

Funding Problems (Continued)

- **Medicaid**

- Current failure to provide a special rate for home visits by clinics
- Rates for private practitioners are discouragingly low
- Rates for mental health day programs are inadequate to provide integrated physical health services.
- Current rates for community residential care are inadequate to provide health services for older adults with co-occurring serious physical and mental health disorders.
- Current rates for nursing homes are based on excessively large caseloads for social workers.

- **Private Insurance**

- Lack of parity in some plans
- No coverage for wrap-around, outreach, and other non-traditional services

Geriatric Mental Health Alliance's Advocacy Goals

Geriatric Mental Health Alliance's Advocacy Goals

- Enable people with mental health problems to remain in, or return to, the community and avoid institutionalization in adult and nursing homes via support for caregivers, in-home services, and housing alternatives to institutions.
- Increase access to services through service expansion, increased mobile and community and home-based services, enhanced cultural competence, and increased affordability.
- Enhance quality of care and treatment in the community and in long-term care facilities through training, dissemination of information about best practices, the development of regulations relevant to older adults, and health and mental health maintenance activities.

Advocacy Goals (Continued)

- Integrate health, mental health, and aging services and heighten awareness of the importance of mental health in the health and aging services systems.
- Increase the capacity of the system to serve cultural minorities through outreach and enhanced cultural competence.
- Provide support for family caregivers of older adults, for older family members caring for adult children with mental disabilities, and for grandparents raising grandchildren.
- Help older adults to age well via mental health maintenance activities and prevention of mental and/or substance use disorders and of suicide.
- Provide public education and outreach to address issues of stigma, ageism, and ignorance about mental health and to engage people who would benefit from mental health services.

Advocacy Goals (Continued)

- Increase research on geriatric mental health: epidemiological, bio-medical, clinical, services, and systems research.
- Develop a workforce of mental health, health, and aging service providers that is clinically and culturally competent and large enough to meet the mental health needs of the elder boom.
- Increase funding and develop finance models that will (a) support best practices and innovative services that are responsive to the unique mental health needs of older adults, (b) promote integrated service delivery, and (c) create incentives to enhance the workforce.

Advocacy Goals (Continued)

- Promote readiness of the public and private sectors for the mental health challenges of the elder boom including
 - Dedicated leadership in federal, state, and local mental health and aging services agencies
 - Interdepartmental structures to integrate planning and service
 - Public-private partnerships
 - Employer-based benefits and supports:
 - For family caregivers
 - For retiring employees
 - For working volunteers