

OLDER ADULTS AND MENTAL HEALTH:

ISSUES AND OPPORTUNITIES

**Department of Health and Human Services
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FOREWORD

That the elderly population will burgeon in the coming decades is of no surprise to any of us. The quest to help Americans live longer, healthier lives has reaped enormous successes. Certainly, the years ahead hold the promise of continued improvements in the standard of living for older Americans. But length of years alone is not enough; we must continue to focus our efforts on making sure that the quality of life they enjoy is the best possible.

As *Mental Health: A Report of the Surgeon General* pointed out, old age is a lively and exciting time for many Americans. But too many of our elders struggle to cope with difficult life situations or mental disorders that negatively affect their ability to participate fully in life. The cost of this loss of vitality—to elders, their families, their caregivers, and our country—is staggering. Moreover, there is ample evidence that much of this suffering could be avoided if prevention and treatment resources were more adequately delivered to older Americans.

It is in this spirit that this companion document to the Surgeon General's Report is presented. *Older Adults and Mental Health: Issues and Opportunities* identifies some exciting initiatives and formidable challenges in the field of mental health and aging. Above all, this report makes clear that now is the time to alleviate the suffering of older people with mental disorders and to prepare for the growing numbers of elders who may need mental health services.

It is my fervent hope that all of those who have a stake in the mental health of older people will view this report as a call to action, and will use it as a guide for progress. It will take the aging network, mental health professionals, providers of community mental health services, long-term care facilities, researchers, policymakers, consumers and advocates working in concert to bring forth a new day for those who suffer needlessly. Only through collaborative efforts among all of these stakeholders and the Department of Health and Human Services can we enhance the well-being of older persons throughout the Nation.

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PREFACE

I am very pleased that *Older Adults and Mental Health: Issues and Opportunities* has been published as an important companion piece to the first-ever Surgeon General's report on mental health. The dawn of a new millennium bears witness to rapid improvements in health and health care in the United States. The average life span of Americans has increased dramatically, and the population aged 85 and over has grown and will continue to grow well into the next century. The majority of older Americans cope constructively with the many changes that accompany the aging process. However, nearly 20 percent of the population aged 55 and older experience mental disorders that are not part of "normal" aging.

Mental Health: A Report of the Surgeon General, the first-ever document of its kind dedicated to mental health, discusses mental health and mental illness across the life span, including a chapter on older adults. Mental illnesses are real health conditions. A growing body of scientific research has highlighted both the potentially disabling consequences of unrecognized or untreated mental disorders in late life, and important advances in psychotherapy, medications, and other treatments. When interventions are tailored to the age and health status of older individuals, a wide range of treatments is available for most mental disorders and mental health problems experienced by older persons, interventions which can vastly improve the quality of late life. Despite this progress, stigma, missed opportunities to recognize and treat mental health problems in older persons, and barriers to care remind us that we still have a great deal of work to do.

In recognition of the importance of assuring mental health for older Americans, a reprint of the chapter of the Surgeon General's report on mental health and older adults has been released as a separate document. As a companion piece, *Older Adults and Mental Health: Issues and Opportunities* focuses on the broad range of community-based preventive and treatment services that are available to older adults and their families. This is a valuable resource for service providers, policymakers and researchers, for by building on these initiatives we can begin to address the many challenges that face us in mental health and aging.

I greatly appreciate the vision and leadership of Dr. Takamura and the Administration on Aging as we work together for the mental health of older Americans.

David Satcher, M.D., Ph.D.
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EXECUTIVE SUMMARY

The design and delivery of mental health services to older persons is a vital societal challenge, in light of the enormous increase in the elderly population that is projected to occur during the first half of this century. The purpose of this report is to highlight major issues in the field of mental health and aging; to discuss efforts to address these issues, including community-based services; and to identify the crucial challenges that must be confronted in the years ahead and strategies to meet them.

This report is written as a companion document to *Mental Health: A Report of the Surgeon General* (USDHHS, 1999a). Because the Surgeon General's report provides an excellent discussion of the nature, diagnosis, and treatment of mental disorders, this report will focus instead on community-based services that can be utilized by a wide range of elders, including older persons in good mental health, for whom outreach and education might be helpful; older persons who are experiencing acute stress or crisis; and those with severe mental disorders. While substance misuse and abuse are closely intertwined with mental health and merit full discussion, the primary focus of this report is on mental health and aging and the services and systems designated to deal with these areas of concern.

Mental health and supportive services must address more effectively the ethnic and racial diversity of our older population. A supplement to *Mental Health: A Report of the Surgeon General* that will address mental health and ethnic minorities is in preparation. The need for and use of mental health services by distinct ethno-cultural

groups over the life span, including a discussion of service use by older adults, is the domain of this second, much-anticipated supplement.

This companion document on mental health and aging consists of six major sections. Each of these sections is summarized below.

Introduction and Chapter 1: Background

Demographic characteristics. The elderly population is projected to grow rapidly between 2010 and 2030 as the 76 million "baby boomers" reach 65 years of age. By 2030, older adults will account for 20% of the nation's people, up from 13% today. Simply by virtue of the growth of the older population, the need for geriatric mental health services will increase. In addition to being larger in number, the older adult population will be much more diverse with regard to generational cohorts, gender, minority status, income, living arrangements, and physical and mental health.

Stressors and adaptations. During the normal process of aging, older persons encounter stressors that may trigger both appropriate and distorted emotional responses. Two of the most stressful unplanned life events include declines in health and loss of loved ones. In addition, chronic strains may also impact the older adult; for example, strains within the community, in relationships, or in the older person's immediate environment are all stressors. Most older persons are able to adapt to these changes and maintain their well-being by marshaling their personal and

environmental resources. These include coping skills, social support, and maintaining a sense of control.

Service delivery issues. While there are substantial needs for mental health services, older adults have made very limited use of these services. The reasons for this underutilization include: denial of problems, reluctance to self-refer, failure by professionals to identify the signs and symptoms of mental illness, and access barriers. At the systems level, lack of collaboration between agencies and systems, funding issues, gaps in services, and shortages of mental health personnel trained in aging and aging professionals trained in mental health can affect access to and provision of appropriate services.

Mental Health and Aging. Most older adults enjoy good mental health, but nearly 20% of those who are 55 years and older experience mental disorders that are not part of normal aging. The most common disorders, in order of prevalence, are anxiety disorders, such as phobias and obsessive-compulsive disorder; severe cognitive impairment, including Alzheimer's disease; and mood disorders, such as depression. Schizophrenia and personality disorders are less common. However, some studies suggest that mental disorders in older adults are underreported. The rate of suicide is highest among older adults compared to other age groups.

Older adults with mental illness vary widely with respect to the onset of their disorders. Some have suffered from serious and persistent mental illness most of their adult life, while others have had periodic episodes of mental illness. A substantial number experience mental health disorders or problems for the first time late in life—problems which are frequently exacerbated by bereavement or other losses which tend

to occur in old age. Yet another variable is severity. Mental disorders can range from problematic to disabling to fatal. Mental health services must be designed to meet the needs of older people at all points of the mental health continuum. However, the assessment, diagnosis and treatment in mental disorders among older adults present unique difficulties that must be contended with. Further efforts aimed at the prevention of mental disorders in older adults are also needed.

Delivery of mental health services to older adults. Older Americans underutilize mental health services. A number of individual and systemic barriers thwart the provision and receipt of adequate care to older persons with mental health needs. These include the stigma surrounding mental illness and mental health treatment; denial of problems; access barriers; fragmented and inadequate funding for mental health services; lack of collaboration and coordination among primary care, mental health, and aging services providers; gaps in services; the lack of enough professional and paraprofessional staff trained in the provision of geriatric mental health services; and, until recently, the lack of organized efforts by older consumers of mental health services.

Initiatives in mental health and aging. While critical challenges and service delivery issues exist, there have been a number of notable endeavors and initiatives to address these issues. Among these are efforts to encourage collaboration in the delivery of mental health and supportive services; organize consumer advocacy groups; heighten public awareness of mental health issues; support research specific to older adults with mental health needs; and expand and better educate the geriatric mental health workforce. These efforts provide an

excellent foundation for confronting critical challenges in mental health and aging.

Chapter 2: Community Mental Health Services

It is estimated that only half of older adults who acknowledge mental health problems receive treatment from any health care provider, and only a fraction of those receive specialty mental health services. The specialty mental health services system consists of private mental health providers funded by private insurance and consumers, and publicly and privately owned providers funded by states, counties, and municipalities. Institutional or facility-based mental health services include inpatient care (acute and long-term), residential treatment centers, and therapeutic group homes. Community-based services include outpatient psychotherapy, partial hospitalization/day treatment, crisis services, case management, and home-based and “wraparound” services.

Historically, public and private funding for adult mental health services was targeted toward intensive and costly institutional care. In the last two decades, due mainly to court decisions restricting the institutionalization of adults with mental illness, the service priorities have changed in favor of less intense community-based services.

Most mental health funding comes from state and local governments, Medicaid, and private insurance. Publicly funded services are thought to be a “safety net” for those unable to afford private insurance or to pay for services. The federal government augments state and local funding through the Community Mental Health Services Block Grant (CMHSBG). The CMHSBG is a joint Federal-state partnership that awards annual

formula grants to the states to provide community-based mental health services to adults with serious mental illness and children with serious emotional disturbance. The Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Mental Health Services administers the CMHSBG. Each state has a state mental health authority whose mission it is to oversee the public mental health system. In order to receive CMHSBG funds, each state must have a comprehensive plan to provide mental health services throughout the state. States vary widely in the organization of their mental health service delivery systems, and in the degree to which these systems interact with providers of other types of services—e.g., primary care, social services, and the aging network.

Access to community-based mental health services is problematic for older people because of several factors, including the growing reliance on managed care; the targeting of mental health services to specialized groups that exclude the elderly; and the emphasis public providers place on serving the severely chronically mentally ill. In addition, community mental health organizations often lack staff trained in addressing non-mental health medical needs, which are especially important for older adults. These organizations also tend not to see treatment of those with cognitive impairments as part of their mission.

Survey findings indicate that while older adults have a tremendous need for services such as elder case management or psychiatric home care services, only a few states designate older adults as priority clients and only a minority of the states address the mental health needs of the elderly through specialized services for them. However, studies have also shown

that the use of specialized geriatric services and staff as well as partnerships between the aging and mental health systems can increase access to services for older persons.

Chapter 3: Primary and Long-Term Care

Primary care. When faced with a mental health problem, older persons frequently first turn to their primary care physician. Over half of older persons who receive mental health care receive it from their primary care physician. Many reasons have been suggested for this pattern: going to a primary care physician does not carry the same stigma that specialty mental health services do; insurance policies encourage use of primary care; and primary care may be more convenient and accessible.

While many older people prefer to receive mental health treatment in primary care settings, diagnosis and treatment of older persons' mental disorders in these settings are often inadequate. Many primary care physicians receive inadequate training in mental health. Physicians often attribute psychiatric symptoms either to changes expected with age or concomitant physical disorders and sometimes inappropriately prescribe psychotropic medications. In addition, some physicians' negative attitudes toward older people appear to undermine their clinical effectiveness.

There are also system barriers to providing mental health care in the primary care setting. It is important to coordinate mental and physical health care, because consumers with emotional problems can also have physical health problems. However, frequently this coordination does not occur.

In response to these shortcomings, several models aimed at improving mental health

services in primary care have been developed. These models call for either collaboration between mental health and primary care providers, or integration of mental health providers into the primary care setting. Currently, there are three ongoing multi-site research efforts in the United States that are examining services to older persons with mental health problems in primary care settings.

Long-term care. Various studies indicate a high prevalence of mental illness in nursing homes. Dementia and depression appear to be the most common mental disorders in this setting. However, most residents with mental disorders do not receive adequate treatment. Barriers to good treatment include: (1) a shortage of specialized mental health professionals trained in geriatrics; (2) lack of knowledge and inadequate training of nursing home staff about mental health issues; (3) lack of adequate Medicaid and Medicare reimbursement to facilities to cover behavioral and mental health problems; and (4) difficulty obtaining the services of psychiatrists and other mental health professionals due to inadequate reimbursement policies. Thus, there is a great need to incorporate mental health care into the basic structure of nursing home care and to make professional services available to patients and their families.

Psychosocial interventions that can be used in nursing homes include individual, group, program, family-based and staff interventions. Each intervention focuses on helping the resident and/or the family adapt to the nursing home environment, changing resident behaviors, improving quality of life, or enhancing staff and resident morale. These are described and discussed in detail.

Chapter 4: Supportive Services and Health Promotion

This chapter describes a number of supportive services and health promotion activities that may be helpful to older people with mental disorders and their families. Examples of each are provided and research findings on the effectiveness of each service are reviewed.

In planning for the delivery of mental health services, it is clear that alternatives to specialty mental health settings must be considered given the stigmatization of mental health services in the minds of many older adults. Senior centers, congregate meal sites, and other community settings that older people frequent and feel comfortable in may offer promising venues for the delivery of mental health services to seniors. Hence, it is essential that the aging network, the mental health system, and primary health care providers form partnerships to explore how to best marshal their various resources in the service of older persons' mental health.

Among the services discussed are:

- *Adult day services* are group programs designed to respond to the needs of functionally and/or cognitively impaired adults. These programs provide older adults with social interaction and health monitoring and also provide respite for caregivers;
- *Health promotion and wellness programs* focus on educating older adults about how to increase control over and improve their mental health, nutrition, or physical exercise. They seek to promote mental health and prevent the onset of mental disorders and costly treatment.
- *Mental health outreach programs* offer early identification and interventions to encourage access to services for high-risk older adult populations. They offer assessment and referral to community treatment and support services. These programs strive to keep older persons in the community by providing supportive services that help to increase functioning;
- *Support groups and peer counseling programs* provide preventive interventions. Support groups have members who share similar problems and pool resources, gather information, and offer mutual support. Peer counseling programs utilize the skills and life experiences of older persons as peers to enable others at risk to be supported and helped. Both of these interventions provide psychosocial support to older people facing life transitions, short-term crises, or chronic stressors.
- *Caregiver programs*, which offer a range of services for caregivers of frail elders such as respite care, support groups, care management, counseling, or home modifications. These services can reduce caregiver stress and improve coping skills so that families can continue to provide care; and
- *Respite care* refers to a range of services that offer temporary relief to caregivers of frail elders, such as short periods of companionship in the home or short stays in residential settings. Respite programs can prevent or alleviate depression and burnout, delay the need for more costly care, and offer an opportunity for mental health outreach by bringing the family into short-term

contact with formal care delivery systems.

Chapter 5: Medicare and Medicaid Financing of Mental Health Care

Basic Medicare mental health benefits are reviewed, including inpatient psychiatric care, outpatient mental health services, and partial hospitalization. The most important issues in Medicare's mental health coverage are identified as: lack of prescription drug coverage, different co-payments for mental health services, limited coverage of community-based services, and a limit on inpatient specialty psychiatric care. Mandatory and optional Medicaid coverages are also summarized as well as the most important issues in this program, including uneven optional benefits among states and reimbursement policies which sometimes make provision of mental health services problematic.

Chapter 6: Challenges in Mental Health and Aging

The areas of mental health and aging are not without challenges and opportunities. These include challenges related to:

- *Prevention and early intervention.* Existing efforts generally focus on the diagnosis and treatment of illness rather than on the early identification of high-risk individuals and families, preventive measures, and the promotion of optimal health;
- *Public awareness and education.* Stigma discourages older adults and their family members from acknowledging mental health problems. It also discourages the pursuit of treatment. Societal stereotypes and

myths can hinder efforts to diagnose and treat mental illness.

- *Workforce issues: shortages and need for education.* There is an insufficient supply of trained professionals and paraprofessionals available to provide mental health services to older people. Training opportunities for those entering and currently working in the field must include multidisciplinary cross-training;
- *Financing mental health services.* Federal, state, and private funding streams are separate, may not be coordinated, and tend to be less than adequate. A prescription drug benefit for seniors under Medicare is needed;
- *Collaboration.* The delivery system encompasses a variety of distinct care systems at both the institutional and community levels: medical care, long-term care, mental health services, and aging network services. These systems operate under different principles, and need to be coordinated in order to best serve older people;
- *Access.* Many mental health services for older adults are consistently in short supply. Some older citizens do not recognize their own need for help or do not know how to access the service delivery system. Most older adults could access mental health care through their primary care physician, but many health professionals are not adequately prepared to identify or refer clients in need of mental health treatment;
- *Research.* An expanded mental health and aging research agenda is needed to deepen our understanding of the biological, behavioral, social, and

cultural factors that prevent and cause disease, especially for at-risk and underserved populations. Research is needed in the areas of prevention, intervention, health services, and training;

- *Consumer involvement.* Consumer and family participation are essential in the care planning and treatment processes. Partnerships have begun to develop among consumers and family members, advocacy groups, and providers to plan and develop mental health research, systems, and services; and,
- *Needs of special populations.* To provide competent assistance, mental health professionals serving special population groups such as racial and ethnic minorities must acquire adequate knowledge about the culture and values of these groups, how services can be tailored to meet the needs of these

groups, and what types of mental health approaches are most effective with minority elders.

The report calls for the concerted efforts of those working to address the mental health needs of older persons. This includes the public and private sectors, policymakers, practitioners, researchers, consumers, family members, and advocacy groups. The opportunity to address these critical challenges is before us. If we hesitate, our service delivery systems will be strained even further by the influx of aging baby boomers and by the needs of underserved older Americans.

By building on the foundations that exist in the fields of mental health and aging, the upcoming crisis in geriatric mental health care can be transformed into an opportunity to address the mental health needs of older adults.

INTRODUCTION

Since 1900, the percentage of Americans age 65 and over has tripled. In 1998, they numbered 34.4 million and represented 12.7% of the U.S. population, or about one in every eight persons. America's older adult population will burgeon between the years 2010 and 2030, when the 76 million members of the "baby boom" generation born between 1946-1964 reach 65 years of age. At that time, older persons will account for 20% of the nation's people (USDHHS, 1999a). The interplay of mental health and aging issues, pointed out in the early 1970's by Butler and Lewis and others, may be expected to become even more evident in the future (Butler and Lewis, 1973). Based upon studies that examine the existing mental health needs of older Americans, it is reasonable to anticipate that the upsurge in the number of older adults in this new century will be accompanied by an increased need for mental health and supportive services tailored to this population. The challenges that mental health and aging policy makers and service providers are already facing and may expect to confront in the future can be readily identified.

This report is written as a companion document to *Mental Health: A Report of the Surgeon General* (USDHHS, 1999a). Because the original report provides an excellent discussion of severe and persistent mental disorders, this supplement focuses upon major issues in the fields of mental health and aging, discusses efforts to address these issues, and identifies a range of community resources, including those which are acceptable to older Americans and their families and may be brought to bear on their

behalf as they contend with mental health concerns.

While substance misuse and abuse all too frequently go hand-in-hand with mental health problems, the primary focus of this report is limited to mental health. It is acknowledged, however, that beyond concerns about the interaction effects of medications taken by older persons is a realm of issues related to substance misuse and abuse, including alcohol abuse, which merit full discussion.

Just as the nation's population is aging, so is it becoming more diverse in terms of race and ethnicity. Because minority populations have greater unmet need for mental health care and concomitantly are less likely to receive appropriate mental health services, mental health and aging professionals must also take into account the special needs of our growing ethnically and racially diverse older population. Among the special needs that must be addressed are the challenges presented in serving persons with limited English proficiency. A supplement to *Mental Health: A Report of the Surgeon General* that will focus on mental health and ethnic minorities is in preparation. Because it will examine the need for, use, and quality of mental health services for distinct ethno-cultural groups and will include discussions of issues pertinent to older adults in these each group, this supplement does not include a full discussion of these issues.

BACKGROUND

This chapter provides a discussion of issues related to the mental health needs of older Americans, including a demographic profile of the nation's elderly population, the mental health problems that tend to be more prevalent among them, mental health and aging dilemmas that concern policy makers as well as service providers, and efforts to give heightened attention to these challenges and to provide programmatic and policy responses.

Older Americans and Their Characteristics

Older Americans are a diverse segment of our nation's population. With the extension of longevity, the diversity of older persons in communities across the U.S. has become even more apparent. Not only do the values, beliefs, and activities of the old-old appear to differ from those of the young old, younger cohorts of older Americans also include more persons of minority ethnicity and race. These differences foreshadow the variations that can be anticipated within the baby boom generation that will come of age beginning in 2006.

The following provides a brief description of the older adult population in the United States:

- *Age.* Older adults are often categorized by their age: young-old (65-75), the old (75-85), and the old-old (85+). The older population itself is getting older. Persons 85 years and older comprise the most rapidly growing segment of the

U.S. population. Among those older Americans are centenarians, numbering 65,000 in the year 2000 (U.S. Bureau of the Census, 1996). While the extension of longevity among older Americans is a result of public health and other successes, the incidence of chronic illness and vulnerability to mental health conditions such as depression and Alzheimer's disease tends to rise in the later years of life. While suicide rates for persons 65 and older are higher than for any other age group, the suicide rate for persons 85+ is the highest of all – nearly twice the overall national rate. According to the Centers for Disease Control and Prevention, there are approximately 21 suicides per 100,000 persons among those 85 years of age and older (CDC, 1999) ;

- *Gender.* Most older persons and especially the old and old-old are women. At 65 - 69 years of age, there are 118 women for every 100 men. At age 85+, there are 241 women for every 100 men (USDHHS, 1999b). According to the U.S. Census Bureau, four out of every five Americans 100 years of age and older are women (U.S. Bureau of the Census, 1999). Women on average live seven years longer than men and are much more likely than older men to be widowed, to live alone, to be institutionalized (Goldstein & Perkins, 1993), and to receive a lower retirement income from all sources. Because they live longer, women are also likely to suffer disproportionately from chronic disabilities and disorders, including

mental disorders. However, white men who are 85+ account for the high suicide rate – 65 per 100,000 persons -- in the elderly population (CDC, 1999).

One subsegment of the older adult population – older gay men and lesbians – have not been a focus of most discussions about aging and mental health. Yet, the challenges faced by gay men and lesbians have become more widely known in recent years. Though there is a dearth of sound research on the mental health needs of gay, lesbian, and bisexual Americans, some have suggested that these individuals may be at increased risk for mental disorders and mental health problems due to exposure to societal stressors such as prejudice, stigmatization, and anti-gay violence (Dean et al, 2000). Social support—which is an important element of mental health for all older people—may be especially critical for older people who are gay, lesbian, or bisexual (Dean et al, 2000). Furthermore, access to health care may be limited because of concerns about health care providers’ sensitivity to differences in sexual orientation (Solarz, 1999). Further research on the mental health needs of older gay, lesbian, and bisexual Americans is needed.

- *Marital Status.* The emotional and economic well-being of older Americans is strongly linked to their marital status. At age 65-74, 79% of men and 55% of women were married in 1998. These numbers decrease significantly in the 8th decade of life, with 50% of men married and 13% of women married at age 85+. Among older Americans 85+, 42% of men were widowers and 77% of women were widows. While only 4% of older men and 5% of older women had never

married, all older persons who were alone because they were widowed, divorced (7%), or unmarried were more apt to live alone, to have a lower household income, and to have fewer caregivers available to assist them (Federal Interagency Forum on Aging Related Statistics, 2000);

- *Minority Status.* Minority populations are expected to represent 25% of the elderly population in 2030, up from 16% in 1998. Between 1998 and 2030, the white population 65 years and over is expected to increase by 79% compared with 226% for older minorities, including Hispanics (341%), African-Americans (130%), American Indians, Native Alaskans, and Aleuts (150%), and Asians and Pacific Islander Americans (323%) (USDHHS, 1999b). Minorities face additional stressors such as higher rates of poverty and greater health problems (Sanchez, 1992). Despite this, access to health care is frequently frustrated by limited English proficiency and by the lack of availability of bilingual health care providers. In a number of minority groups, Westernized mental health treatment modalities that tend to be dependent upon verbal inquiry, interaction, and response do not appear to present a comfortable “fit” with many minority cultural beliefs and practices. Consequently, minority communities have consistently called for assistance from persons who are bilingual and bicultural. Where these are not available, there has been a call for mental health services and provided by professionals who have an understanding and appreciation for their cultural values, norms, and beliefs and are culturally competent;

- *Income.* A number of studies have identified poverty to be a risk factor associated with mental illness (Bruce & McNamara, 1992; Cohen, 1989; Sanchez, 1992). For those individuals who are poor or who have limited incomes, the lack of adequate financial resources can seriously constrain access to health and mental health services. While the economic status of older Americans has improved, there is wide disparity in the distribution of income, especially among subgroups within the elderly population (Siegel, 1996; U.S. Bureau of the Census, 1996). One of every six (17.0%) older persons was poor (below poverty level) or near-poor in 1998. (USDHHS, 1999b). Among older persons, women, African-Americans, persons living alone, very old persons, those living in rural areas, or those with a combination of these characteristics tend to be at greater risk of poverty (Siegel, 1996). In fact, divorced African American women who are 65-74 years of age were among the poorest of the poor in 1998, with a poverty rate of 47% (Federal Interagency Forum on Aging Related Statistics, 2000);
- *Living Arrangements.* Living arrangements are closely tied to income and, specifically, being at risk of poverty, health status, and the availability of caregivers (Federal Interagency Forum on Aging Related Statistics, 2000). In 1998, the majority (67%) of older Americans lived in the community in a family setting with spouses, children, siblings, relatives or nonrelatives; however, this proportion decreases with age. Almost one-third of those in the community lived alone and were more likely to be at risk than those who lived within family settings. While only a small percentage (4.2% or 1.43 million) of older persons lived in nursing homes in 1996, this percentage increases dramatically with age (USDHHS, 1999b). The majority of nursing home residents have such mental disorders as dementia, depression, or schizophrenia. Moreover, a recent Supreme Court decision, *Olmstead v. L.C.*, requires states to provide community-based services for persons with disabilities—including mental disorders—who would otherwise be entitled to institutional services, provided that community placement is appropriate, the affected persons do not oppose such a plan, and the placement can be reasonably carried out considering the resources of the state. Thus, mental health services must be designed to fit the needs of persons irrespective of their living arrangements.; and
- *Physical Health.* The majority of older persons report that they are in good health compared with others their age (APA Working Group on the Older Adult, 1998). However, most older persons have at least one chronic condition and many have multiple conditions such as arthritis, hypertension, heart disease, cataracts, or diabetes. In 1994-1995, over 4.4 million (14%) had difficulty in carrying out activities of daily living such as bathing or eating and 6.5 million (21%) had difficulty with activities such as shopping, managing money, doing housework, or taking medication, many because of chronic disabling conditions. Although poor physical health is a key risk factor for mental disorders (Kramer et al, 1992), recent studies have established that all too often symptoms of mental disorders escape detection and treatment by health professionals who

are treating older persons for physical ailments. Yet, the prevalence of chronic conditions in the elderly population should be a cause for anticipating possible comorbidity. Understanding the relationships between physical and mental health is a central task in the assessment and treatment of older persons by health care professionals (APA Working Group on the Older Adult, 1998). Moreover, potential adverse effects of medications, and specifically of drug interaction effects, are more likely among older persons, who tend as a group to use more prescription drugs, and should thus be a point of routine inquiry by health care professionals.

Successful Aging: Stressors and Adaptations

During the normal process of aging, older persons encounter stressors, such as retirement from a career or job, that may trigger both appropriate and distorted emotional responses. However, exposure and adaptation to these stressors varies with each person's economic resources, gender, ethnicity, level of education, life experiences, and perception of the meaning of the stressor itself. Pearlin and Skaff (1995) view older persons as confronted with two main types of stressors: life events and chronic strain, and their conceptualization is used in discussing these events.

The life events thought to be the most stressful are those that are unscheduled or undesired rather than those that can be planned for, such as a lack of an occupational role in retirement. As older persons confront undesired life events, there is an intricate balance of physical, social, and emotional forces, any one of which can

upset or involve the others. The initial event or primary stressor may lead to secondary stressors such as those described below:

- *Health-Related Events.* Health events such as a fall or a heart attack have been found to have a more depressive effect than many other types of events (Ensel, 1991; Murrell et al., 1988). For example, an elderly woman falls and breaks her hip, which necessitates hospitalization and surgery. Upon her return home, she finds that stress proliferates as she needs help with shopping and the maintenance of her home, experiences economic strain, and is unable to participate in leisure activities. It may be difficult to distinguish the depressive effects of acute health events from the chronic problems that result from these events; and,
- *Loss of loved ones.* The loss of relatives, friends, or a spouse during the advanced years of life can result in loneliness, an increased sense of vulnerability, increased isolation, and other psychosocial dilemmas. Frequently adding to the emotional toll of bereavement is the need to also make practical decisions--where to live, what to do about the family home and possessions (Butler et al, 1998). Social roles may change, as can connections to friends, family, and community. Some persons may gain a new sense of independence and competence (Lopata, 1979; Wortman & Silver, 1992) as they adapt to these losses and changes. However, bereavement is a well-established risk factor for depression (Zisook & Shuchter, 1993; Zisook et al, 1994).

In addition to these unplanned life events, chronic strains may also impact the older adult (Pearlin & Skaff, 1995):

- *Strains related to their community or neighborhood of residence.* Relocation may place an older person in an unfamiliar environment. If the person remains in his old neighborhood, the older person may feel separated from previous support networks because familiar neighbors may no longer be there. A deteriorating or changing neighborhood may be upsetting, and access to transportation, convenience to shopping and medical care, and availability of a senior center or movie theater are all amenities whose absence may constitute ambient stressors. Also, growing frailty may leave people feeling less able to defend themselves against physical dangers;
- *Relationship strains.* These strains may occur in relation to family members. Older people may experience disappointments with regard to their children's situation in life, especially if it does not coincide with their own values or desires. For example, their children may not be raising their own children in a way that meets with the elder's approval, or may not be supportive or respectful of the older person. Additionally, assuming caregiving responsibilities for a spouse may lead to secondary stressors such as family conflicts, financial strains, or the loss of the caregiver's identity. Finally, financial hardship and chronic health problems may create undesired dependency on others; and,
- *Strains in the older person's immediate environment.* These are the ordinary logistical problems or "hassles" that

people face in their daily lives. Studies of the old-old who are living independently have focused attention on this class of stressors (Barer, 1993). They include such ordinary activities as getting out of the bathtub, managing the steps on a bus, seeing the fine print in a telephone book, changing a lightbulb, or removing trash for pickup. For people of advanced age these activities may be major obstacles to be overcome each and every day.

Historically, our society has held ambivalent views of aging and of older persons. Among these are many persistent myths that have resulted in the devaluation of the potential of older adults. For example, the myth that older adults are set in their ways and incapable of learning, growth, and change does not take into account the fact that declines in some intellectual abilities generally are not severe enough to cause problems in daily living. More importantly, such a myth disregards determinations by researchers that the aging brain has the capacity to make new connections, absorb new data and thus acquire new skills (Rowe and Kahn, 1998). Furthermore, it disregards recent analyses which have suggested that creativity is not lost in old age (Cohen, 2000).

Yet another myth incorrectly suggests that lack of productivity is associated with old age. It miscasts older people as no longer capable of being productive on the job, of being socially active, or of being creative. Instead, older adults are cast as disengaged, declining, and disinterested in life. However, most older people tend to remain actively concerned about their personal and community relationships and many are still employed (APA Working Group on the Older Adult, 1998; Butler et al, 1998; Rowe and Kahn, 1998).

Acknowledging such myths is important in order for communities to support the self-esteem of older persons, their ability to live and work successfully, and their ability and motivation to maintain and improve the quality of their lives. Health, mental health, human services, and aging programs will be miscast if old age is perceived to be a time of inevitable isolation, decline and decay. Thus, mental health and aging professionals must be attentive to their biases and stereotypes if they are to effectively serve older persons (Roff and Atherton, 1989).

Recent research helps to further debunk ageist stereotypes by revealing that older persons as a group cope and adapt well and tend to be very resilient. This resilience is comparable to and sometimes exceeds that of their younger counterparts (Foster, 1997). Older persons also appear to have the capacity for constructive change, even in the face of mental illness, adversity, and chronic mental health problems (Cohen, 1988).

Whether older persons can face stressors, function well, and maintain their well-being appears to depend upon the resources that older persons possess and use. Several key adaptive mechanisms used by older persons have been identified (Pearlin and Skaff, 1995):

- *Coping.* Coping involves managing situations giving rise to stress, managing the meaning of these situations, and managing the stresses resulting from these situations. Older persons tend to use “emotion-focused coping,” a strategy that refers to managing the meaning of the situation or controlling the symptoms of stress rather than trying to manage the stressful situation itself (Chiriboga, 1992; Martin et al., 1992). Some of the stressors experienced by

older people such as frailty and chronic health problems are not easily modified by problem-solving; thus, older persons may cope by reshaping the meaning of the situation or restructuring their priorities. For example, an elderly woman who has painful arthritis and cannot tolerate the side effects of the medication is very disappointed that she can no longer play the piano. She may choose to continue to enjoy music and to find satisfaction by coaching students. Older persons also cope by universalizing their situation and comparing themselves with others, using family and friends as reference points. This strategy helps them to see that hardships are not aimed solely at themselves, but also impact their peers;

- *Social support.* Social support includes both concrete and emotional assistance provided by families, friends, neighbors, and volunteers or by acceptable private or governmental organizations, including religious organizations and senior centers that have high levels of legitimacy within their community and their peer group. For example, older persons may be active in church groups, supported by a circle of friends, or may receive concrete support in the form of homemaker or chore services and home-delivered meals when needed. An extensive body of research has shown that social support is an important predictor of good physical and mental health, life satisfaction, and reduced risk of institutionalization among older adults (LaGory & Fitzpatrick, 1992; Forster & Stoller, 1992; Sabin, 1993; and Steinbach, 1992). Social support may also buffer the adverse effects of various stressors common to aging (Feld & George, 1994; Krause & Borawski-Clark, 1994). Researchers point out

however, that the effectiveness of social support depends on the situation, the person, and his or her needs; thus, goodness-of-fit is essential. Unneeded, unwanted, or the wrong type of support may reduce older persons' independence or self-esteem (Pearlin and Skaff, 1995; Rowe and Kahn, 1998); and,

- *Sense of control.* Many older people are able to maintain a sense of mastery over the circumstances of their lives and this sense extends into late life as a resource important to well-being (Rodin, 1986). Those working with older persons can reinforce this sense of control by respecting their right to make decisions or to initiate, withdraw, or terminate treatment (APA Working Group on the Older Adult, 1998). A sense of control has also been found to be an effective buffer mitigating the impact of stressors (Cohen & Edwards, 1989; Krause & Stryker, 1984). For example, in Alzheimer's caregivers, a strong sense of mastery protects the caregiver against the stressors arising in the daily care of the patient (Skaff, 1991).

In their study of older persons who are functioning at a high level, Rowe and Kahn (1998) found three characteristics that define successful aging: (1) low risk of disease and disease-related disability; (2) high mental and physical function; and (3) active engagement with life. And they found that successful aging is most fully represented by the *combination* of all three of these factors. However, Pearlin and Skaff (1995) remind us that the outcome of successful aging must be examined not only in relation to the above three criteria, but with respect to the social, economic, and cultural conditions to which people are exposed as well as their adaptive mechanisms. This psychosocial perspective assures that we acknowledge the

diversity of older persons and view each individual as having unique interactions with his or her environment.

Ideally, aging is a dynamic process in which an individual confronts the stressors and challenges of later life not as a passive victim but as an actor drawing on resources developed over a lifetime. Even the impact of losses that may be irreversible, such as those that involve personal health and the deaths of significant others, can be minimized by restructuring personal meaning, with the availability and use of social supports, and a sense of mastery over important circumstances of life (Pearlin & Skaff, 1995).

The Mental Health of Older Americans

Most older adults enjoy good mental health, but almost 20% of those who are 55 years and older experience specific mental disorders that are not part of "normal" aging. The most common disorders, in order of prevalence, are anxiety disorders, such as phobias and obsessive-compulsive disorder; severe cognitive impairment, including Alzheimer's disease; and mood disorders, such as depression. Schizophrenia and personality disorders are less common (USDHHS, 1999a).

There are suggestions, however, that mental disorders in older adults are underreported. One study, for example, estimates that 8-20 percent of older adults in the community and up to 37 percent of those who receive primary care experience symptoms of depression. It is particularly noteworthy that the rate of suicide, frequently a consequence of depression, is highest among older adults (Hoyert et al, 1999). In addition, approximately two-thirds of those in nursing homes suffer from mental disorders,

including Alzheimer's and related dementias (Burns et al, 1993).

Older adults with mental illness vary widely with respect to the onset of their disorders. Some have suffered from serious and persistent mental illness most of their adult life, while others have had periodic episodes of mental illness. A substantial number experience mental health disorders or problems for the first time late in life—problems which are frequently exacerbated by bereavement or other losses which tend to occur in old age. Yet another variable is severity. Mental disorders can range from problematic to disabling to fatal.

Clearly, then, treatment and prevention efforts must take into consideration the range of experiences and needs of older adults with mental disorders in order to provide appropriate care for older persons at all points of the mental health continuum. But there are major barriers to overcome.

For example, assessment and diagnosis of mental disorders in older people can be particularly difficult (USDHHS, 1999). Older people with mental disorders may present with different symptoms than younger people—emphasizing somatic complaints rather than psychological troubles (USDHHS, 1999). In addition, it can be hard to determine whether certain symptoms—like sleep disturbances—are indicative of mental disorders or another health problem (Lebowitz et al, 1997). Moreover, there is significant underdiagnosis of mental illness among primary care providers. A survey of primary care physicians found that just over half felt confident in diagnosing depression, and only 35% felt confident in prescribing antidepressant medications to older people. (Callahan et al, 1992).

Treatment also presents a number of challenges. Older people metabolize medications differently due to physiological changes, which may make them more vulnerable to side effects of psychoactive medications. They are also likely to be taking medications for other disorders, placing them at risk for unintended medication interactions. Older adults with cognitive deficits may also have difficulty managing medications or remembering appointments (USDHHS, 1999). Psychosocial interventions can be an important component of effective treatment, but lack of transportation may make it difficult to get to counseling appointments or support group meetings. As noted earlier, there is convincing evidence that depression and other mental disorders typically are unrecognized and thus fail to be treated by primary care providers.

Efforts to prevent mental disorders among older adults have also been inadequate. At this time, there is no national agenda to promote mental health and prevent mental and behavioral disorders (Center for Mental Health Services [CMHS], 2000). Present knowledge about effective prevention techniques is not as extensive as is our understanding of the diagnosis and treatment of mental disorders. Preventing mental disorders before they occur—or primary prevention—requires some understanding of their etiology, risk factors, pathogenesis, and course (USDHHS, 1999). As noted in a 1994 Institute of Medicine (IOM) report, the base of knowledge about prevention for some disorders is considerably more advanced than for others (Mrazek & Haggerty, 1994). Among older adults, for example, the largest pool of primary prevention research focuses on depression that develops late in life (USDHHS, 1999). Moreover, there has been a history of disagreement within the mental health

community about how to define prevention (Mrazek & Haggerty, 1994). Nonetheless, there has been a growing awareness that certain psychosocial factors can heighten the risk of developing mental disorders or exacerbate them when they occur. Further research is needed on the prevention of mental disorders in older adults. In addition, greater effort must be devoted to translating research advances that have already been made into practice.

Delivery of Mental Health Services to Older Adults

While there is strong evidence of the need by older persons of mental health services, older adults have made limited use of these services (Demmler, 1998). It is estimated that only half of all older adults who acknowledge mental health problems actually are treated by either mental health professionals or primary care physicians (Blazer et al, 1988). A very small percentage of older adults – less than 3% -- report seeing mental health professionals for treatment. This rate of utilization is lower than for any other adult age group (Lebowitz et al, 1997). Older Americans account for only 7% of all inpatient services, 6% of community-based mental health services, and 9% of private psychiatric care, despite comprising 13% of the U.S. population (Persky, 1998). And, in a study examining community mental health services and older persons, 40 percent of community mental health providers identified non-health-related services such as transportation and home help services as unmet needs, suggesting that the comprehensive needs of these persons are not being met (Estes et al, 1994).

Unfortunately, individual and systemic barriers thwart the provision and receipt of adequate care to older persons with mental

health needs. The following are among the barriers most frequently noted in the literature (Birren, et al, 1992; Butler et al, 1998; Estes, 1995; NCOA, 1999; Persky, 1998):

- *Stigma.* Stigma surrounding the receipt of mental health treatment affects older people disproportionately (USDHHS, 1999a), and as a result, older adults and their family members often do not want to be identified with the traditional mental health system. The stigmatization of mental illness has deep, historical roots dating back to Descartes' conceptualization of the separation of mind and body. During centuries past, the stigma surrounding mental illness was reinforced in both European and American societies by fears about deviant, violent behaviors. While considerable progress has been made to achieve increased scientific understanding of mental disorders, the social meanings attached to mental illness and the treatment of most conditions continue to place the moral identity of the individual at risk of degradation. Today's older Americans grew up during decades in which institutionalization in asylums, electroshock treatments, and other treatment approaches, understandably, were regarded with fear. Moreover, among older persons who tend to be defined in large measure by their pre-retirement work roles and by any ongoing community involvement, the possibility of becoming more vulnerable, falling victim to ageist perspectives, and then being doubly jeopardized and demeaned can only raise the specter of a loss of dignity and of place in society.
- *Denial of problems.* Anxiety, depression, memory loss, and dementia

may complicate the ability of older persons to recognize that they have a mental health problem for which they should seek help. However, mental health problems may also be denied. Health professionals, family members, and policy makers may internalize society's negative attitudes toward older persons and give superficial attention to or be dismissive of their problems. Moreover, as older persons themselves become more dependent, they may fear a loss of control over their lives and thus become resistant to the idea that they may need help;

- *Access barriers.* Access to services by older persons is thwarted in a number of ways. Affordable, accessible transportation to services may be unavailable. For some older people, the cost of mental health treatment—especially prescription drugs—may be too expensive. Older persons who live alone are a particularly hard-to-reach population. They may live in rural areas that do not have adequate mental health services, or they may live near services but far from family members. They may not be able to come to an office as a result of their physical frailty. The isolation of older adults means that outreach workers who go into the home may be needed to build relationships and provide day-to-day monitoring and support. Outreach activities may also involve approaching the family of the elder, but the only “family” may be neighbors or a service coordinator; for example, in a public housing project;
- *Funding issues.* Typically, funding streams for aging and mental health are separate and limited. As in other fields of health and human services, the separation of funding streams can

complicate efforts to collaborate and can result in the fragmentation of services. Perhaps of greater concern to most service providers, families, and older persons with mental health problems is the fact that current funding for both of these systems is not ample enough to cover the mental health service needs of the elderly population. While Medicare and Medicaid provide insurance coverage for older person's mental health needs, these benefits are limited;

- *Lack of collaboration and coordination.* The mental health and aging networks are separate and distinct in most state and local communities across the nation. Coordination issues are thus as relevant in mental health and aging as in other fields of health and human services. Although interdisciplinary practice and coordination have long been advocated, there has been a continuing need to emphasize their importance and to ensure that they occur. Interdisciplinary collaboration and the coordination of multiple services are especially essential in work with elders who are poor, have limited English proficiency, or physical health problems.
- *Gaps in services.* While the mental health system has tended to not serve older persons in quite the same proportion as children or adults, the Aging Network has tended, in relation to mental health and aging, to serve primarily persons with Alzheimer's disease. Even when community-based service providers have the capacity to respond to the mental health concerns of older adults, they frequently are challenged by the lack of adequate reimbursement and by the lack of a complement of staff needed to provide appropriate, culturally sensitive

prevention and treatment services to minority elders and continuing care to those who are chronically mentally ill.

- *Workforce issues.* There are national shortages of health and social service professional and paraprofessional personnel who have expertise in providing geriatric mental health care. Shortages across disciplines are sure to become even more problematic as the population ages and the demand for specialized mental health services increase. For example, presently, there are 200-700 geropsychologists and 2,425 board-certified geriatric psychiatrists. One promising trend has been noted. General psychiatrists are seeing a greater proportion of geriatric patients in their practices. In 1996, 18% of psychiatrists had a geriatric caseload in excess of 20%; this represented an increase of 148% and 25% from 1982 and 1989 respectively (Colenda et al, 1999). However, this does not come close to meeting the projected need for at least 5,000 in each psychiatry and psychology specialty (Jeste et al, 1997). Moreover, less than 5 percent of members of the National Association of Social Workers identify their primary focus of practice as Aging (Gibelman & Schervish, 1997), and only 15 percent of clients of direct service social workers in mental health are 60 years of age and older, although the proportion of elders estimated to have mental health problems is 20-22 percent (Gatz & Smyer, 1992). A survey of state home health associations found low to moderate availability of home health aides who serve primarily older adults. Despite the fact that many older adults in need of home health services have complex physical and mental problems, few home health

workers had any aging-related education (Dawson & Santos, 2000).

Thus, there is a critical need for training opportunities for those entering and currently working in the area of mental health and aging. Surveys suggest that 53 percent of graduate social work programs have no fieldwork faculty in aging and 21 percent have no classroom faculty (Dye, 1993; Mellor & Solomon, 1992). And, of 637 nursing baccalaureate programs, only about 14 percent have required training content in gerontological nursing (Dye, 1993; O'Neal, 1994). Barriers to education include a lack of trained faculty, lack of training sites, student and faculty resistance, curricula that are too full, and a view of the elderly as a low-priority population.

- *Organized consumer support.* At the state, local and national levels, there has been recent success in organizing consumer groups that include older persons who are consumers of mental health and/or substance abuse services, their families, and advocates, but expansion of these efforts is needed.

Although these important service delivery issues and the critical challenges mentioned at the outset of this chapter continue to remain concerns, there have been strong, though intermittent, efforts to give heightened attention to mental health and aging issues and to develop and provide programmatic and policy responses.

Advances in Mental Health and Aging

Despite the lack of a sustained nationwide emphasis on mental health and aging, there have been a number of notable endeavors and initiatives and a strong and abiding commitment to advance the agenda among a cadre of leaders in mental health and aging. In 1973, a groundbreaking text, Aging and Mental Health, was published. Co-authored by geropsychiatrist Dr. Robert Butler, the first Director of the National Institute on Aging and the author of the Pulitzer Prize winning treatise on aging and older persons, Why Survive?, and Myrna Lewis, a psychiatric social worker whose specialty is work with older persons, it cast a spotlight on aging and mental health issues. The nation's aging and mental health policy and practice landscape were drawn for public and professional discussion, the latter pursued in earlier years by a small but influential, multidisciplinary group of experts.

At the federal level, this was followed by the establishment in 1978 of the President's Commission on Mental Health, due to the personal advocacy of First Lady Rosalynn Carter. The Commission appointed a task panel specifically to study the needs of older Americans. Among the recommendations of the panel were expanded outreach efforts to elders with mental health needs; enhancing Medicare reimbursement for community-based mental health services; expansion of training programs for geriatric mental health professionals; improved access to home health care; and accelerating scientific research into dementia. The task panel set forth an agenda for mental health and aging that continues to resonate today.

Since then, there has been a wide range of innovations and initiatives, such as the

identification and dissemination of key program and policy issues, conduct of important research studies, the development of guidelines for clinical practice, and the formation of national, state, and local coalitions and older adult consumer groups. Many of these efforts have been supported and implemented with funds from foundations and federal, state, and local governments. More recent developments, a few of which are highlighted below, serve as a foundation for a significant, sustained, and concerted effort to address the mental health needs of older people:

Collaboration

Coalition Building. There is a growing number of mental health and aging coalitions engaged in efforts to improve the availability and quality of mental health preventive and treatment services to older Americans and their families through education, research, and increased public awareness. At the national level, the National Coalition on Mental Health and Aging (NCMHA), which has been in existence since 1991, includes in its membership thirty-seven national organizations. In 1994, the Coalition published a practical guide on how to build state and community mental health and aging coalitions (NCMHA, 1994). The Coalition has developed an Action Plan for mental health and aging utilizing the work that was done at the Coalition's conference meeting in 1999 (NCMHA, 1999).

During the mid-1990's the Substance Abuse and Mental Health Services Administration (SAMHSA) funded two coalition-building initiatives that were implemented by the American Association for Retired Persons (AARP) and by the National Association of State Mental Health Program Directors (NASMHPD) for the purpose of identifying,

designing, and training networks of older adults, mental health service providers, and advocates to build mental health and aging coalitions at the state level. The goal of these coalitions was to increase public awareness of mental health and aging issues while improving the provision of mental health services to older adults (NTAC, 1997). Again, in 1998, SAMHSA funded a similar project implemented by AARP. This activity included both state and local coalitions and both primary care and substance abuse in the coalition process. As a result of these and other independent efforts, there are approximately 35 state and 10 local coalitions. Furthermore, SAMHSA is currently funding a project through AARP that will review and analyze the results of earlier coalition-building activities to identify factors that contribute to successes and failures. Technical assistance materials will be developed to facilitate coalition-building in additional states;

Medicare Coordination of Care Demonstration. As a result of the Balanced Budget Act of 1997, HCFA is conducting a demonstration to test the effectiveness of coordinating care for chronically ill fee-for-service Medicare beneficiaries. The study will examine the impact of coordination on clinical outcomes, client satisfaction, quality of life, and the appropriate use of covered services (HCFA, 2000). The demonstration will be conducted in at least nine sites and will focus on chronic conditions which represent high costs to Medicare, and which are amenable to care management. Four of the eleven targeted conditions are mental health conditions including psychoses, Alzheimer's disease, alcohol and drug abuse, and depression. Participating beneficiaries will receive interventions to improve self-care, identify complications early, avoid hospitalization, and better coordinate treatments and medications for

multiple conditions. The demonstrations will be independently evaluated. Demonstration awards will be made in early 2001;

Consumer Involvement

Consumer Involvement. In May 1998, older mental health consumers ranging in age from 60-87 gathered in Washington DC to organize a group to voice their concerns and to promote awareness of the need for home- and community-based services. This meeting was convened by the Judge David L. Bazelon Center for Mental Health Law and financed by the Center for Mental Health Services (CMHS), the Retirement Research Foundation, and the Nathan Cummings Foundation. The conference brought together 31 consumers from 27 states and representatives from advocacy organizations and caregivers. In May 2000, a second meeting of these older consumers, also convened by the Bazelon Center and supported by CMHS, resulted in the formation of the Older Adult Consumers of Mental Health Alliance (OACMHA). The main purpose of OACMHA is to improve the quality of and access to mental health services for older adults. OACMHA plans to organize state and local chapters that will advocate for older persons with mental health needs (Bazelon Center, 2000);

Public Awareness and Education

Surgeon General's Initiatives: In December, 1999, *Mental Health: A Report of the Surgeon General* was released (USDHHS, 1999a). This groundbreaking report, the result of collaboration between the Center for Mental Health Services and the National Institute of Mental Health, provides an up-to-date review of scientific advances in research on mental health and mental illness and calls upon communities, agencies, policy makers, employers, and

citizens to take concerted action. The report includes a chapter entitled, “Older Adults and Mental Health” that reviews normal developmental milestones of aging, discusses mental disorders in older persons, identifies mental health interventions, and points out obstacles in the delivery of services. A summary of this chapter is included in the Appendix of this report.

Furthermore, the Surgeon General’s report also documented the extent to which members of diverse ethno-cultural groups are less likely to receive appropriate mental health care than are members of the population as a whole and the extent of unmet mental health needs. As a result, a supplement to the first report that will focus on mental health and ethnic minorities is currently being written by staff from SAMHSA’s Center for Mental Health Services, the National Institute of Mental Health, and the Office of the Surgeon General. It will summarize available knowledge on the unmet need for mental health care among minority groups across the life span, including minority older adults, and discuss promising directions for improved research and services.

Also in 1999, the Surgeon General unveiled *The Surgeon General’s Call To Action To Prevent Suicide*. This document sets forth a number of steps that can be taken by individuals, communities, organizations and policymakers to prevent suicide, and served as a precursor for the National Suicide Prevention Strategy, which the Surgeon General plans to release in 2001;

White House Mini-Conference on Emerging Issues in Mental Health and Aging. In February, 1995, a Mini-Conference sponsored by the National Coalition on Mental Health and Aging was held prior to the White House Conference on Aging

(WHCoA). A set of resolutions was developed and introduced at the WHCoA (Gatz, 1995) and served as the primary document from which the final Mental Health and Aging resolution evolved. Furthermore, the white papers that were prepared for the Mini-Conference were published under the title *Emerging Issues in Mental Health and Aging* (Gatz, 1995);

White House Conference on Mental Health. On June 7, 1999, the first White House Conference on Mental Health was held in Washington D.C. This conference brought together consumers, advocates, researchers, and business and medical professionals to discuss mental health issues that affect over 50 million Americans. The conference examined issues such as mental health research, pharmacology, service delivery, and insurance coverage;

Education Toolkit. SAMHSA and the National Council on Aging (NCOA), with the assistance of the Administration on Aging, are developing an Education Kit that will enable aging services organizations such as senior centers, meal programs, and senior housing organizations to conduct educational programs for staff and clients on substance abuse and mental health issues for older adults. This kit will include educational materials (e.g. video, brochure), a step-by-step implementation guide, and a Community Linkages Manual containing information about 16 local and state programs that exemplify best practices with regard to the establishment of linkages between aging and substance abuse and aging and mental health organizations. The kit is scheduled for release in 2001;

Nursing Home Comparisons. As discussed later in this report, many nursing home residents suffer from mental disorders. In an effort to increase nursing home

accountability, HCFA has posted data about the number and types of staff at individual nursing homes, each facility's care and safety record, records of deficiencies found by state survey agencies, facility ownership, and ratings of each facility in comparison to state and national averages on the new Nursing Home Compare Internet site at www.medicare.gov. The information provided on this site allows consumers to search by zip code or by name for information on each of the 16,500 nursing homes participating in Medicaid or Medicare and to consider the comparative potential for quality of life and mental health as a consequence of care provided in various nursing homes;

Seniors and the Internet. One way that older Americans can keep abreast of health information and communicate with family and friends is by using the Internet. Older persons have made it clear that they can use the Internet and that they do not want to be left behind in the Information Age. Several studies have examined computer training programs for older adults. One of these, a Train-the-Trainer project implemented by the Setting Priorities for Retirement Years (SPRY) Foundation (1998) found that the training had a positive impact on seniors' confidence in using computers and the Internet, in conducting consumer health information searches online, and in sharing health care information with doctors, families, and friends. Another study (Cody et al, 1999) found that those who learned to surf the Internet had more positive attitudes toward aging, higher levels of perceived social support, and higher levels of connectivity with others. This suggests that more attention needs to be paid to the mental health implications of connectivity via computers and the Internet in the older adult population;

Research

Mental Health and Aging Research. Three major multi-site studies are currently evaluating strategies for the treatment of mental disorders in older primary care patients. The National Institute of Mental Health supports the Prevention of Suicide in the Primary Care Elderly Collaborative Trial (PROSPECT) study (Bruce & Pearson, 1999), and the Hartford Foundation and the California HealthCare Foundation are funding Improving Mood: Promoting Access to Collaborative Treatment for Late Life Depression (IMPACT) (Hartford Foundation, 2000a). These studies are comparing the effectiveness of traditional models of care with service delivery models in which treatment for depression and other risk factors for suicide is delivered within primary care practices by mental health specialists.

Through the Primary Care Research in Substance Abuse and Mental Health for Elders Study (PRISMe), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Department of Veterans Affairs, the Health Resources and Services Administration, and the Health Care Financing Administration are evaluating the relative effectiveness of integrated mental health services delivered to older persons in the medical care setting. They are comparing the effectiveness of these services versus the referral of these same persons to mental health professionals outside the primary care setting. All of the foregoing studies are testing the effects of interventions in relation to an array of outcomes including functioning, general health outcomes, health-related quality of life, and health care use (Harvard Coordination Center, 2000).

Another important large-scale multi-site study, the Clinical Antipsychotic Trials of Intervention Effectiveness project (CATIE) (NIMH, 2000), is designed to evaluate the clinical effectiveness of atypical antipsychotics in the treatment of 450 outpatients with Alzheimer's disease. Funded by NIMH, the study is a randomized, parallel group, double-blinded study comparing treatment using three antipsychotic drugs and a placebo in Alzheimer's patients with delusions or hallucinations and/or clinically significant aggression or agitation;

Outcome and Performance Measures. Funded by SAMHSA, the State Indicator Pilot Grant project involves 16 state mental health authorities in the piloting of 32 performance measures over a three-year period. Indicators, focused on mental health service provision in the participating states, cover the four domains of access, quality or appropriateness, outcome, and plan/management. Data are gathered by age, gender race/ethnicity, and diagnosis. State grantees will report on these performance indicators in 2001. There are plans to complete a comparative analysis of the data on the states.

The New Hampshire (NH) Dartmouth Outcomes-Based Treatment Plan (OBTPA) for Older Adults Tool Kit (NH-Dartmouth Psychiatric Research Center, 1999) developed with support from the New Hampshire Health Care Fund, Community Grant Program and the Robert Wood Johnson Foundation includes a variety of instruments that integrate assessment, treatment planning, and outcome measurement for older adults in the community with chronic mental health concerns. The tools included in the kit consist of an Assessment Toolkit, a Treatment Planning Guide and Outcomes

Checklist. This instrument was piloted in three states and is currently being used and administered statewide through New Hampshire's Office of Community Mental Health Administration;

Workforce Issues

Education and Training. Under the sponsorship of the John A. Hartford Foundation, an Aging and Health Program is funding a variety of initiatives in academic geriatrics and training (Hartford Foundation, 2000b). In 1994, the Foundation implemented a Geriatric Interdisciplinary Team Training Program to train clinicians in teamwork and collaboration, with the aim of improving the effectiveness of interdisciplinary care. By 2000, over 2,500 trainees in 17 disciplines had completed the program. The Foundation has also established an Institute for the Advancement of Geriatric Nursing Practice at New York University's School of Education's Division of Nursing to train nurses in geriatrics. Outstanding junior medical faculty conducting aging research are supported for a three-year period by individual awards from the Foundation's Paul Beeson Physician Scholars in Aging Research Program. Finally, the Foundation supports the Strengthening Geriatric Social Work Initiative -- an effort to build a consensus on standards for geriatric social work education, create a cadre of faculty members committed to research and teaching about the needs of older adults, and developing geriatric field training sites (Hartford Foundation, 2000c).

In addition, the Bureau of Health Professions, Health Resources and Services Administration, has issued a series of reports outlining a national agenda for geriatric education. These reports detail the state of the art and set forth recommendations for

improving geriatric education for a wide variety of professions, including dentistry, nursing, medicine, public health, and social work (Bureau of Health Professions, 1995);

The HCFA Nursing Home Staffing Study. A groundbreaking study released by HCFA in August, 2000 indicated a strong association between staffing levels in nursing homes and quality of care (De Parle, 2000). For the first time, it points to a clear, statistically valid relationship between staffing levels and quality of care. It found that, on average, serious erosion of quality of care occurs when care falls below certain minimum ratios – 2 hours per resident day for nurses’ aides, 45 minutes per resident day for total licensed staff (RNs and LPNs), and 12 minutes per resident day for RNs. More than half of the nation’s nursing facilities (54 percent) were below the suggested minimum staffing level for nurses’ aides, nearly one in four (23 percent) were below the suggested minimum staffing level for total licensed staff, and nearly a third (31 percent) were below this same level for RNs. This has particular mental health implications because many nursing home residents suffer from mental disorders. Future plans call for the expansion of research efforts beyond the initial study;

Clinical Practice. Several professional organizations have convened consensus conferences and issued practice guidelines for the diagnosis and treatment of late-life depression (Katz, 1996) and Alzheimer’s disease and related dementias (Rabins, P, 1998; Small et al, 1997). The American Association for Geriatric Psychiatry (AAGP) has produced a set of guidelines for primary care physicians to use in determining whether to refer older people with depression to a geriatric psychiatrist.

The group recommends referral when there is uncertainty over the diagnosis, when symptoms are especially severe, when the patient is at high risk of harming himself or others, when treatment is complicated, or for maintenance management (AAGP, 1997). Furthermore, Volume 29, No. 1 of *Professional Psychology: Research and Practice*, published by the American Psychological Association, contains a series of articles that review the knowledge base needed in work with older adults (APA Working Group on the Older Adult, 1998). The articles include discussions about training in geropsychology (Qualls, 1998), and provide guidelines for the assessment of competency and capacity of the older adult (Baker et al, 1998);

As the discussion in this chapter notes, the older adult population has unmet mental health needs that are expected to rise in number as the number of older persons grows dramatically over the next 30 years. The chapters that follow discuss supportive services, primary care, and mental health services in relation to older persons at risk of or contending with mental disorders. Considerable attention is given to the variety of community-based resources that are already acceptable access points for information, referral, and supportive assistance among older adults and their families. Provided that system barriers can be removed, these may be particularly helpful to persons with several types of mental health needs, including persons with serious mental illness who previously resided in institutions; those who develop serious mental illnesses later in life; and those who have mental health problems, but have not been diagnosed with serious mental illness.

COMMUNITY MENTAL HEALTH SERVICES

The mental health system is comprised of a full spectrum of public and private sector, community-based, and institutional services.

The specialty mental health services system consists of private mental health providers funded by private insurance and consumers, and publicly and privately owned providers funded by states, counties, and municipalities. Institutional or facility-based mental health services include inpatient care (acute and long-term), residential treatment centers, and therapeutic group homes. Community-based services include outpatient psychotherapy, partial hospitalization/day treatment, crisis services, case management, and home-based and “wraparound” services. These services are often tailored to respond to the specific needs of a community; for example, programs in rural areas may offer mental health outreach programs. Many community-based organizations, as part of their charter, provide services regardless of an individual’s ability to pay. Unfortunately, community mental health organizations generally tend to underserve older people (Jeste et al, 1999).

Historically, public and private funding for adult mental health services has been targeted toward costly, intensive institutional care. However, over the last several years national and state policies to increase home and community-based health and human services, such as efforts to further downsize psychiatric hospitals, have reflected a continuing interest in shifting

clients to community mental health services (Demmler, 1998). As an example, the Nursing Home Reform Act of 1987 specifically seeks to decrease the likelihood of transinstitutionalization, or the recycling of former mental patients into other forms of institutional care. To accomplish this, it mandated Pre-Admission Screening and Annual Resident Review (PASRR) for all potential and existing nursing home residents. PASRR helps to ensure adequate identification of the mental health needs of nursing home residents and to exclude from nursing homes individuals who are more appropriately treated elsewhere—either in the community or in another type of institution (USDHHS, 1999). Moreover, over the last two decades, due mainly to court decisions calling for the care of persons with mental illness in least restrictive environments, states and communities have sought to reorder their service priorities away from institutional care and toward the provision of community-based services in more home-like settings.

This chapter acknowledges this trend and focuses on these community-based mental health services. The principles of community mental health practice include the following: (1) services should be accessible and culturally sensitive to those who seek treatment; (2) services should be accountable to the entire community, including the at-risk and underserved; (3) services should be comprehensive, flexible, and coordinated; (4) continuity of care should be assured; and (5) treatment providers should utilize a multidisciplinary

team approach to care (Sands, 1991; Stroul, 1988).

How do community mental health systems address mental health needs?

Community-based mental health services address both acute and chronic mental health needs. Outpatient individual or group counseling aims to improve personal and social functioning through the purposeful use of psychotherapy, behavioral therapy or medications (CMHS & NIMH). Day treatment may be appropriate for persons who are able to reside in the community and receive therapeutic and rehabilitative care. Emergency services are available on a 24-hour basis through telephone crisis lines, walk-in treatment, or agencies specially designated to provide emergency care. Intensive outpatient services are provided through partial hospitalization for those with severe and persistent mental disorders (SPMD) and for others who may thus be able to avoid relapse and/or hospitalization (NCCBH, 2000).

Inpatient services, often provided at community hospitals, offer short-term intensive treatment. Psychosocial rehabilitation is offered to those with SPMDs who may benefit from any combination of educational or vocational training or other transitional services. Residential programs run the gamut from transitional facilities where individuals recently discharged from hospitals are treated and supervised in a community setting, to houses that provide an opportunity for independent living. And, specialized services may be geared to a particular group; for example, mental health outreach programs may focus on increasing access to care for older persons (NCCBH, 2000).

The need for primary and secondary prevention is also addressed by community mental health systems through early casefinding and intervention, education and community consultation, rehabilitation, and psychotherapy (NCCBH, 2000).

How are community mental health systems implemented?

Most mental health funding comes from state and local governments, Medicaid, and private insurance. Today, more than two-thirds of the funding for the overall *public* mental health system – nearly \$10 billion – is provided by the states, while Medicaid (with a mix of Federal, state and county contributions) provides an additional 22 percent. Medicare and other Federal spending provide about 7 percent, and private health insurance accounts for 4 percent (NCCBH, 2000). Chapter 5 describes Medicare and Medicaid mental health benefits in more detail. While Medicare provides only minimal support to the public mental health system, it is a major source of overall mental health funding.

Publicly funded services generally are intended to serve as a “safety net” for those who are unable to afford private insurance or to pay for services. The federal government augments state and local funding through the Community Mental Health Services Block Grant (CMHSBG). The CMHSBG is a joint Federal-state partnership that awards annual formula grants to the states to provide community-based mental health services to adults with serious mental illness and children with serious emotional disturbance. The Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Mental Health Services administers the CMHSBG.

In order to receive CMHSBG funds, each state must have a comprehensive state plan for the provision of mental health services and a mental health planning council that includes consumers of mental health services. Although states vary widely in the organization of their mental health service delivery systems, and in the degree to which these systems interact with providers of other types of services—e.g., primary care, social services, and the aging network, every state must have a plan which includes case management and encourages partnerships among a wide range of health, dental, mental health, vocational, housing, and educational services (CMHS, 1999). A state mental health authority oversees the state public mental health system by funding and organizing the range of services necessary for those with SPMDs, who are often indigent or have exhausted their health insurance (Lin, 1995). SAMHSA is responsible for federal oversight of state mental health plans and implementation reports.

Access to community-based mental health services is problematic for older people because of several factors, including the growing reliance on corporate mental health providers (i.e., managed care) and the attendant restrictions on specialty mental health care; the targeting of mental health services to specialized groups that tend not to include older Americans; and the emphasis public providers place on serving the severely chronically mentally ill (Estes et al, 1994). In addition, community mental health organizations often lack staff trained in addressing non-mental health medical needs, which are especially important for older adults. Many organizations also tend not to see treatment of those with cognitive impairments as part of their mission (Jeste et al, 1999).

Some mental health programs are successfully serving older adults. As an example, a program located in the Midwest facilitates collaboration between a university geriatric clinic, a neighborhood social services agency, and a small outpatient treatment center affiliated with a community hospital. Each of these agencies refers clients to the other two. Thus, a client referred to the university clinic can access health care and specialized geriatric programs. Or, those referred to the social service agency receive outreach services in the form of case management, transportation, or chore services. All staff have been trained to be culturally competent. And, an interdisciplinary team is involved in developing comprehensive objectives with clients. The three partners collaborate with many other community resources including Meals-on-Wheels, food banks, Section 8 housing providers, and legal services.

How effective are community-based mental health systems?

While a limited number of studies have examined the efficacy of different models of mental health care in managing geriatric clients in the community (Colenda & vanDooren, 1993); there are surveys that have focused on the nature and implementation of mental health services for older persons.

One of these surveys, conducted by the National Association of State Mental Health Program Directors' (NASMHPD) Research Institute, indicates the extent to which state mental health programs vary in their emphasis on the needs of older persons. Data from the State Mental Health Agency Profiling System gathered in 1996 indicated that older adults were priority clients for

only 4 of 47 responding jurisdictions; however, 13 out of 47 of the jurisdictions reported that other state policies target older adults. Accurate data regarding the percentage of CMHSBG funds spent on older Americans is not available because most of the states do not separate out older adults from the adult population when collecting their data. However, of the 13 jurisdictions that did gather specific data about the percentage of CMHSBG funds spent on services for older persons in 1999, nine indicated that these funds went towards elderly services, ranging from 2-36 percent. Additional 1999 state profile data indicated that 24 of 42 responding jurisdictions operate a specialized treatment unit/program for elderly clients and 19 of 42 jurisdictions reported that case management is mandated by the state mental health authority for those 65 years of age and older (NASMHPD, 1996).

A survey of mental health services in an eastern state (Bartels & Miles, 1996) documented both needs and unmet needs among older adults with mental disorders. From 1987-1994, the percentage of those over age 60 served by community mental health centers more than doubled from 6.9% to 14.4% of clients served. And, findings indicated a need for a 120% increase in the service capacity of community group homes. With respect to outpatient services, the greatest gaps were in psychiatric nursing, family services, partial hospitalization, and substance abuse treatment. Overall, the greatest single service gap was in home health services. A survey of home health care and residential providers found that one-quarter of their clients were judged to have a serious mental health problem, yet less than half of those in need received any treatment. Specific services most needed to address the unmet need were specialized psychiatric home care services, adult day

care and respite services, and case management services.

Similar findings were reported in a study by Estes et al (1994). They found that the greatest unmet needs reported by community mental health providers in five states were for non-health and in-home services. They also found that these providers were least likely to have established ties with agencies most directly serving the long term care needs of older persons —adult day care, nursing homes, and home care providers--thus influencing the ability of providers to offer a continuum of care to older adults living in the community.

In another survey, Light et al (1986) found that community mental health centers (CMHCs) that had specialized geriatric services or staff were able to lower access barriers for older clientele. And, in a companion piece, Lebowitz et al (1987) found that affiliation of a CMHC with an Area Agency on Aging was associated with more indirect services of all types (e.g., consultation and education), more sites where mental health programs were offered to older persons, and more provision of direct services such as Alzheimer's disease treatment and management, family support, and respite. Furthermore, the affiliated centers also had a 31 percent higher caseload of those age 60 or older when compared to nonaffiliated centers. However, the difficulties of forming these affiliations were also noted. For example, the geographic areas served by a community mental health center and an area agency on aging may not be the same. Moreover, the aging network and community mental health system have separate funding streams and different requirements with respect to use of their funding. Furthermore, each system reports to different government agencies at

the state level. Lastly, mental health professionals and aging professionals have distinct perspectives based on differences in their expertise and professional training (Lebowitz et al, 1987).

Finally, in examining the effectiveness of a specific intervention, Rabins et al (2000) reviewed the Psychogeriatric Assessment and Treatment in City Housing (PATCH) model, which combines the assertive community treatment and gatekeeper strategies to reach elderly persons living in urban public housing developments. The objective of this prospective randomized trial conducted between March 1993 and April 1996 was to determine whether a nurse-based mobile outreach program for SPMD elderly persons is more effective than usual care in diminishing levels of depression, psychiatric symptoms, and undesirable moves (e.g., nursing home placement or eviction). The intervention consisted of (1) training of indigenous building workers to identify those at risk for psychiatric disorder; (2) the identification and subsequent referral of potential clients by these workers to a psychiatric nurse; and (3) psychiatric evaluation and treatment in the residents' homes. Results at 26 months of follow-up indicated that residents receiving outreach and treatment at the intervention sites had significantly less

depression and behavioral disorder and fewer psychiatric symptoms than those at the nontreatment comparison sites. However, there was no significant difference between the groups in undesirable moves.

In summary, community-based mental health care involves a complex set of public and private services that are delivered through four systems: specialty mental health, primary care, human services, and the voluntary support network. There is great variation in the services that are offered in communities across the country. Access to community mental health services is problematic for older persons due to many factors, both individual and systemic such as stigma, inadequate financing mechanisms, lack of trained personnel, and the use of CMHSBG funds for those with SPMD. Survey findings indicate that while older adults have a tremendous need for services such as elder case management or psychiatric home care services, only a few states designate older adults as priority clients and only a minority of the states address the mental health needs of the elderly through specialized services for them. However, studies have also shown that the use of specialized geriatric services and staff as well as partnerships between the aging and mental health systems can increase access to services for older persons.

PRIMARY AND LONG-TERM CARE

Mental Health Services in Primary Care

When faced with mental health problems, older persons frequently turn first to their primary care physicians. Primary care encompasses services provided by general practitioners, family physicians, general internists, certain specialists designated as primary care physicians (such as obstetricians-gynecologists), nurse practitioners, physician assistants, and other health care professionals (USDHHS, 1999). Over half of older persons who receive mental health care are treated by their primary care physician (Lebowitz et al, 1997). Many reasons have been suggested for this pattern: going to a primary care physician does not carry the same stigma that specialty mental health services do; insurance policies typically encourage use of primary care as contrasted with specialty care; and primary care may be more convenient and accessible (USDHHS, 1999; Bane, 1997).

While many older people prefer to receive mental health treatment in primary care settings (Unutzer et al, 1997), the diagnosis and treatment in primary care setting of mental problems experienced by older persons tends to be inadequate (USDHHS, 1999). A significant number of older adults with depression are underdiagnosed and undertreated by their primary care physicians. According to several studies, as many as 70 percent of older adults had seen their physicians within one month of their

committing suicide (Cooper-Patrick et al, 1994; Courage et al, 1993; NIMH, 2000).

Many primary care physicians receive insufficient training in mental health (Bane, 1997) and in geriatric assessment and care. Because of this, physicians often attribute psychiatric symptoms either to changes associated with aging or concomitant physical disorders. Jeste et al (1999) cite several studies that found that many physicians believe depression is “understandable” or part of normal aging. The authors conclude that these findings suggest that “pervasive ageism” exists in medical practice (Jeste et al, 1999, p. 850). Along a related vein, physicians’ attitudes toward older people appear to shape their clinical approach. One survey of physicians found that those with the lowest negative biases toward older people also had greater knowledge of late-life depression. The same study found gaps in physicians’ general knowledge about aging (Zylstra & Steitz, 2000). Because physicians as well as elders frequently do not recognize the signs of mental illness, older adults are not apt to receive treatments that could alleviate their suffering. When steps are taken to treat them, it is not uncommon for the older person to receive inappropriate prescriptions of psychotropic medications (Kaplan et al, 1999).

There are also system barriers to providing mental health care in the primary care setting. Effective care for chronic mental disorders requires the ability to recognize these disorders in older persons and to provide proactive follow-up treatment—

neither of which primary care providers are well equipped to offer (USDHHS, 1999). Even in managed care plans, coordination of care can be challenging. In these plans, mental health care may be “carved-in”—i.e., directly integrated into the package of general health care services—or “carved-out”—i.e., provided through a contract with a separate specialty mental health organization that provides only these services and accepts the financial risk (USDHHS, 1999). In either arrangement it is important to coordinate mental and physical health care, because it is not uncommon for consumers with emotional problems to have physical health problems. Moreover, several reports on Medicaid managed care have indicated that there is room for improving the coordination of physical and mental health care, whether the programs are integrated or carved-out (GAO, 1999; Bazelon Center for Mental Health Law & Millbank Memorial Fund, 2000).

In response to these shortcomings, several models aimed at improving mental health services in primary care have been developed. These models call for either collaboration between mental health and primary care providers or for the integration of mental health providers into primary care settings. They are designed to address the issues of underdiagnosis and undertreatment of mental health problems in the primary care setting and in the community. In each instance, mental health professionals assist primary care physicians and their staff to educate patients, monitor and reinforce adherence to physician recommendations, coordinate treatment, and help patients with behavioral and lifestyle changes that can produce desired outcomes. The community-based models emphasize consultation with and the education of local care providers.

Gask et al (1997) describe these models as follows:

- *Attached mental health professional* – Many primary care practices have affiliations with a mental health professional, who may be a psychiatrist, nurse, clinical psychologist, social worker, or other mental health professional. The professional can screen for mental health problems, conduct therapy sessions, and monitor medication compliance. Coordination with the primary care staff does not tend to be as intensive or as integrated as in the consultation-liaison model described below;
- *Consultation-liaison* – This model emphasizes teamwork and regular collaboration between a mental health specialist and the primary care team. The goals are to treat milder mental disorders, selectively encourage referral of serious mental illness, and enhance the primary care physicians’ skills in the detection and management of mental illness; and,
- *Community mental health teams* – These teams operate within the community but are often based in psychiatric hospital services. They serve as a single point of referral for multi-disciplinary care with pooling and discussion of referrals. They provide assessments, education, and consultation in varying patterns of integration with primary care and community agencies.

How are the primary care and mental health models implemented?

The following are examples of how the three models have been implemented:

- *Attached mental health professional.* In an example of this model described by Katon et al (1996), patients (ages 18-80 years) diagnosed by primary care physicians as having major depression consent to antidepressant therapy. Prior to their first visit, patients are provided written materials and a video about depression, medications, and treatment techniques. Patients then have four to six contacts in the primary care setting with a psychologist who implements a highly structured program that includes teaching cognitive-behavioral skills for depression management and counseling to improve medication adherence. A psychiatrist tracks each patient's process and recommends changes in medication which are made by the primary care provider;
- *Consultation-liaison.* This model is characterized by a high degree of collaboration between the specialist (i.e., psychiatrist or other mental health professional) and primary care staff. There is regular face-to-face contact among the mental health specialist and the primary care physician, other primary care team members, and members of the community mental health team as appropriate. Some patients are managed by the primary care team without referral to the mental health specialist, but only after discussion at a face-to-face meeting. When a referral is made to the mental health specialist the primary care team receives progress reports and maintains a management role (Gask et al, 1997); and,
- *Community mental health team.* Stolee et al (1996) describe a geriatric mental health outreach program based at a regional psychiatric hospital in Canada.

The program works with community caregivers, including family members, family physicians, and staff of community agencies and long-term care facilities. It has four components: (1) a home visit team (HVT), (2) Specialized Information and Resource Service (SIRS); (3) pilot educational service initiatives; and (4) active involvement in system-level planning and coordination.

The HVT consists of an interdisciplinary team of health professionals that conducts home or community-based assessments, but does not take over the care of the older adult. Care plans are developed for each patient and client-centered case consultations are held with health care providers. The SIRS uses a telephone-based service to provide community care professionals with consultation, clinical advice, and referral. The purpose of the pilot educational service is to develop the capacity of community-based agencies and long-term care facilities by enhancing in-house resources such as staff skills or by promoting greater collaboration among service providers. Finally, in their system-level planning and coordination functions, members of the geriatric outreach team actively participate with community groups in the planning, development, and coordination of mental health services for older persons.

In addition to formal models, there are other outreach efforts initiated by professionals in the mental health and aging networks to educate primary care physicians and their staffs. For example, in one state, an outreach psychiatrist working through the state mental health system is visiting every primary care physician to provide them with information on current issues and

interventions relevant in treating older persons.

Several states have used memoranda of understanding to improve coordination in managed care plans. For example, one state required the mental health plan to establish linkages with HMOs and with the substance abuse carve-out plan to ensure coordination of services. The mental health carve-out provider can also ask consumers for a medical history during the intake process. If contractors are held responsible by states for Medicaid targeted case management, connections between non-Medicaid services such as housing and employment and Medicaid-funded treatment and rehabilitation services can be facilitated.

Are these primary care and mental health models effective?

Controlled studies examining primary care and mental health models for patients of all ages have achieved mixed results. Some have indicated positive results (Brown & Schulberg, 1995; Katon et al, 1996; Scot and Freeman, 1992; Wells, 2000). Katon et al (1996) found that at a 4-month follow-up significantly more patients treated for major and minor depression in a primary care and mental health model had adhered to antidepressant medication compared to the customary care patients. These patients also rated the quality of care they received for depression as good to excellent. While collaborative care improved the outcomes of patients with major depression, it did not appear to affect outcomes for patients with minor depression.

Other studies that included patients of all ages had less favorable outcomes. For example, Balestrieri et al's (1988) meta-analysis of studies comparing referral to mental health specialists based in primary

care settings with physician "as usual" care demonstrated only moderate improvements in patient outcomes. The outcomes were not commensurate with the increased costs of care. And, Katon & Gonzales (1994) found that screening for depression or screening along with one psychiatric interview resulted in increased prescriptions for antidepressants. However, the screenings but did not affect patient distress levels.

The benefits of a community development effort that focused solely on older persons have been presented in the descriptive study by Stolee et al (1996) discussed earlier in this section. Stolee and his colleagues found that levels of functioning could be maintained and psychiatric hospital admissions could be avoided among frail elders with complex physical and mental health problems.

Currently, three ongoing multi-site research efforts in the United States are examining services to older persons with mental health problems in primary care settings. These efforts were briefly mentioned in Chapter 1 and are presented in greater detail below.

The first of these studies is called Improving Treatment of Late-Life Depression in Primary Care (IMPACT). A 4-year study funded by the John A. Hartford and the California HealthCare Foundation, it compares older adults assigned randomly to two, groups. A clinical specialist (i.e., nurse, psychologist, or social worker) conducts a brief structured form of psychotherapy with back-up from a team psychiatrist in one group. The other receives "care as usual" from their regular primary care providers. The first year of this study ended in July 2000. Thus, outcomes have not yet been reported by the

IMPACT Coordinating Center at UCLA Neuropsychiatry Institute in Los Angeles.

The second, the Primary Care Research in Substance Abuse and Mental Health for Elders (PRISMe) Study, is a four-year study evaluating differences in outcomes between models that refer older persons to specialty mental health/substance abuse services outside the primary care setting (Referral Model) and those that provide mental health specialist services within the primary care setting (Integrated Model). Funded by the Substance Abuse and Mental Health Services Administration (Center for Mental Health Services, Center for Substance Abuse Prevention, Center for Substance Abuse Treatment), the Department of Veterans Affairs, the Health Resources and Services Administration, and the Health Care Financing Administration, the study targets persons who have problems with depression, anxiety, and alcohol abuse and misuse. The study design incorporates a consumer-oriented approach, focuses on culturally competent practice interventions, and uses 11 study sites to capture a geographically and ethnically diverse population. Recruitment began in March 2000 by the Harvard Coordinating Center at Harvard Medical School.

The third and final multi-site study – Prevention of Suicide in Primary Care Elderly Collaborative Trial (PROSPECT) – is funded by the National Institute of Mental Health and is being conducted at three of their Intervention Research Centers. This study is investigating the effectiveness of an intervention aimed at improving the recognition of suicidal ideation and depression. Health specialists collaborate with physicians to increase their recognition and identification of depression, offer timely and targeted treatment recommendations, and encourage adherence to treatment. The

impact of this intervention will be compared to practices offering “care-as-usual.” A reduction of depressive symptoms and suicidal ideation and behavior is expected.

It is hoped that the three multi-site studies will help to identify the most effective systems of care, types of interventions, and collaborative arrangements in the primary care setting for treating older persons who suffer from mental illness.

Mental Health Services in Long-Term Care Facilities

There is strong evidence of a high prevalence of mental illness in nursing homes (Lombardo et al, 1996). One study found that up to 88 percent of all nursing home residents exhibit mental health problems, including dementia (Smyer et al, 1994). These individuals exhibit a wide range of symptoms, from delusions and hallucinations to sadness and anger at their loss of privacy and independence (Lombardo et al, 1996). Depression is a major problem in long term care facilities with estimates ranging from about 12 to 22.4 percent for major depression, and an additional 17 to 30 percent for minor depression (Burrows et al, 1995; Katz et al, 1995).

A number of interventions can be used to address the mental health needs of the residents of nursing homes, but often they are generally not made available. Thus, many residents do not receive the mental health care they need (Burns et al, 1993; Shea et al, 1995). A 1994 study found that only 19% of nursing home residents with mental illness, excluding those with dementia, received mental health treatment at least once (Smyer et al, 1994).

Although there is a need to incorporate mental health care as a basic component of nursing home care and to make professional services available to patients and their families, there are major barriers to obtaining treatment for mental health conditions in nursing homes. These have been outlined by Lombardo et al (1996) in a descriptive summary of key policy issues. They include: (1) a shortage of specialized mental health professionals trained in geriatrics; (2) lack of knowledge among and inadequate training of nursing home staff about mental health issues; (3) lack of adequate Medicaid and Medicare reimbursement to facilities to cover behavioral and mental health problems; and (4) lack of adequate reimbursement to obtain the services of psychiatrists and other mental health professionals..

As continuing care retirement communities, assisted living facilities, and other types of living arrangements become more commonplace, attention will need to be given to ensuring that residents of these facilities have access to mental health services. In addition, research is needed to determine types of interventions and services that are most appropriate and effective in these settings.

A wide range of psychosocial interventions is appropriate for use in the nursing home. Smyer & Frysinger (1985) have categorized them as follows:

- *Individual interventions* include interpersonal skill training, psychotherapy, reality orientation, self-care training, or social interaction for the treatment of a specific resident;
- *Group interventions* involve several patients and may use interpersonal skill

training, education and discussion, group therapy, or socialization therapy;

- *Program interventions* are not specific to one person or a group, but rather impact many residents by focusing on the facility's environment or its quality of life; for example, the therapeutic use of animals, social hours, reality orientation classes, activities programs, environmental stimulation, or intergenerational programs;
- *Family-based interventions* include in-service training with family members and staff, short-term counseling groups for children of elderly parents, conjoint therapy with elderly couples, pre-admission groups, post-admission counseling, group therapy, education and support programs, and information and counseling for caregivers of patients with Alzheimer's disease; and,
- *Staff interventions* include weekly staff meetings; training or workshops for staff; environmental alternatives to increase social interactions among patients, staff, and family members; or a core group of administrators that focuses on staff relations and attitudes.

What mental health needs are addressed by psychosocial interventions in nursing homes?

Individual and group interventions can be utilized to help the resident to adapt to the nursing home environment and to role changes. For example, residents can be assisted to regain or maintain orientation to their surroundings or, with withdrawn residents, increasing their social activities. Other similar interventions can decrease specific problems or achieve specific behaviors such as social interaction. Also,

interventions can be designed to prepare residents to return to the community.

Program interventions offer benefits and can help to improve quality of their lives. In a ten state study, ethnographic researchers found that quality of life issues, such as dignity, independence, freedom of choice, self-image, and a sense of purpose and privacy, were important to residents (Teitelbaum, 1995).

Family-based interventions usually focus on providing accurate information about the aging process and the specific difficulties troubling the resident, enabling family members to better understand their own reactions to the older adult's impairments and increasing the ability of caregivers to provide optimal care while continuing their own personal development. Finally, the purpose of staff interventions is to improve both staff and resident morale and functioning.

How are these interventions implemented?

Mental health interventions can be implemented in the nursing home setting in a variety of ways. Due to the scarcity of mental health professionals who work directly with residents, consultation and education with staff are often utilized. There may be an arrangement with one or more mental health specialists who monitor and train the staff, consult with attending physicians, and assist staff in conducting assessments and developing individual care plans. Or, there may be a senior nurse with knowledge and skill in mental and behavioral areas who advises staff.

While program strategies that include mental health interventions are being implemented in some nursing homes, there

is a paucity of outcome-oriented research on the effectiveness of such efforts. Selected examples of innovative interventions that are in practice in facilities are described below (Lombardo et al, 1996):

- *Mobile psychogeriatric teams.* In one innovative model, nursing homes in rural areas are supported through state-funded mobile mental health intervention teams. A mobile psychogeriatric team consisting of a psychiatrist, a psychiatric nurse, and a clinical social worker are available, upon request, to 23 nursing and 28 residential care facilities in a rural catchment area. The team provides assessments, treatment services, and medication reviews for individuals with mentally illnesses or behavioral disturbances; works with staff on the development of care plans; and trains staff. The program is prevention-oriented, aims to avoid having psychiatric crises develop, and thus works to reduce the likelihood of admissions to acute hospital settings;
- *In-facility mental health department.* A mental health department staffed by a psychiatric mental health clinical specialist was established within a facility. The specialist reviews psychotropic medications to ensure the appropriateness of the drugs, dosages, and times of administration; develops nursing interventions that can be used in addition to or in place of medications; and works closely with staff to suggest how behavioral problems can be addressed; and,
- *Preadmission Screening and Resident Review (PASRR) agency collaboration with Health Department.* The mental health and public health systems and the aging network collaborate on the

implementation of PASRR, instituted by the Omnibus Budget Reconciliation Act of 1987 (OBRA). Some States have set up systems to use PASRR Level II screening results to establish treatment plans to improve the mental health care of residents. In one example, the PASRR screening agency sends the Department of Health a list, by nursing facility, of all residents or prospective residents who received Level II screening, are appropriate for admission, and need mental health services. Surveyors then spot check records of residents to see whether they are receiving recommended mental health services. If residents are not receiving the services, facilities may be cited for deficiencies and may be required to develop a plan of correction.

How effective are psychosocial interventions in nursing homes?

While there is no way to reverse the most common causes of dementia, research has shown that depression and anxiety in older persons with chronic diseases, including some forms of dementia, usually can be treated successfully with medication and with various forms of psychotherapy and cognitive behavioral therapy (Burns, 1992; Fogel, 1993; Gallagher-Thompson, 1994, Kamholz & Gottlieb, 1990).

There are many studies that evaluate the various types of interventions. Examples of outcomes from studies that examined individual, group, program, and staff interventions are described in this section. In a 5-year study, Haight et al (1998) followed 256 newly relocated nursing home residents who received individual interventions. Group members participated in “life review” activities conducted by a therapeutic listener on a one-to-one basis

while those in the control groups received friendly visits. Life review is a form of reminiscence therapy, involving reciprocal acts of telling and listening. The listener helps the older person reframe and integrate life periods and events. Controlling for the effects of adjustment over time, researchers found that at 8 weeks, experimental group members were significantly less depressed. At the end of the first year, there was significantly less depression and hopelessness and greater psychological well-being and life satisfaction in the life review groups compared to the control groups. Researchers concluded that over time, life review can alleviate despair in frail elders newly admitted to a nursing home.

In a review of 29 studies that focus on improving the quality of life in nursing homes Wieland et al (1995) included a group intervention (Moran & Gatz, 1987) that evaluated the effect of task-oriented versus insight-oriented group therapy conducted in two different groups on locus of control and life satisfaction. Results were compared with a wait-list group. Twelve weekly sessions, each 75 minutes in length, were held with the residents. The task-oriented group improved on locus of control, active coping, striving for social desirability, and sense of well-being, but not on trust. The insight group improved on locus of control and trust. However, trust decreased in the control group. The residents indicated they liked these groups, and there was less than 20% attrition in attendance.

A new program model that has drawn considerable attention, the Eden Alternative, provides a more humane habitat for residents of nursing facilities, using the companionship of animals and other humans. For example, birds, dogs, cats, rabbits, and even chinchillas are brought into the facility. Rooms and halls are filled

with green hanging plants, and residents can plant vegetables and flowers in gardens on the grounds. Children play onsite and mingle with residents for several hours most days as part of a day care program. Three years after the project began in a nursing facility, staff found a 15 percent drop in the death rate compared to a nearby nursing facility that served as a control. Infection rates dropped by about 50 percent. Staff turnover rates plunged by 26 percent, saving the facility the cost of recruiting and training nursing assistants -- about \$2,000 per individual. The average number of prescriptions per resident fell to 3.01, compared to a national average of 5.60. And, medication costs fell to less than 56 percent of the U.S average (Lombardo et al, 1996; Thomas, 1994; Vilbig, 1995).

Finally, Smith et al (1994) describe a Geriatric Mental Health Care Training Project that trained nurses and nursing personnel in rural long-term care facilities to care for residents with psychiatric and behavioral problems. A 2-day train-the-trainer training covered six modules focused

on mental health topics, including the causes of problem behaviors, management techniques, and the impact of the care providers' feelings and reactions. Geropsychiatric nurse specialists trained 43 nurse leaders, and then these leaders trained 520 staff in their own facilities. Two-way interactive telecommunications techniques were also used to reach leaders in rural facilities. The nurse trainers viewed the program materials as relevant and user-friendly, while the trainees gave the overall quality of the program, its relevance, and usefulness high marks. There was a significant increase in knowledge on the part of both the trainers and trainees. And, pre-to post-test attitude changes were overwhelmingly positive for the trainees. The leaders/trainers--who had more positive attitudes to begin with--showed a less dramatic pattern. Prior to the training program, many problem behaviors were attributed wrongly to the resident being manipulative rather than to impairments or to feeling threatened. After the training, these attitudes improved.

SUPPORTIVE SERVICES AND HEALTH PROMOTION

Most older persons with mental health problems are served in community-based settings, a trend that is likely to continue (Demmler, 1998). Mental disorders do not only affect those who suffer from them. Family, friends, and others also feel their impact. Thus, older adults and those who care about them can benefit from an understanding of supportive services that can be utilized.

This chapter describes a number of supportive services and health promotion activities for older persons with mental disorders and their families. The chapter opens with services that may be most useful to individuals with mental disorders, and ends with services for family members or caregivers of elders.

Many of the services described in this chapter are provided through the aging network and funded through the Older Americans Act and/or by state, local, or private sources. Others are supported through Title XX, Medicare, or Medicaid. Medicare and Medicaid payment policies are described in Chapter 5.

Alternatives to specialty mental health settings must be considered in planning for the delivery of mental health services because many older Americans stigmatize mental health services. Senior centers, congregate meal sites, and other community settings which older Americans frequent and at which they feel comfortable may offer promising venues for the delivery of mental health services. Hence, it is essential that the aging network, the mental health system,

and primary health care providers form partnerships to explore how to best marshal their various resources in the service of older persons' mental health.

ADULT DAY SERVICES

Adult day services (ADS) are community-based group programs designed to respond to the needs of ambulatory, but functionally and/or cognitively impaired adults as identified through individual plans of care. These supervised, structured, and comprehensive programs provide a variety of health, social, and related support services in a protective setting. Adult day centers generally operate during normal business hours 5 days a week. Typically, a client attends 2-3 days each week for about 5 or more hours each day. However, employed caregivers may need their relatives to attend 5 days a week. A few programs offer services in the evenings and on weekends (NCOA, 1997).

ADS are available in many communities. There has been significant growth in the number of ADS from 2,100 centers in 1989 to about 4,000 today (NCOA, 1997). Most are operated on a nonprofit or public basis and many are affiliated with larger organizations such as home care agencies, skilled nursing facilities, medical centers, or multi-purpose senior organizations.

What mental health needs can adult day services address?

ADS provide social interaction and recreation, rehabilitative training/skill

building, and health monitoring and maintenance for the elders they serve. These interventions may be especially helpful in addressing the behavioral and mood-related symptoms of Alzheimer's disease--such as agitation and depression--and could delay declines in functional abilities as well. Cognitively intact older persons with depression may also benefit from the socialization and recreation provided by ADS programs. By providing a safe, secure place for impaired elders, ADS play a crucial role in providing respite for the caregiver and in enabling the caregiver to continue working.

How are adult day services implemented?

According to the standards developed by the National Adult Day Services Association, there are three levels of ADS. Centers may provide more than one level of service:

- *Core services.* Core services include assessment and care planning, assistance with activities of daily living (ADLs), health-related services, social services, therapeutic activities, nutrition, transportation, and emergency care;
- *Enhanced services.* These services include some or all of the following in addition to the core services: moderate restorative, supportive or rehabilitative nursing care; assessment and referral for psychosocial services; follow-through with recommended treatments in the plan of care; and physical, occupational, and speech therapy to maintain optimal levels of functioning; and,
- *Intensive services.* In addition to the core and enhanced services, intensive nursing services may be necessary to manage precarious medical conditions,

therapies at a restorative or rehabilitative level, intensive psychosocial services, or specialized supportive services.

Medicare does not cover the cost of ADS. The availability of Medicaid coverage depends on whether the older adult meets state eligibility and service requirements. Private medical insurance policies sometimes cover a portion of day care costs when registered, licensed medical professionals are involved with the care (Senior Resource for Adult Day Care, 2000). The average cost of a day at an adult day center is often less than the cost of home health nursing services and about half the cost of skilled nursing facility care.

How effective are adult day services?

In general, older adult participants have expressed high levels of satisfaction with ADS, especially with transportation to and from centers, the amount of attention received from staff, and program hours (Weissert et al, 1990). Family members whose relatives have dementia have reported the positive effects of the ADS environment and the opportunity for their relative to socialize and to participate in activities. They also said that there was improvement in mood, less agitation, and improved sleep patterns on days that dementia participants attended ADS (Zarit et al, 1999; Levin et al, 1989; Gottlieb & Johnson, 1995. Wimo et al (1993) found that while the well-being of older persons with dementia improved, there was no effect on activities of daily living (ADL) functions or behavior problems.

There are very few studies that have examined whether the use of ADS decreases nursing home usage. These studies have indicated that enrollment in ADS was not related to nursing home placement (Weissert et al, 1990; Hedrick et al, 1993).

Reports of caregiver satisfaction with ADS are consistently high (Gottlieb & Johnson, 1995; Weissert et al, 1990). Henry and Capitman (1995) found in a study of ten demonstration programs that regardless of dementia status, programs that offered activities to promote growth and provided interaction with caregivers had lower discharge rates than programs focused solely on providing respite for the caregiver. This was especially true when the caregiver was a spouse.

However, analyses of specific mental health benefits for the caregivers indicate mixed results. Two studies (Levin et al, 1989; Rothman et al, 1993) found no differences in social and psychological health between caregivers using ADS and caregivers in a control group. However, Strain et al (1988) reported increased life satisfaction among caregivers when measured over a one-year time period. Some evaluations have found that caregivers utilizing adequate amounts of ADS on an ongoing basis had lower levels of overload and less depression (Gottlieb & Johnson, 1995; Wimo et al, 1993; Zarit et al, 1998). Finding ways to encourage caregivers to make adequate and timely use of ADS may be one key to enhancing the effectiveness of these services.

HEALTH PROMOTION AND WELLNESS PROGRAMS

Health promotion programs focus on educating older adults about how to increase control over and improve their health in a variety of areas; for example, nutrition, physical activity, mental health, alcohol and substance reduction, tobacco use, and other areas. Wellness programs--a type of health promotion program--involve all aspects of the individual: mental, physical, and spiritual. Both types of programs provide

structured opportunities to increase knowledge and skills in specific areas, such as stress management, or environmental sensitivity. They also provide a supportive environment to nurture the emotional and intellectual aspects of participants, and aid individuals in becoming increasingly responsive to their health needs and quality of life (Weiss, 1995). These programs are usually short-term and educational rather than therapeutic in nature.

There are many challenges associated with aging. But it is a more difficult process when an individual does not have certain essential tools to achieve healthy aging, such as knowledge of proper exercise and nutrition, peer support, and the ability to cope with the psychological and physical health changes due to aging. Wellness and health promotion programs help older adults to understand the complexity of and ingredients for optimal psychosocial and physical well-being (Weiss, 1995).

What mental health needs can health promotion and wellness programs address?

These programs can help to promote mental health by assisting older persons to normalize the aging process and optimize their potential. They can encourage self-expression, teach coping skills, improve social skills, foster peer support, and address key transitions and losses (Weiss, 1995). The goal of preventive interventions is to help older adults find pleasure and meaning in their lives, use appropriate supports, and retain or assume as much control over their lives as possible (Waters, 1995).

Health promotion and wellness programs can assist older adults to develop a balanced "social portfolio," a concept advocated by Cohen (1995). Cohen believes that adults

should prepare for aging by developing a balanced and satisfying social portfolio that includes individual, group, active (high energy/mobility), and passive (low energy/mobility) activities. By educating older persons about many types of activities that can be pursued, wellness and health promotion programs can help them to identify potential components of their social portfolio.

Finally, wellness and health promotion programs can present opportunities for linking older persons with appropriate resources. For example, when participants raise concerns about the stressfulness of their caregiving responsibilities or show signs of depression, the professional is well positioned to suggest appropriate sources to contact for help. Education about and identification of mental health needs and resources can and should be an integral part of wellness and health promotion programs.

How are health promotion and wellness programs implemented?

Wellness programs for older adults residing in the community are usually conducted groups in community settings such as health care clinics, neighborhood centers, senior centers, community organizations, libraries, and religious or educational institutions. The location of these programs is important because most older adults tend to be uncomfortable being in traditional mental health settings, in part because of the stigma they attached to mental health treatment. Community settings have the advantage of being “safe.” That is, participants are more apt to be able to discuss their depression or worries without being stigmatized (Waters, 1995).

Health promotion and wellness programs that focus on aspects of mental health can be

incorporated into existing programming. States and Area Agencies on Aging receive Title III-F Older American Act (Disease Prevention and Health Promotion Services) funding through a formula grant. These monies can be utilized to include these programs. Depression screening could be one component of a health fair or could be available at senior centers as part of community-based health promotion activities for older adults.

One example of a well known mental wellness program is *Alert and Alive* (Perlstein, 1992). *Alert and Alive* uses a holistic approach to growing older, integrating mind, body, and emotional needs. The program has four basic components: 1) a 12-session mental wellness education course; 2) a six-session volunteer training in leadership skills; 3) three volunteer-led mental wellness activities; and 4) program implementation through in-service training and supervisory monitoring. Sessions are conducted at senior centers in order to reach healthy elderly and ensure a base of continuity. Topics include coping with stress; memory; normal aging; caregiver concerns; depression; loss; communication with others; community resources; and friendship, intimacy and sexuality. Program participants learn how to think creatively, relieve stress, exercise their bodies, and work comfortably with their emotional concerns.

How effective are health promotion and wellness programs?

There are a limited number of controlled studies that examine health education or wellness programs. Brice et al (1996) reviewed 12 health promotion programs and reported that the existing data are primarily descriptive and qualitative in nature. Brice

and colleagues summarize the results of eight descriptive studies, reporting that as a result of their involvement, participants believed that their motivation and confidence to change their health-related behaviors increased and that their overall health improved. Participants also expressed overall satisfaction with their wellness program experiences. The four controlled studies that Brice et al reviewed supported the positive findings of the descriptive studies.

An example of a health promotion program that has been studied using a control group is STAYWELL, a precursor of the *Alert and Alive* program, and a comprehensive health promotion program for older adults (Brice et al, 1996; New York City Department for the Aging, 1988). This program recruits participants through senior centers and focuses on their taking personal responsibility for their health, exercise, nutrition, stress management, physician access, and care management. Findings indicate that at a 9-month follow-up, those who participated in the program were twice as likely as those in the wait-listed group to believe that their behavior changes could impact their health, and significantly more likely to report positive changes in their health behaviors, such as engaging in regular exercise and relaxation, taking fewer medications, or abstaining from smoking or drinking.

In another study, (Taylor et al, 1997), nurse-managed wellness clinics for older adults were located in urban, high-rise apartment buildings subsidized by the Department of Housing and Urban Development. Advance practice nurses conducted the clinics and utilized geriatric health and mental health assessment tools. Their emphasis was on implementing a population-based wellness program that would reduce the need for

hospitalization and institutionalization. Medical problems were referred to primary physicians.

Outcomes of the older adults participating in these clinics indicated that regularly monitoring blood pressure, weight, and appetite enabled nurses to detect onset of problems such as hypertension, depression, and decline in physical or mental functioning. Ongoing assessment by the nurses resulted in referrals to mental health clinics for depression management, arrangements for Meals-on-Wheels, referrals to the geriatric assessment center, identification of resources for food shopping, and referrals for dental care. Examples of behavioral changes included individuals following regular exercise plans, residents reporting improved sleep patterns with nonpharmacological interventions, persons reporting decreased chronic pain, and an individual who accomplished decreased alcohol intake. In addition, involvement in programs such as nutrition classes and chair exercises showed increasing participant attendance and satisfaction.

Another program, the Collaborative Health Education Training Program for African American health ministers and community service providers, is an example of a health promotion effort that worked within a community's cultural context to increase the cultural sensitivity of community agency staff. This 56-hour interdisciplinary "train-the-trainer" model was developed in the Southern U.S. for lay representatives (health ministers, often parish nurses) of African-American churches and in-service directors from community-based health and social service agencies (Lloyd et al, 1994). The program was designed to use both the informal system (health ministers) and formal systems (in-service directors) to

reach African American elders. The health ministers function as natural caregivers for older adult members of their congregations and the in-service directors are responsible for educational programs at their work sites. Biweekly training sessions that included both groups spanned 4 months. A multidisciplinary faculty affiliated with a nearby university's center for geriatrics taught the sessions and made use of discussion, games, simulations, and audiovisual materials. Content included issues impacting African Americans; for example, diabetes, stroke, heart disease. The health ministers and in-service directors then implemented interventions in their own settings.

The Collaborative Health Education Training Program demonstrated positive outcomes including increased networking, new formal linkages between the African American community and agencies serving older adults, and new collaborations within the African American community that focused on health promotion activities. Problems encountered included resistance of religious organizations around becoming involved in health education, difficulties in role shifts among the health ministers, and the need for cultural competency among service providers.

MENTAL HEALTH OUTREACH SERVICES

Mental health outreach programs enable early intervention and facilitate access to preventive services for older adults at risk of cognitive impairment, depression, or other mental health problems. Many older persons do not use mental health services that might improve their quality of life even when these services are available (Smith et al, 1993). It is estimated that over 40% of at-risk individuals over 60 go unserved or

remain unidentified (Estes, 1979; Raschko, 1990). Some older persons do not access traditional clinic-based services because they are isolated, impoverished, physically frail, or have transportation difficulties. Others are deterred by the stigma that surrounds mental health treatment. Outreach programs can offer these individuals assessments and referrals to appropriate community treatment and supportive services. In some communities, health, mental health, and human service agencies collaboratively plan and deliver mental health outreach services.

What mental health needs can outreach programs address?

Mental health outreach programs strive to keep older persons in the community by providing individually tailored, supportive services that enable them to maintain and increase their level of functioning. Counseling, medication monitoring, chore or visiting nurse services provided through the area agency on aging can be preventive if they reach the older adult before the point of crisis.

How are mental health outreach services implemented?

Outreach services can be organized and delivered creatively. However, the following are core elements in ideal programs:

- *Case-finding.* Both traditionally (e.g., public health nurses) and nontraditionally (e.g. meter readers, utility workers) trained personnel identify and refer persons who may be at risk of mental health problems. These older persons are individuals who would otherwise be overlooked. The media are also used in case-finding efforts. For

example, television, newspaper and radio ads encourage use of treatment programs;

- *Assessment.* A comprehensive psychosocial and physical health assessment is conducted by a multidisciplinary team of professionals with experience in geriatric mental health;
- *Referral.* A multidisciplinary team develops and implements a plan of care in cooperation with the client, family, and providers of supportive services. Elders and their families are educated, assisted, and gradually linked to support and treatment services. In some programs, staff become case managers for older persons and their families. The team may meet regularly to discuss how a client is doing;
- *Consultation, education and training services.* Some outreach programs may also provide consultation, education, and training to community agencies, and care providers to help them understand the needs of older adults who need assistance in accessing services.

For example, one outreach service uses a mobile multidisciplinary geriatric team based at a mental health center that serves primarily Hispanic and African-American older adults (Hernandez & Schweon, 1989). This bilingual team provides evaluation and counseling at seniors' homes and in retirement and nursing homes. To reach the Latino community, the mental health center has TV spots in Spanish. It also works with local churches, and is in contact with private physicians. A county-based older adult task force refers and links clients to area agencies on aging, senior centers, and other service organizations.

The Gatekeeper Program, started in 1978 by Elder Services in Spokane, is a well-known outreach program that has been replicated throughout the U.S. Elder Services provides both mental health and aging services through funded by blending Older Americans Act and state mental health dollars. The program was developed to identify at-risk older adults who do not typically come to the attention of the service delivery system. Nontraditional community referral sources, or gatekeepers, are trained to identify individuals at risk of losing their ability to live independently. Meter readers, utility workers, bank personnel, apartment and mobile home managers, postal carriers, police, pharmacists, cable television company staff, and others serve as gatekeepers for the most isolated community-dwelling older adults. (Florio et al, 1998).

The gatekeepers receive training that focuses on the signs and symptoms of distress. The case-finding component of the program is accompanied by an interdisciplinary in-home clinical case management component that responds to referrals from the gatekeepers, and provides and coordinates the in-home services necessary to maintain the older individuals in their homes (Florio et al, 1998).

How effective are mental health outreach programs?

A study of one-year outcomes of older adults referred to the Gatekeeper program found that these individuals were more likely to live alone and to be socially isolated than persons referred by other sources, but less likely to have physical health problems. They were also less likely to have a physician at referral, but this difference was not found one year later.

Similarly, cognitive problems were significant concerns at the time of referral, but not after one year. Thus, interventions by Elder Services appeared to have made a measurable difference. After a year, the gatekeeper-referred clients were also more likely to be receiving clinical case management than those referred by other sources, indicating a possible need for more intensive follow-up. At the time of referral, the gatekeeper-referred clients had greater service needs, but after one year their service use did not exceed that of clients referred by other sources. Following the interventions by the Gatekeeper program, clients were no more likely to be placed out of the home than those referred by other sources. Finally, the Gatekeeper model was comparatively inexpensive to implement.

Russell (1997) evaluated a mental health outreach program that is part of a large, urban health care system. The program, which began in 1993, has a structure similar to the basic outreach model described above, except that it offers support and self-help groups both in the clinic and in the community. It also has a component that provides education for the staff of residential care homes. Russell reported that of the 102 individuals who participated in the outreach program, 54 had psychiatric hospitalization prior to their involvement in the program. However, only four hospitalizations were necessary among participants of the outreach program. Moreover, because of the availability of post-discharge mental health services, the average length of a hospital stay was reduced by 50 percent. For a one-year period, 89 percent of those studied reported a decrease in symptoms, exceeding the program's goal of maintaining or increasing the level of independent functioning among at least 80 percent of those who had a psychiatric hospitalization or were at risk of one.

Finally, an outreach approach that used an alternative method of identification and referral was reported by Dorfman et al (1995). In this program, a well elderly population is screened for depression using a computer-assisted telephone system that tracks several common measures of mental health. During the second phase of the screening, those persons with scores indicating major depression are seen at a one-day community-based screening and health promotion clinic. During this second phase, a social worker conducts a clinical evaluation to determine whether an individual is suffering from major depression. The social worker provides brief counseling and refers the older person to appropriate resources, including mental health clinics and family physicians. A letter summarizing the results of this second phase is sent to the client's primary physician if there is confirmation of clinical depression. Study findings indicated that the social workers are able to identify many previously undetected cases of major depression. A majority of the older adults who were referred to treatment were seen and treated by a medical doctor.

SUPPORT GROUPS AND PEER COUNSELING PROGRAMS

Support Groups. A support group is comprised of people with a common problem or situation who pool resources, gather information, and offer mutual support, services, or care. For example, there are groups that provide support to persons who have lost a spouse or who have chronic mental or physical illness. Support groups share three basic elements: an intense need expressed by the members; the requirement that members be willing to share personal experiences, and a real or perceived similarity in their suffering.

Commonly, support groups are characterized by a high degree of cohesiveness and emotional intensity. Members often experience new possibilities for feeling, perceiving, and behaving as a consequence of the cognitive restructuring generated by group processes (Lieberman, 1993).

Peer Counseling Programs. These self-help programs utilize the skills and life experiences of older volunteers who are trained to provide telephone reassurance, social activities, shopping excursions, and home visits to help other older persons in the community. While they are most often conducted on a one-to-one basis, peer counseling programs may also use a group format.

The burgeoning self-help movement in the United States suggests that people are taking a more active and self-reliant role in maintaining and improving their physical and mental health (Butler et al, 1998). The following factors may explain why older persons use support groups and peer counseling programs, both of which feature mutual help:

- Older persons may feel that professionals are not as interested in working with them;
- Professional services may be too costly;
- Medicare reimbursement for mental health services may be too low for many older persons;
- Stigma is associated with use of traditional mental health services; and,
- The underfunded mental health system may not offer special services targeted towards older adults (Bratter & Freeman, 1990).

What mental health needs can support groups and peer counseling programs address?

Support groups and peer counseling are especially effective as prevention interventions. They can provide crucial psychosocial support to older people facing life transitions, short-term crises, chronic stressors, and other difficulties. Even the most resilient older persons can find themselves overwhelmed and at risk of depression or other mental disorders. For example, epidemiological research indicates that bereavement reactions that are common among older persons can increase the risk of depression and that conjugal bereavement is associated with a higher risk of physical deterioration and death.

Many older people find support groups and peer counseling more acceptable than other forms of treatment. Support groups allow elderly participants to be both recipients and providers of assistance (Schneider & Kropf, 1992). Additionally, support groups enable important supportive relationships to develop. They offer relief and problem-solving opportunities to participants who can normalize or universalize their problems because other members have the same problem (Lieberman, 1993).

Peer counseling and support groups can also ready participants to access and use mental health services. Older adults who suffer from mental impairments may lack the judgment, desire, and capacity to call for help (Rogers et al, 1993). Peer counseling programs tailored to the specific needs and circumstances of these persons can help bridge the gap to mental health treatment and can connect them with the range of supportive services offered by the aging network.

How are support groups and peer counseling programs implemented?

Support Groups. The goal of support groups is to improve the older person's ability to cope with life transitions and short-term crises as well as chronic stressors. There are many types of support groups. They can have a combination of one or more of the following characteristics (AARP, 2000):

- *Open-ended groups.* These groups have no set number of sessions, and participants may participate as long as necessary;
- *Closed-ended groups.* These groups are time limited, usually 6-12 weeks;
- *Self-help groups.* Mutual help groups include people who have a common problem and are committed to help one another. Usually the facilitator has experienced the same loss as other group members. These groups are usually free or are offered at very low cost. Group facilitators are frequently volunteers;
- *Professionally-led groups.* These are groups facilitated by a trained health professional. Participants may be charged a fee, although these costs may be reimbursed through health insurance; and,
- *Specific or general content groups.* Some groups are general in nature; for example, bereavement groups are often open to anyone who is dealing with the death of a family member or close friend regardless of the relationship between the deceased and the survivor (i.e., children, spouses, or siblings). Others focus on a specific relationship like widow/widowers or suicide survivors.

While not limited to the elderly, some support groups that are especially relevant for older persons are targeted towards those

with mental illness, Alzheimer's disease, breast or other cancers, emphysema, arthritis, terminal illness, stroke, diabetes, Parkinson's disease, or heart disease (Butler et al, 1998).

Peer Counseling Programs. Staff from the sponsoring agency are involved in careful screening and recruitment of older volunteers to serve as peer counselors, and then an intensive training session is conducted for them. The peer counselors must give a clear and firm weekly time commitment, which includes weekly group supervision, a monthly in-service meeting, and home-visits to one or more clients, recordkeeping, and travel. While most work on a one-to-one basis with older adults in their homes, peer counselors also work in senior citizen centers, nursing homes, day treatment programs, and with Alzheimer's support groups (Brattner & Freeman, 1990). The sponsoring agency must view these counselors as an important resource requiring time, attention, and commitment and must indicate this by providing mental health specialists to train and support them (Rogers et al, 1993).

For example, a geriatric peer counseling program in the Northwestern U.S. is part of a mental health center. This program serves older adults with chronic mental illness as well as those who are depressed and lack social contacts and those in crisis. The project advisory group consists of representatives from county government, the Area Agency on Aging, the senior information and referral service, and other programs working with older adult clients. This group assists the program through consultation, referral of clients, and linkage to community services. The sponsoring mental health center has the capacity to provide emergency and short-term inpatient care, geriatric day treatment, and

consultation to nursing homes and other agencies.

A coordinator administers the project, recruits volunteers, and prepares the training curriculum. The coordinator and geriatric mental health specialists from the center all play a role in the 50-hour training, and upon completion of the training, the volunteers receive five credit hours from a local community college. The counselors work on a one-to-one basis in the homes of clients who have had an evaluation by the center's multidisciplinary staff, and are supervised by geriatric specialists from the mental health center. Portions of the manual have been translated into Spanish for use by Spanish-speaking peer counselors (La Follette & Rowe, 1994).

How effective are support groups and peer counseling programs?

Bereavement Support Groups. In reviews of studies examining the outcomes of bereavement support groups, researchers have concluded that a large segment of the bereaved can meet their social and psychological needs in these groups. For example, in one study, participants in bereavement self-help groups were compared over a one-year period to bereaved psychotherapy patients as well as to those who sought no formal help (Lieberman & Videka-Sherman, 1986). Those in the self-help groups showed improved mental health status, whereas those in the control groups showed deterioration on all mental health indicators except depression. Researchers found that the mere passage of time did not alone account for positive changes in mental health. However, level of involvement in the group was an important factor. Those who made social linkages in the self-help groups became less depressed and anxious,

used less psychotropic medication, felt increased well-being and self-esteem, and reported greater overall improvement compared to widowed people who attended group meetings but did not link up with other members. Thus, significant positive changes occurred only for those who participated actively in the support groups.

In another study, a two-year examination of the Widowed Persons Service (WPS) program, which pairs widows with a widow contact who provides emotional support and practical assistance, found that most women recovered from bereavement with or without help. However, those receiving the intervention recovered more quickly (Vachon et al, 1980).

Researchers have identified several respects in which support groups need further study. They note that the lack of consistency among the various studies regarding intervention conditions make it impossible to determine efficacy precisely, or to determine at what points in the grieving process such groups would be helpful (Lieberman, 1993; Stroebe et al, 1993). For example, support groups may be controlled and directed by their members, led by mental health professionals, or led by trained lay persons. Finally, there is an important gap in bereavement research because most of it focuses on women, even though it is known that older males are isolated very early in the bereavement process (Gallagher-Thompson et al, 1993) and an impoverished social network is associated with increased mortality rates for men.

Peer Counseling Programs. Few outcome evaluations have been done on these programs probably because many of them began in an informal manner, serving obvious needs rather than focusing on

research. Most available information consists of descriptions of peer-counseling programs in various settings, and the most commonly used methods of evaluating the effectiveness of peer counseling programs are evaluation forms, supervision, and client self-report.

One descriptive study used a questionnaire to obtain responses from 80 agencies that had purchased a peer counseling training package. Findings indicated that the median age of peer counselors was 55-78, and the mean number of counselors available at each agency was 20. The most common reasons that clients sought counseling were illness, loss, and emotional difficulties. While most of the work was done individually, some counseling was done with groups, families, and couples. Most clients were seen weekly, and were involved for 1-12 months; however a smaller subgroup was seen for as long as was needed (Brattner & Freeman 1990). Research on the efficacy of peer counseling programs is needed.

CAREGIVER PROGRAMS

These programs offer a range of services for caregivers of frail elders and persons with disabilities. Supportive services can include: respite, specialized information and referral, family consultation/care planning, support groups, care management, education and training, family caregiver assessment, counseling, home modifications, emergency response, and legal consultations (Feinberg & Pilisuk, 1999). Most caregiver support services are provided through voluntary agencies (e.g., the Alzheimer's Association or the American Cancer Society) or as a part of the Older Americans Act, Medicaid waivers, or state general funded programs (Feinberg, 1997).

State-funded caregiver programs are few in number, differ from state to state, and are dependent upon individual state priorities and resources. Respite is the service that is most typically funded by state governments (Feinberg, 1997; Feinberg & Pilisuk, 1999). Most of the state-funded programs focus on two clients—the informal caregiver and the person with disability. Eligibility criteria vary by state according to age, diagnostic/functional criteria, or income.

In November 2000, a new National Family Caregiver Support Program was established by Congress and President Clinton as part of the reauthorization of the Older Americans Act. It was one of four long-term care initiatives proposed in the President's FY 2001 budget to help families care for an older relative with serious chronic illness or disability. The program is administered by the Administration on Aging. Under this program, State Units or Offices on Aging, working in partnership with local Area Agencies on Aging, community service providers, and consumer organizations will be expected to put in place at least five program components: (1) individualized information on available resources to support caregivers; (2) assistance to families in locating services; (3) caregiver counseling, training, and peer support; (4) respite care; and (5) limited supplemental services.

Caregiving will preoccupy American families well into the 21st century, as the 76 million baby boomers join the ranks of older Americans. Currently, nearly one out of every four U.S. households provides care to a relative or friend aged 50 or older (National Alliance for Caregiving & AARP, 1997). Informal, unpaid care from family, friends or neighbors is the main source of help for the majority of older people with disabilities living in the community. The

average age of these primary caregivers is over 60 years old, and almost three-quarters of them women. Also, almost one-third of all caregivers are balancing employment and caregiving responsibilities (Feinberg & Pilisuk, 1999).

Although willingly undertaken and often a source of great personal satisfaction, prolonged caregiving frequently has negative effects on the emotional and physical health of caregivers (Whitlach & Noelker, 1996; Zarit et al., 1980). Studies show that caregivers experience a sense of burden, and an estimated 46 percent are clinically depressed (Cohen et al, 1990; Gallagher, 1985). Working caregivers are especially prone to physical and mental strains (Fredman & Daly, 1997; Scharlach, 1988). Up to half of the primary caregivers caring for someone with Alzheimer's develop significant psychological distress (Schultz et al, 1995). However, only 10-20 percent of family caregivers use formal services through public or private agencies (Brody, 1990; Gwyther, 1990).

What mental health needs can caregiver programs address?

Caregiver services can reduce caregiver distress and improve coping skills so that families can continue to provide care. Consequently, caregiver programs support the strong preference of older people to remain at home, in their communities, or with their families, for as long as possible.

The specific purpose of each service varies. Some focus on providing education and support, while others seek to provide more concrete assistance. Psychotherapeutic interventions such as short-term cognitive therapy, behavioral therapy or psychodynamic therapy help the caregiver to gain control over mood, activities and

thinking patterns; deal with anticipatory grief reactions; and provide specific training in coping skills and problem solving (Gallagher, 1985).

How are caregiver programs implemented?

Home and community-based services can directly assist families with their day-to-day caregiving responsibilities. These include a range of information, social, emotional, and financial support services.

The following are examples of various types of caregiver programs:

- The Alzheimer's Disease Demonstration Grants to States program focuses on developing models of care for persons with Alzheimer's disease, their caregivers, and families through partnerships involving area agencies on aging, dementia care advocacy and service providers, and local community agencies. State agencies compete for grant funding from the Administration on Aging to develop the systems of care and to provide services such as adult day care, companion care, respite, and other services needed by families coping with Alzheimer's disease. To date, more than 31 state agencies and 300 community organizations have been involved in creating and integrating dementia care services. A special focus of many of these efforts has been the targeting of services to hard-to-reach populations such as ethnic minorities and low-income or rural families. Program innovations have included: adult day services programs for Asian/Pacific Islander and Hispanic elders; the use of client outreach and advocacy coordinators for Native American elders; mobile day care

services; and a support center for Chinese Americans with dementia.

- A state-funded caregiver support program aims to reduce caregiver stress and burden by providing benefits and resources counseling; training and education; and support and financial assistance with expenses for purchasing caregiving-related services, supplies, and durable goods. The program is administered by the area agency on aging.

The program provides up to \$200/month service reimbursement and a one-time \$2,000 grant for home modification. The program is consumer-driven and flexible, supporting the primary caregiver and family in ways specific to their needs and preferences. The program allows for several respite care options; for example, hiring a neighbor or friend or using an agency-based respite program (Feinberg & Pilisuk, 1999).

How effective are caregiver programs?

There are few studies that examine caregiver programs by looking at all of their component services. Knight et al (1993) and Zarit et al (1999) both examine several types of caregiver support programs. Knight et al's review is limited to controlled studies conducted between 1980 and 1990 that focus on psychosocial interventions and respite care. Knight and his colleagues found a moderately strong effect for individual psychosocial interventions and for respite care programs. Group psychosocial interventions resulted in a small, but positive effect on caregiver distress. In reviewing both studies of multicomponent and single caregiver

programs, Zarit et al (1999) found that although many studies indicated positive results, effects were often modest. Caregivers were found to benefit from regular, sustained use of respite. However, a consistent theme across studies is that caregivers do not always make use of available services.

The effectiveness of respite care and adult day services is discussed in other sections of this report. This discussion thus will focus on the effectiveness of caregiver support groups. However, because of the different experiences of caregivers caring for older persons with and without dementia, general findings from studies focusing on caregivers in general will be discussed first.

Many studies have reported high levels of satisfaction by participants. However, significant improvements in objective measures of caregiver well-being such as burden, anxiety, depression, life satisfaction or self-esteem have not been indicated (Biegel et al, 1991; Montgomery & Borgatta, 1985; and Toseland & Rossiter, 1989), or effects, while positive, have been small to modest (Knight et al, 1993; Zarit et al, 1999). Researchers have suggested that these findings may reflect the diversity of attendees' motivations and needs, or that the studies may not have assessed some of the most helpful aspects of support group participation, such as decreasing psychotropic medication, developing new friendships, or reducing health problems (Gage & Kinney, 1995).

Research has indicated that caregivers of persons with dementia experience greater caregiver strain, have greater physical and mental health problems, and have less time for leisure and other family members than caregivers supporting older persons without dementia (Ory et al, 1999). Among the

studies that examine the effectiveness of support groups specifically for these caregivers, Gage & Kinney (1995) found that those who attended the support groups engaged in more help-seeking behaviors, but did not differ from nonattendees with respect to caregiving hassles or self-help, negative focus, or coping strategies. However, other studies have found more positive results (George & Gwyther, 1986; Mittelman et al, 1995; Ostwald et al, 1999). For example, a longitudinal treatment/control study (Mittelman et al, 1995) examined the effects of a comprehensive support program on depression in spouse-caregivers. Intervention included individual and family counseling (i.e., six sessions within four months after intake), continuous availability of ad hoc counseling, and support group participation. In the first year after intake, the control group became increasingly more depressed, whereas the treatment group remained stable. By the eighth month, the caregivers of persons with dementia were significantly less depressed than those in the control group.

Ostwald et al (1999) summarize the literature on caregiving interventions by noting three general conclusions: (1) interventions that have taken multiple, rather than single, approaches (e.g., support and education versus support alone) have been more successful in affecting the targeted outcome, such as depression or caregiver burden; (2) intervention programs tailored to particular caregiver situations or to specific patient behaviors, rather than a general framework or approach have been more successful in affecting the identified outcome; and (3) caregivers can acquire skills and knowledge that permit them to carry out sophisticated tasks.

Recent studies have indicated that the use of caregiver services is related to the postponement of nursing home placement (Mittelman et al, 1993; 1996; Mohide et al, 1990). These studies showed both the short- and long-term effectiveness of a family multicomponent intervention with caregivers of persons with dementia in postponing or avoiding nursing home placement. For example, in their 1996 study, Mittelman et al reported that caregivers who received individual and family counseling, support group participation, and ad hoc counseling were significantly less likely to place their spouse in a nursing home than those in the control group, particularly during the early to middle stages of dementia when nursing home placement is generally least appropriate. In fact, spouse caregivers who received the combination of caregiver support services deferred institutionalization of their spouse by an average of 329 days.

RESPIRE CARE

Respite care refers to a wide range of services intended to give temporary relief to caregivers of frail elders. This relief can be provided in a variety of ways from use of volunteers providing short periods of companionship in the home to short stays in institutions. The only common element to these services is the intent of providing a rest for caregivers (Montgomery & Kosloski, 1995).

Informal care provided by family members is the main source of help for the majority of disabled elders living in the community (USDHHS, 1998). What has been consistently reported across studies are the constraints or restrictions of this informal caregiving on time for leisure, social, or personal activities. Overall, 55 percent of caregivers reported less time for other

family members and for vacations, leisure time or hobbies (Tennstedt, 1999; National Alliance for Caregiving and Alzheimer's Association, 1999; McKinlay et al, 1995). This personal time restriction is greater when the needs for care are greater, as is true in dementia care. Respite care is an intervention that aims to alleviate some of the pressures that can accompany caregiving.

What mental health needs can respite care address?

Respite care is provided to benefit both caregivers and elders. For caregivers, respite programs can prevent or alleviate depression and burnout by allowing timeout for the caregiver to use in whatever way he or she determines is needed. This is important for caregivers' mental health and also enables older persons and their families to use community-based rather than institutional services. Research has indicated that the caregiver's capacities and health may be as important in predicting institutionalization as is the physical condition of the person receiving the care (McFall & Miller, 1992; Pruchno et al, 1990). Thus, a major force driving the development of respite has been the belief that respite programs result in net savings to society by reducing or delaying the need for more costly forms of care.

In addition, by bringing families at risk for mental health problems into contact with formal care delivery systems, respite programs offer an opportunity for mental health outreach. For example, the respite provider, after assessing the family situation may be able to increase the family's awareness of needed services available through the aging network – adult day services, meals-on-wheels, or senior center

activities—and to link the family with these services, if they are interested.

How is respite care implemented?

There are many ways that respite care is provided and paid for. Respite care is among the services included in the newly established National Family Caregiver Support Program under the Older Americans Act.

Programs may vary along a continuum from low to high levels of care and respite episodes may range from a few hours to stays of up to six weeks. Clients may use services as frequently as once or twice a week or as infrequently as once or twice a year. There are three models of respite care:

- *In-home services.* The most frequently requested and utilized form of respite service is in-home respite care, which can be provided by a volunteer, homemaker, home health aide, or a nurse. This type of care can include assistance with housework, physical needs, or sitting with the older person. Most in-home programs provide services for a period of three to four hours, although some offer more extended overnight or weekend services;
- *Out-of-home respite.* This type of respite can be provided in a group or institutional setting such as a foster home, adult day care center, respite facility, nursing home, or hospital. Institutional respite usually takes the form of holiday or intermittent readmissions, and some facilities require cumbersome medical exams or other assessments. The most common form of out-of-home respite is provided through adult day care centers, which are

discussed in a separate section of this report; and,

- *Comprehensive care models.* In comprehensive respite programs, the family is able to select from a variety of in-home or out-of-home respite options that offer differing levels of care according to the service that best fits their needs at the time. For example, in one respite program, family members are able to choose from three types of respite for a one-year period: a short nursing home stay, adult day care, or in-home respite from a home health aide or visiting nurse.

Respite care is provided through a range of aging, public mental health, or social service agencies or private organizations. Eligibility may be determined using income and diagnostic criteria. Some private organizations serve a specific type of client, such as the Alzheimer's patient and family.

An example of how respite services can be organized and delivered includes a joint endeavor between a healthcare agency and an Area Agency on Aging. These two organizations operate a service that provides homecare aides who offer companion, personal care, homemaker, or skilled care services. They also have facilities to provide overnight respite care, including supervision by a healthcare worker and participation in day care activities if the respite stay exceeds one night. Payment varies depending on whether the client is entitled to coverage through Medicaid or a social service agency.

How effective is respite care?

In their beginning efforts to study respite, researchers have examined three outcomes: caregiver satisfaction, caregiver

burden/well-being, and institutionalization. While many studies show modest but positive results, evidence regarding the effectiveness of respite care is limited and inconsistent (Zarit et al, 1999). Researchers cite the complexity of the issue as a reason for the mixed findings; for example, variation in the levels, types, and quality of care as well as the characteristics of the elder and caregiver. Additional research is needed to come to definitive conclusions.

The most pervasive finding in the literature is that caregivers like respite programs and find them valuable, especially in-home respite care (Berry et al, 1991; MaloneBeach et al, 1992; Montgomery & Kosloski, 1995; Zarit et al, 1999). Families report benefits including relief from tasks, psychological support, stimulation for the elder, and health assessments of the older person that led to changes in medical routines. Concerns caregivers had about respite care centered on increased confusion and dependency of the elder, disruption of home routines, and relinquishing responsibility and control; however, these problems are more frequently associated with out-of-home services, especially in hospital settings.

Findings with regard to caregiver burden/well-being are inconsistent. Some studies report no significant changes in either caregiver well-being or caregiver strain (Burdz et al, 1988; Deimling, 1991; Lawton et al, 1989; Knight et al 1993), while other studies indicate a lessening of objective or subjective burden for the caregiver (Kosloski and Montgomery, 1993; Montgomery & Borgatta, 1985 and 1989).

Montgomery & Kosloski (1999) examined the factors that influence caregivers' utilization of respite care. They report that caregivers become most receptive to respite programs only when they (1) reach the point

at which they are providing extensive care; *and* (2) have identified themselves as caregivers. It is at this point that respite programs can be expected to have their greatest impact.

Finally, findings with regard to whether respite care prevents or delays institutionalization are mixed. Some studies found that respite had no impact on nursing home placement (Montgomery and Borgatta, 1985 & 1989; Montgomery & Kosloski, 1995); however, another study found the greater the amount of respite use, the less the probability of nursing home placement (Kosloski and Montgomery, 1995).

Assisting older adults with mental health needs requires attention to the body, mind, and spirit. The services described in this chapter can be a vital part of a holistic support system for older people and their families, but could likely be even more effective if the many systems involved—aging, health, and mental health—collaborated to coordinate care and form partnerships with other community organizations. Finally, there is a need to develop innovative models for delivering mental health outreach and care in alternative settings.

MEDICARE AND MEDICAID FINANCING

Among the reasons people do not seek needed mental health care is the cost of such care. Mental health benefits are often restricted by limits on their use or by greater co-payments than for other health services. Studies show that the gap in insurance coverage between mental health and other health services does not just exist – it has been getting wider (Buck & Umland, 1997; HayGroup, 1998; USDHHS, 1999a).

Federal and state legislation to finance mental health services on a comparable basis to general health services has attempted to address this inequity. The Mental Health Parity Act of 1996, implemented in 1998, is geared primarily to the commercial market that covers workers. In June, 1999, the President issued an Executive Order requiring the Office of Personnel Management to implement parity in the coverage of both mental health and substance abuse disorders in the Federal Health Benefit Program by 2001. During the last decade, 43 States have implemented some type of parity requirement. Some state laws include only people with severe mental disorders, while others use a broader definition of mental illness (USDHHS, 1999a). Studies of the effect of parity laws have shown that costs are minimal and that introducing or increasing the level of managed care can limit or reduce the costs of benefit parity (USDHHS, 1999a). Both Medicare and Medicaid are in compliance with the Mental Health Parity Act of 1996, which defines parity in terms of annual or lifetime dollar limits on coverage.

Since 1994, managed care has played an increasing role in both Medicare and Medicaid. About 15 percent of the Medicare population is enrolled in managed care plans and 40 percent of Medicaid enrollees are in these plans (Merchant, 1997). Furthermore, projections are that 35% of all Medicare beneficiaries (15.3 million persons) will be in managed care by 2007 (USDHHS, 1999a). Some states are providing long-term care services in a managed care environment through home and community-based service waivers (HCFA, 1999a).

Despite the potential of managed care to provide comprehensive and preventive care, specialized geriatric programs and clinical case management for older persons tend to be inadequate or poorly implemented (Kane et al., 1997; Pacala et al., 1995). Most managed care systems appear to lack the array of specialized long-term and support services needed by older persons with severe and persistent mental disorders (SPMDs) (Knight et al, 1995). Although studies have shown that managed care reduces mental health care costs, clinical outcomes are mixed. Negative outcomes were found to be more common in patients with chronic conditions, those with conditions requiring more intensive services, low-income enrollees in worse health, impaired or frail elderly, or home health patients with chronic conditions (Miller & Luft, 1997), all risk factors that may apply to older adults with SPMD.

Another recent development that will influence how mental health services for

older persons are delivered is the recent Supreme Court decision, *Olmstead v. L.C.* (1999). The case involved two Georgia women who were mentally retarded and mentally ill and lived in state-run institutions, despite professional assessments that they could be served appropriately in a community setting. Under the Court's decision, states are required to provide community-based services for persons with disabilities when community placement is appropriate, the affected persons do not oppose such a plan, and the placement can be reasonably carried out considering the resources of the state and the needs of others with disabilities. As a result, the Health Care Financing Administration and the Department of Health and Human Services' Office for Civil Rights have encouraged states to develop comprehensive working plans for providing services to eligible individuals in more integrated community-based settings and to ensure the availability and coordination of community-integrated services (HCFA, 2000a).

The discussion that follows will review the current mental health benefits for older persons in the Medicare and Medicaid programs.

Medicare

Medicare is a health insurance program for persons 65 years and older, some persons with disabilities under age 65, and individuals with end-stage renal disease. It consists of Hospital Insurance (Part A) that includes care in hospitals, skilled nursing facilities, hospice, and some home health care, and Medical Insurance (Part B) which is optional and includes doctors services, outpatient hospital care, physical and occupational therapy, and some home health care (USDHHS, 1999b).

Under the original Medicare plan, an older person can go to any doctor, specialist or hospital that accepts Medicare. Most people do not have to pay a monthly premium for Part A, as they paid Medicare taxes while they were working (USDHHS, 1999b). In addition, the older person pays his share in the form of deductibles and copayments and Medicare pays its share. In some parts of the country, Medicare offers Medicare+Choice or various types of managed care plans as Medicare Part C. These plans must cover all Medicare Part A and Part B health care, and some cover extras like prescription drugs (USDHHS, 1999b).

Currently, Medicare mental health benefits include the following (USDHHS, 1999b):

- *Inpatient psychiatric care* if in a general hospital or psychiatric unit of general hospital (few limits). In a psychiatric hospital, coverage is limited to 190 days (lifetime);
- *Outpatient psychotherapy* requires a 50% copayment, while a 20% copayment is required for medical management, diagnostic services and professional services for evaluation; and,
- *Partial hospitalization* is a structured program of intensive services for those in acute psychiatric distress who would be hospitalized without these services. Certification by a physician is required. This benefit is unlimited and a 20% copayment is required. Services can be provided by approved community-based mental health centers, hospital-based programs, or free-standing partial hospital programs. There are 1,150 Medicare certified community mental health centers and 1,000 hospital

outpatient departments that provide these services (HCFA, 1998a; NAMI, 2000).

The most important gaps in Medicare's mental health benefits include the following (NAMI, 2000):

- *Lack of prescription drug coverage.* The new generations of medications represent a major advancement in treatment technology for the mental health field. Some Medicare managed care and Medigap plans cover prescription drugs, but many beneficiaries have no prescription drug coverage. The President's proposal to create a prescription drug benefit under Medicare would address this issue.
- *Differences in co-payments.* A 50% copayment is required for beneficiaries who use outpatient psychotherapy services, while only a 20% copayment is required for most other outpatient health services. HCFA estimates that 33 percent of Medicare beneficiaries have secondary coverage for this additional co-insurance from Medigap or Medicaid plans.
- *Limited coverage of community-based services.* Community care programs such as crisis or assertive community treatment teams, psychosocial rehabilitation, wrap-around services, or intensive case management for persons with severe mental illnesses are not covered under Medicare. These type of care coordination approaches have been successful in helping older adults remain in their own homes and preventing them from being inappropriately admitted to costly institutions. As mentioned previously, HCFA is conducting a demonstration to test the effectiveness of coordinating care for those with certain

serious mental health conditions including psychoses, Alzheimer's disease, alcohol and drug abuse, and depression; and,

- *Limited inpatient specialty psychiatric care.* Medicare has a limit of 190 lifetime days for inpatient treatment in specialty psychiatric hospitals. This is not an absolute limit on inpatient care, since beneficiaries exceeding the 190 days in specialty hospitals could access inpatient care in general hospitals, but this limit can disrupt continuity of care and may not be appropriate to every patient's needs.

Medicaid

Medicaid is a joint Federal and State program that covers medical costs for some people with low incomes and limited resources. It is the principal source of funding for long-term care for the elderly and those of all ages with disabilities, covering 68% of nursing home residents and over 59% of nursing home costs (HCFA, 1996). In 1995, Medicaid served 4.4 million elderly.

Within broad Federal guidelines, each state determines the amount and duration of services offered under its Medicaid program. While Medicaid is more likely than Medicare to provide reimbursement for community care services, there is considerable flexibility at the state level as to whether, and at what rate, a service will be reimbursed (Cohen et al, 2000). Medicare beneficiaries who have low incomes, limited resources, or meet other criteria may receive help paying for their out-of-pocket expenses from their state Medicaid program. And, there are various benefits available to "dual eligibles," or those able to receive both Medicare and

Medicaid. Services covered by both programs will be paid first by Medicare and the difference by Medicaid up to the State's payment limit. Medicaid also covers additional services (e.g., nursing care beyond the 100 day Medicare limit, prescription drugs, eyeglasses and hearing aids) (HCFA, 1999b).

States also have the option of providing Medicaid coverage for other categorically needy groups who are similar to the mandatory groups discussed above, but eligibility criteria are more liberally defined. These groups could include certain aged, blind, or disabled adults, institutionalized individuals, and persons who would be eligible if institutionalized, but are receiving care under home and community-based services waivers. Additionally, a state may choose to include the medically needy population or those who have too much income to qualify under the mandatory or optional categorically needy groups. These persons who may be aged, blind, or disabled may "spend down" to Medicaid eligibility by incurring medical expenses so that their income is below the maximum allowed by the State (HCFA, 1999b).

Certain basic Medicaid services are mandatory and must be offered to the categorically needy population in any State, or those who receive Federally assisted income maintenance payments such as Supplemental Security Income (SSI) recipients including the aged, blind, and disabled; low income families with children; and certain Medicare beneficiaries. Mandatory services include: inpatient hospital services, outpatient hospital services, physician services, nursing facility services for those over 21 years old, and home health care for persons eligible for nursing facility services (HCFA, 1999b).

Those mandatory Medicaid services most relevant to the mental health of older persons are described below (HCFA, 2000b):

- *Nursing facility services* for those age 21 and over include skilled nursing care, rehabilitation services, and health-related services. The facility must maintain an on-going program directed by a qualified professional designed to meet the physical, mental, and psychosocial well-being of each resident as well as treatment required by mentally ill and mentally retarded residents not otherwise provided for by the state. (HCFA, 1999c); and,
- *Home health services* for individuals entitled to nursing facility services. Services must be provided at a recipient's place of residence and must be ordered by a physician and reviewed every 60 days. These services include nursing and home health aide services provided by a home health agency and medical supplies or equipment suitable for use in the home. (HCFA, 1999d).

Medicaid optional services most relevant to mental health include:

- *Rehabilitation services* may be provided in any setting and generally include mental health services such as individual and group therapies; psychosocial services; and physical, occupational, and speech therapies. These benefits must be recommended by the physician (HCFA, 1999e);
- *Targeted case management services* assist an individual to gain access to needed medical, social, educational and other services. These services enable States to reach beyond the bounds of the Medicaid program to coordinate a broad

- range of activities and services; for example housing or legal services. States must submit a separate plan amendment for each target group being served (HCFA, 1998b);
- *Institutions for mental diseases (IMDs)*. States may provide optional coverage for those 65 years of age or older who are in hospitals or nursing facilities that have inpatient facilities of 16 or more beds and a patient roster consisting of more than 51% severe brain disorders by primary admitting diagnosis (HCFA, 1999f). This means that a facility that qualifies as an IMD may receive a higher reimbursement rate if the state in which it is located chooses to provide this benefit;
 - *Personal care* services are provided to individuals who are not inpatients or residents of a hospital, nursing facility, or institution for mental disease. They are most often related to performance of activities of daily living or instrumental activities of daily living; for example, eating, bathing, light housework or medication management. They must be authorized by a physician and be provided by a qualified individual who is not a family member (HCFA, 1999g);
 - *Hospice services*. The purpose of the hospice benefit is to provide for the palliation or management of the terminal illness. It is available to those who have been certified by a physician as terminally ill. Eligible individuals may reside at home or in a nursing facility. Services must be related to the management of the patient's terminal illness, symptom control, or the maintenance of activities of daily living and basic functional skills. Services include nursing care, medical social services, counseling services, respite care, and drugs (HCFA, 1997); and,
 - *Home and community-based services (HCBS)*. States may request waivers of certain Federal requirements in order to develop Medicaid financed community-based treatment alternatives. Federal regulations permit HCBS programs to cover services for specific groups rather than for all Medicaid beneficiaries; for example, the elderly, persons with physical disabilities, the developmentally disabled, mentally retarded, or those with mental illness. Furthermore, waivers allow states to cover Medicaid services that the state has not otherwise elected to make available under the state's Medicaid plan; to cover services on less than a statewide basis; or to cover additional services that are not within the scope that a state could otherwise elect to include in its Medicaid program. With the approval of HCFA, states create their own package of HCBS for persons who would otherwise be in an institution without these services.
- In a waiver program developed for the elderly, a person would have to be 65+, certified as needing the level of care in a nursing home, and meet income eligibility criteria set by the State which may be up to 300% of the Supplemental Security Income (SSI) requirement. There are currently over 240 HCBS waiver programs (HCFA, 2000b). All states have waiver programs for the elderly, but the services included vary by each state. Services may include case management, personal care, respite care, adult day health services, homemaker/home health aide services, habilitation, and other services. The law also permits day treatment or other

partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness (HCFA, 2000c).

Medicaid is a major resource for providing persons who are poor and who have disabilities access to services in both the private and public sectors. Factors that restrict Medicaid coverage of community treatment models include (Taube et al, 1990):

- *Uneven optional benefits.* States have the option of offering minimal or no optional benefits. Thus, Medicaid beneficiaries who need certain services may not have access to them if their

State does not cover these services. The *Olmstead* decision may lead to greater access to community-based services under Medicaid.

- *Reimbursement policies.* The Medicaid program, in general, sets rates lower than those paid by commercial and other third-party insurers. Medicaid payments may not reflect the cost of caring for the behavioral and mental health problems that occur in nursing homes. Furthermore, states determine the payment rates for providers. If these reimbursements are low, highly trained mental health professionals may be reluctant to serve Medicaid beneficiaries (USDHHS, 1999a).

CHALLENGES IN MENTAL HEALTH AND AGING

This report has highlighted some important efforts in the field of mental health and aging. However, a national crisis in geriatric mental health care is emerging and critical challenges must be addressed by policymakers, practitioners, researchers, and consumers. Organized, consistent, and thoughtful efforts are necessary to confront these challenges, especially in light of the expected increase of older adults in our population and their need for a wide range of mental health services.

Many of the challenges discussed below interrelate and overlap with one another. Furthermore, this discussion provides a sampling of potential mental health and aging policy and program responses. The key themes for these challenges were taken from Resolutions of the White House Mini-Conference (Gatz, 1995), *Mental Health: A Report of the Surgeon's General* (USDHHS, 1999a), a report entitled, *Engaging the Aging Services Network in Meeting Substance Abuse and Mental Health Needs of Older People* (NCOA, 1999), the *National Coalition on Mental Health Conference Report* (NCMHA, 1999) and its Draft Action Plan, as well as the research that was done to compile this report.

Prevention and Early Intervention

Challenge: There is a need for early identification of high-risk individuals and families, preventive measures, and mental health promotion.

Strategies: Increase outreach and prevention efforts by: 1) offering mental health education and outreach in locations frequented by older adults and their families, such as doctors' offices, senior centers, and religious organizations; 2) encouraging joint efforts between health, mental health, and aging services care providers; 3) supporting self-help groups; 4) providing opportunities for older adults to have a voice in the development of their own programs; 5) increasing opportunities for meaningful work, both paid and volunteer; 6) supporting research on effective prevention strategies; and 7) utilizing funds provided under Title III-F of the Older Americans Act (Disease Prevention and Health Promotion Services) as well as private monies to implement and evaluate prevention models that address mental health, are holistic, and culturally acceptable (Waters, 1995).

Workforce Issues: Shortages and Need for Education

Challenge: More geriatric mental health professional and paraprofessional personnel are needed in the fields of medicine, mental health, and social services. To meet the growing need for trained professionals and paraprofessionals, recruitment efforts will need to be heightened and more education and training opportunities will be necessary. In this regard, Gatz and Finkel (1995) have noted a lack of consistent funding for graduate specialty programs in aging/mental health and difficulty recruiting adequate numbers of trainees into these programs.

Strategies: Expand the pool of mental health personnel and training opportunities through: 1) increasing specialty training programs in geriatric mental health; 2) integrating aging and mental health content into the curriculum of professional degree programs, including coursework and clinical training; 3) offering advanced workshops, continuing education, certification, and supervised experience for professionals and paraprofessionals; 4) promoting faculty development through career development awards and higher salaries; 5) offering incentives and practicum support for students; 6) targeting paraprofessionals and volunteers in settings such as senior centers or nutrition sites for training in basic communication and helping skills; and 7) emphasizing interdisciplinary practice and cross training between the mental health, substance abuse, primary care, and aging networks

Financing Mental Health Services

Challenges: Federal, state and private funding streams need to be coordinated and strengthened. Access to services may be increased by adjusting public and private reimbursement policies for mental health services, and by encouraging community-based care. Financing and oversight of the provision of mental health services for older persons in nursing homes must be adequate.

Strategies: Improve the financing of mental health services for older persons by: 1) supporting President Clinton's plan to establish prescription drug coverage under Medicare; 2) coordinating benefits for those dually eligible for Medicare and Medicaid; 3) including older adults as a priority population in Community Mental

Health Block Grant funding; 4) encouraging HCFA to review reimbursement methods for nursing home care to determine their impact on the provision of adequate mental health services; and 5) including a focus on the mental health needs of older adults in discretionary grant programs.

Collaboration

Challenges: The delivery system is complex, encompassing a variety of distinct care systems at both the institutional and community levels: primary care, long-term care, mental health services, and aging network services. These multiple systems operate on different principles, and include gaps and overlaps in services. Under such conditions, turfism may predominate and competition rather than cooperation characterizes the system. For example, organizations may limit their services to existing clients rather than accept those who may "belong" to some other system (Gatz, 1995).

Strategies: Encourage collaboration by: 1) promoting partnerships among mental health, substance abuse, primary care, and aging services at national, state, and local levels in order to develop policies and plan programs by developing referral protocols, coordinating care for clients, disseminating research, and sharing best practice information; 2) utilizing collaborative relationships among a wide range of organizations, such as housing programs, churches, and hospitals to provide continuity of care and more comprehensive services; and, 3) expanding and improving case management services for older adults with SPMD; 4) developing a national demonstration program of local partnerships involving aging, mental health, primary care, substance abuse providers and

consumer groups to offer prevention, screening, and referral services.

Access to Mental Health Services

Challenges: Many older persons do not recognize their own mental health needs or do not know how to access and use the service delivery system. Those who live alone, are geographically isolated, frail, or physically disabled have particular difficulty accessing services, which tend to be in short supply. Older adults often use primary care providers as a point of entry, but too many primary care physicians are not adequately prepared to identify mental health needs or refer to appropriate resources.

Strategies: Assure access to an affordable, comprehensive range of quality mental health care by: 1) integrating mental health services with primary and long term care and aging network services; 2) establishing and maintaining culturally sensitive case-finding strategies to reach isolated, rural, and frail elders; 3) training nontraditional “gatekeepers”; 4) routine screening for cognitive, behavioral, and emotional disorders by health care providers; 5) setting performance standards for access, client outcomes, and consumer satisfaction; 6) using state and local networks to address gaps and to coordinate multiple providers and funding streams.

Public Awareness and Education

Challenge: Stigma around mental illness and its treatment is a factor in the underutilization of mental health services. Psychological problems are denied and diagnoses are rejected because of embarrassment or the fear of being ostracized. As a result of these fears, many

older persons are not comfortable with traditional mental health settings or services. Societal stereotypes, such as the belief that depression is an inevitable part of aging, can also hamper efforts to diagnose and treat mental illness.

Strategies: Work to change attitudes and behavior through: 1) educating the public about mental illness and its prevalence among older people, the difference between normal aging and mental illness, how these problems can be diagnosed, treated, and prevented, and available resources; 2) widely disseminating research findings about prevention and treatment interventions; and 3) reinforcing the role of national consumer, service and advocacy groups in educating their membership about these issues.

Research

Challenge: An expanded mental health and aging research agenda is needed to enlarge our understanding of the biological, behavioral, social, and cultural factors related to mental illness, especially for at-risk and underserved populations. This agenda must focus on elucidating which current prevention and treatment strategies are most efficacious, effective, and cost-effective; on developing new models of mental health care; and on measuring and assessing the quality of mental health care for older people.

Strategies: Promote an expanded research agenda as follows: 1) identify and promote a cadre of well-trained researchers representing population diversity and interdisciplinary approaches; 2) foster linkages among researchers, practitioners and service providers, and consumer groups; 3) encourage evidence-based, outcome-oriented research as well as the use of a mix

of qualitative and quantitative methods. Outcomes can include measures of quality of life, self-maintenance, reduction in disability, family functioning, and cost; 4) support research in the areas of prevention, intervention, health services, training, and the translation of basic research into clinical applications; and 5) disseminate research results to a wide audience.

Consumer Involvement

Challenges: Issues of access, comprehensiveness, and quality of mental health services depend in considerable part on consumer and family involvement, participation, and advocacy. Until recently, there has not been an organized national constituency to advocate for expanded funding and the provision of accessible, culturally appropriate, and effective mental health services for older persons. More education, training, and support for families and others caring for older persons with mental illness are needed.

Strategies: Encourage involvement by: 1) recognizing that older adults of all ethnicities, cultures, and socioeconomic circumstances are themselves a primary resource for the maintenance and achievement of mental health; 2) fostering an active constituency of consumers and significant others to advocate for the reduction of stigma and educate the public and providers about the care and treatment of mentally ill older persons; 3) including consumers and family members in partnership with providers on advisory committees at Federal, state and local levels to plan and develop mental health research, systems, and services; 4) assisting recovery from mental illness and substance abuse by providing a supportive environment for self-help support groups.

Addressing the Needs of Special Populations

Challenges: There is a need to address the mental health needs of ethnic and other minorities. Members of ethnic minority groups are less inclined than whites to seek treatment and to use outpatient treatment services, and there is an insufficient number of mental health professionals from ethnic minority groups. Furthermore, language barriers exist in many programs, possibly leading to inadequate services. Asking family members or other acquaintances to act as interpreters increases the person's vulnerability, compromises their confidentiality, and can hinder a full and open discussion of the individual's mental health needs. Finally, there is a need for mental health approaches that are effective for older adults in special populations.

Strategies: Tailor approaches to special populations of older persons by: 1) recruiting, training, and employing practitioners knowledgeable about these populations; 2) developing specialized minority-oriented programs that include aggressive outreach efforts and encourage styles of practice best suited to the problems of these populations; 3) training all mental health practitioners and policymakers to be culturally competent by recognizing and responding to the concerns of ethnic minorities and the other special populations, including their histories, traditions, beliefs, and value systems; 4) encouraging all professional schools to include content pertaining to ethnic and cultural diversity, socioeconomic status, gender, sexual orientation, physical disability, and rural settings in their curriculum; 5) building systems that recognize, incorporate, practice, and value cultural diversity; 6) encouraging a heightened sensitivity to language assistance needs and assure

language assistance in the provision of mental health services for older persons with limited English proficiency; and 7) recruiting and training an ethnically and racially diverse mental health workforce.

Conclusion

Addressing these challenges will require the concerted efforts of all those working for better mental health of older persons in both the public and private sectors, including policymakers, practitioners and service providers, researchers, consumers and family members, and other advocates. And, the time to address these critical challenges is surely upon us, for if we wait, our service

systems will be overwhelmed with the influx of aging baby boomers and the suffering that many seniors who are not able to access mental health services currently endure will continue.

We can take advantage of the numerous efforts in mental health and aging that have been implemented and can use them as a foundation for crafting policies, programs, and research that will enhance the mental health of older persons and their families. The emerging crisis in geriatric mental health care also provides the opportunity to work in partnership across services systems and disciplines to address the mental health needs of older adults.

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CHAPTER 6: CHALLENGES IN MENTAL HEALTH AND AGING

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SUMMARY OF SURGEON GENERAL'S REPORT

Many of the themes introduced in this report are discussed in Chapter 5: Older Adults and Mental Health in *Mental Health: A Report of the Surgeon General*. The following is the concluding section of Chapter 5 (USDHHS, 1999a, p. 381):

- Important life tasks remain for individuals as they age. Older individuals continue to learn and contribute to the society, in spite of physiologic changes due to aging and increasing health problems;
- Continued intellectual, social, and physical activity throughout the life cycle are important for the maintenance of mental health in late life;
- Stressful life events, such as declining health and/or the loss of mates, family members, or friends often increase with age. However, persistent bereavement or serious depression is not “normal” and should be treated;
- Normal aging is not characterized by mental or cognitive disorders. Mental or substance use disorders that present alone or co-occur should be recognized and treated as illnesses;
- Disability due to mental illness in individuals over 65 years old will become a major public health problem in the near future because of demographic changes. In particular, dementia, depression, and schizophrenia, among other conditions, will all present special problems in this age group:
 - Dementia produces significant dependency and is a leading contributor to the need for costly long-term care in the last years of life.
 - Depression contributes to the high rates of suicide among males in this population.
 - Schizophrenia continues to be disabling in spite of recovery of function by some individuals in mid to late life;
- There are effective interventions for most mental disorders experienced by older persons (for example, depression and anxiety), and many mental health problems, such as bereavement;
- Older individuals can benefit from the advances in psychotherapy, medication, and other treatment interventions for mental disorders enjoyed by younger adults, when these interventions are modified for age and health status;
- Treating older adults with mental disorders accrues other benefits to overall health by improving the interest and ability of individuals to care for themselves and follow their primary care provider's directions and advice, particularly about taking medications;
- Primary care practitioners are a critical link in identifying and addressing mental disorders in older adults. Opportunities are missed to improve mental health and general medical outcomes when mental illness is underrecognized and

- undertreated in primary care settings; and,
- Barriers to access exist in the organization and financing of services

for aging citizens. There are specific problems with Medicare, Medicaid, nursing homes, and managed care.

RESOURCES ON MENTAL HEALTH AND AGING

The resources included in this section are a collection of national organizations that focus on mental health or aging or both areas and may be of interest to practitioners, policymakers and researchers. The listing of non-governmental entities or services does not constitute an endorsement or recommendation. While many of these organizations may be good sources of information, the Department of Health and Human Services does not endorse any specific products or services provided by them.

The organizations are listed in alphabetical order and each listing includes contact information organized by:

- name of organization;
- address;
- telephone number and fax number;
- toll-free number or hotline, if available;
- Internet web site address or URL if available; and,
- summary of the services and resources provided by the organization.

Federal Government Resources

Administration on Aging

330 Independence Avenue, SW
Washington, DC 20201
(202) 619-4541
<http://www.aoa.gov>

The Administration on Aging (AoA) is the Federal focal point for services to older Americans. Under the Older Americans Act, the AoA and its nationwide network of

State and Area Agencies on Aging, Tribal Organizations, and service providers plan, coordinate, and develop community-level systems of services that help vulnerable older persons to remain in their homes and communities. A range of Older Americans Act supported services are offered at the State and local levels including nutrition, transportation, information and assistance, the long-term care ombudsman program, and legal services. AoA's web site contains information for older persons and their families, practitioners, the aging network, and researchers and students, including a resource directory of organizations relevant to older persons.

▪ Eldercare Locator

Washington, DC

(800) 677-1116

<http://aoa.gov/elderpage/Locator.html>

The Eldercare Locator is a nationwide directory assistance service designed to help older persons and caregivers locate supportive resources for aging Americans at the local level. The toll-free number is operated as a cooperative partnership of the Administration on Aging, the National Association of Area Agencies on Aging, and the National Association of State Units on Aging. Information specialists provide callers the names and telephone numbers of the most appropriate local information and referral resources weekdays from 9 a.m. to 11 p.m (EST).

Health Care Financing Administration

7500 Security Boulevard
Baltimore, MD 21244-1850
(410) 786-3000
<http://www.hcfa.gov>

The Health Care Financing Administration is the Federal agency that administers the Medicare and Medicaid programs. HCFA sponsors health care quality assurance programs such as the Medicare Hotline. HCFA also sets eligibility requirements for Medicare recipients, develops claims procedures for health care providers, and regulates the contractors that process Medicare claims. HCFA works with states to jointly fund and administer the Medicaid program. In addition to providing health insurance, HCFA also performs a number of quality-focused activities, including regulation of laboratory testing, surveys and certification of health care facilities, development of coverage policies, and quality-of-care improvement. HCFA's web site includes the Information Clearinghouse, an online source for HCFA publications, and information on its insurance programs, statistics, and research.

Health Resources and Services Administration

5600 Fishers Lane
Room 14-05 Parklawn Building
Rockville, MD 20857
(301) 443-2216
FAX: (301) 443-1246
www.hrsa.gov

The Health Resources and Services Administration (HRSA) directs national health programs that improve the Nation's health by assuring equitable access to comprehensive, quality health care for all. HRSA works to improve and extend life for people living with HIV/AIDS, provide primary health care to medically

underserved people, serve women and children through State programs, and train a health workforce that is both diverse and motivated to work in underserved communities.

National Institute on Aging

Public Information Office
Building 31, Room 5C27
31 Center Drive, MSC 2292
Bethesda, MD 20892-2292
(301) 496-1752
Fax: (301) 496-1072
<http://nih.gov/nia>

The National Institute on Aging (NIA), one of the 25 institutes and centers of the National Institutes of Health, leads a broad scientific effort to understand the nature of aging and to extend the healthy, active years of life. The NIA's mission is to improve the health and well-being of older Americans by conducting high quality research on aging processes, age-related diseases, and special problems and needs of the aged. NIA also trains highly skilled research scientists from all population groups, develops and maintains state-of-the art resources to accelerate research progress, and disseminates information to the public and interested groups on health and research advances and new directions for research. Information on NIA's research programs is available on its web site. Their Alzheimer's Disease Education and Referral Center is a service provided through NIA; this resource is listed separately in this resource guide.

▪ **Alzheimer's Disease Education and Referral Center**

P.O. Box 8250
Silver Spring, MD 20907-8250
(301) 495-3311
(800) 438-4380
Fax: (301) 495-3334
<http://www.alzheimers.org>

The Alzheimer's Disease Education and Referral (ADEAR) Center, a service of the National Institute on Aging, distributes information about Alzheimer's disease to health professionals, patients and their families, and the general public. The Center responds to written and telephone inquiries and provides information about the diagnosis and treatment of Alzheimer's disease, research, and services available to patients and family members. The bibliographic references of the Center are included in the Combined Health Information Database (CHID), a computerized index available through a commercial database vendor.

National Institute of Mental Health

NIMH Public Inquiries

6001 Executive Boulevard, room 8184,
MSC 9663

Bethesda, MD 20892-9663

(301) 443-4513

Fax: (301) 443-4279

<http://www.nimh.nih.gov>

The National Institute of Mental Health (NIMH), part of the National Institutes of Health, conducts and supports research to learn more about the causes, prevention, and treatment of mental and emotional disorders. NIMH supports researchers in hospitals, universities, and mental health centers around the country who are studying biological, genetic, psychological, social, and environmental factors related to mental health and mental illness. Its Mental Disorders of the Aging Program specializes in research about how the aging process affects mental health and mental illness. NIMH collects and distributes scientific and technical information related to mental illness, as well as educational materials for the general public. NIMH does not provide

referrals to mental health or health care providers, nor counsel people on specific mental health problems. Its web site is designed for the public, members of the research community, and health practitioners and includes fact sheets on mental illnesses, statistics, clinical trials, informational materials in Spanish, and information about intramural research and funding opportunities.

Office of the U.S. Surgeon General

5600 Fishers Lane, Room 18-66

Rockville, MD 20857

(301) 443-4000

Fax: (301) 443-3574

<http://www.surgeongeneral.gov>

The Office of the Surgeon General administers the U.S. Public Health Service (PHS) Commissioned Corps, a career force of public health professionals who can respond to both current and long-term health needs of the Nation. The Office protects and advances the health of the Nation through educating the public; advocating for disease prevention and health promotion programs; and providing a symbol of national commitment to protecting and improving the public's health. In addition, the Office articulates to the President and Secretary of Health and Human Services scientifically based health policy analysis and advice on the full range of public health, medical, and health system issues facing the Nation. And, the Office provides leadership in promoting special Departmental health initiatives and advancing standards and research priorities for public health practice.

Substance Abuse and Mental Health Services Administration

5600 Fishers Lane
Room 12-105 Parklawn Building
Rockville, MD 20857
Office of the Administrator: (301) 443-4795; Fax: (301) 443-0284
Office of Communications (301) 443-8956;
Fax: (301) 443-9050
<http://www.samhsa.gov>

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the Federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitation services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illness. SAMHSA exercises leadership in: eliminating stigma; developing, synthesizing and disseminating knowledge; providing strategic funding to increase the availability of services; promoting effective prevention, treatment, and rehabilitation policies and services; developing standards for service delivery; developing models for training and education; and implementing data collection and evaluation systems. The following programs are part of SAMHSA:

- **Center for Mental Health Services**
5600 Fishers Lane
Room 17-99 Parklawn Building
Rockville, MD 20857
Office of the Director: (301) 443-0001;
Fax: (301) 443-1563
Office of External Liaison: (301) 443-2792; Fax: (301) 443-5163
(800) 789-2647 (Knowledge Exchange Network)
<http://www.mentalhealth.org/cmhs/index.htm>

The Center for Mental Health Services (CMHS) helps States improve the

quality and range of their treatment, rehabilitation, and support services for adults and children with serious mental illness, their families, and communities. CMHS oversees the Community Mental Health Block Grant, leads Federal efforts in delivering mental health services, generates and applies new knowledge, and establishes national mental health policy. It supports outreach and case management programs for Americans with severe mental illness who are homeless and supports the adoption of models for improving services. And, the Center collects data pertaining to managed care delivery systems in the public sector and promotes consumer participation in the delivery of mental health and related support services. Finally, the Knowledge Exchange Network (KEN) provides information about mental health via a toll-free number (listed above), a web site, and more than 200 publications.

- **Center for Substance Abuse Prevention**
5600 Fishers Lane
Room 900, Rockwall II
Rockville, MD 20857
Office of the Director: (301) 443-0365;
Fax: (301) 443-9140
Prevention Application & Education:
(301) 443-0373; Fax: (301) 443-5592
(800) 967-5752 (Workplace Helpline)
<http://www.samhsa.gov/csap>

The Center for Substance Abuse Prevention (CSAP) provides national leadership in the Federal effort to prevent alcohol, tobacco and illicit drug problems. CSAP connects people and resources to innovative ideas and strategies, and encourages efforts to reduce and eliminate alcohol, tobacco, and illicit drug problems both in the

United States and internationally. CSAP participates in the development of new knowledge about prevention, disseminates it in a user-friendly manner, and encourages its application in settings where it is likely to prevent or reduce substance abuse. CSAP sponsors the National Clearinghouse for Alcohol and Drug Information that provides information in English and Spanish (listed separately in this guide), the Workplace Helpline that provides telephone consultation services on how to implement prevention programs in the workplace, PREVline, an electronic communication system via the Internet, and public education campaigns.

- **National Clearinghouse for Alcohol and Drug Information**

11426 Rockville Pike, Suite 200
Rockville, MD 20852-3007
(800) 729-6686
Fax: (301) 468-6433
<http://www.health.org>

The National Clearinghouse for Alcohol and Drug Information (NCADI) is the information service of the Center for Substance Abuse Prevention. NCADI services include: an information services staff (English, Spanish, TDD capability) equipped to respond to alcohol, tobacco and drug (ATD) inquiries; distribution of free or low-cost ATD materials, including fact sheets, brochures, monographs, posters, and video tapes; a repertoire of culturally-diverse prevention, intervention, and treatment resources for parents, teachers, youth, communities, and prevention/treatment professionals; and access to the Prevention Materials database including over

8,000 prevention-related materials and the Treatment Resources Databases, available to the public in electronic form.

- **Center for Substance Abuse Treatment**

5600 Fishers Lane
6th Floor, Rockwall II
Rockville, MD 20857
Office of the Director: (301) 443-5700;
Fax: (301) 443-8751
Office of Communications & External
Liaison: (301) 443-5052; Fax: (301)
443-7801
(800)-662-4357 (National Drug &
Alcohol Treatment Routing Services)
<http://www.samhsa.gov/csat>

The Center for Substance Abuse Treatment (CSAT) works cooperatively across the private and public treatment spectrum to identify, develop and support policies, approaches and programs that enhance and expand treatment services for individuals who abuse alcohol and other drugs and that address individuals' addiction-related problems. CSAT administers the Substance Abuse Prevention and Treatment (SAPT) Block Grant as well as various demonstration programs. CSAT also operates the Treatment Improvement Exchange (TIE) Forum web site that includes information exchange services, information on special topics, and State information. CSAT's data resources include the National Directory of Drug and Alcohol Treatment and Prevention Programs, Treatment Outcomes and Performance Pilot Studies (TOPPS) and National Evaluation Data Services. Finally, the Center operates the National Drug & Alcohol Treatment Routing Services using a toll-free number (listed above) to

offer alcohol and other drug abuse-related information and/or referrals to people seeking treatment programs.

- **The Office of Applied Studies**
Publications and Data Dissemination
5600 Fishers Lane, Room 16-105
Rockville, MD 20857
(301) 443-6239
Fax: (301) 443-9847
<http://www.samhsa.gov>

The Office of Applied Studies serves as SAMHSA's focal point for data collection, analysis and dissemination activities. Data are collected on the incidence and prevalence of substance abuse, the adverse health consequences associated with drug use, and the Nation's treatment system and outcomes. Statistics, research, and publications are available on its web site.

Non-Federal Resources

- Alliance for Aging Research**
2021 K Street NW, Suite 305
Washington D.C. 20006
(202) 293-2856
Fax: (202) 785-8574
<http://www.agingresearch.org>

The Alliance for Aging Research is a citizen advocacy organization aimed at promoting scientific research in human aging and working to ensure healthy longevity for all Americans. The Alliance serves as a clearinghouse of information about the state of aging research in the United States and abroad and conducts educational programs to increase communication and understanding among professionals who serve older people.

Alzheimer's Association

919 North Michigan Avenue, Suite 1100
Chicago, IL 60611
(312) 335-8700
Fax: (312) 335-1110
(800) 272-3900
<http://www.alz.org>

The Alzheimer's Association is a voluntary organization that sponsors public education programs and offers supportive services to patients and families who are coping with Alzheimer's disease. The Association offers a 24-hour toll-free hotline that provides information about Alzheimer's disease and links families with local chapters, which are familiar with community resources and can offer practical suggestions for daily living. The Association also funds research to find a cure for Alzheimer's disease.

American Association for Geriatric Psychiatry

7910 Woodmont Avenue, Suite 1050
Bethesda, MD 20814-3004
(301) 654-7850
Fax: (301) 654-4137
<http://www.aagppa.org>

The American Association for Geriatric Psychiatry (AAGP)'s mission is to improve the knowledge base and standard of practice in geriatric psychiatry through education and research and to be an active advocate for the mental health needs of a growing aging population and the physicians working to meet those needs.

American Association of Homes and Services for the Aging

901 E Street NW, Suite 500
Washington, D.C., 20004-2037
(200) 783-2242
Fax: (202) 783-2255
<http://www.aahsa.org>

The American Association of Homes and services for the Aging (AAHSA) is the national association of nonprofit organizations dedicated to providing quality housing, health, community, and related services to older people. AAHSA's mission is to represent and promote the common interests of its members through leadership, advocacy, education, and other services. AAHSA offers continuing education programs, encourages community involvement in homes for the aging to ensure quality of care, and sponsors the Continuing Care Accreditation Commission which accredits qualified continuing care retirement communities.

AARP

601 E Street NW
Washington, DC 20049
(202) 434-2277
(800) 424-3410
<http://www.aarp.org>

AARP (formerly the American Association of Retired Persons) is a nonprofit organization dedicated to helping older Americans achieve lives of independence, dignity, and purpose. Local AARP chapters, which are listed in the telephone directory, sponsor educational programs on crime prevention, consumer protection, defensive driving, and income tax preparation. Members of AARP may participate in group health, auto, life and home insurance programs; an investment program; and an annuity program. Ageline is a bibliographic database produced by AARP that can be accessed through online search services or a CD-ROM.

- **AARP Widowed Persons Service**
601 E. Street NW
Washington, DC, 20049
(202) 434-2260
(800) 424-3410
www.aarp.org/griefprograms/wpsprog.html

AARP Widowed Persons Service (WPS) is a community-based program in which trained widowed volunteers reach out to the newly widowed. WPS is a self-help program offering one-to-one support, group work, public education, a telephone and referral service, and an outlet for rebuilding life as a single person. In participating communities, community cosponsors bring local leadership and resources, while AARP provides technical support, training materials, consultative expertise, and a national identity. The toll-free number listed above can be used to locate the nearest WPS program.

American Federation for Aging Research
1414 Avenue of the Americas, 18th Floor
New York, NY 10019
(212) 752-2327
Fax: (212) 832-2298
<http://www.afar.org>

The American Federation for Aging Research (AFAR) is a private, nonprofit, volunteer organization that supports research aimed at understanding the aging process and the diseases and conditions that affect older people. AFAR funds studies on biomedical mechanisms of aging, genetics, human growth and development, environmental and lifestyle factors and their relationship to aging, and diseases that cause disability or that affect the lifespan.

American Foundation for Suicide Prevention

120 Wall Street, 22nd Floor
New York, NY 10005
(212) 363-3500
(888) 333-2377
Fax: (212) 363-6237
<http://www.afsp.org>

The American Foundation for Suicide Prevention (AFSP) is dedicated to advancing the knowledge of suicide and the ability to prevent it. The Foundation's activities include supporting research projects that help further the understanding and treatment of depression, the prevention of suicide, and providing information and education about depression and suicide. The toll-free line is an information and referral center, providing educational materials and a database of survivor support groups across the Nation. Contact information for AFSP chapters is listed on the web site.

American Geriatrics Society

The Empire State Building, Suite 801
350 Fifth Avenue North
New York, NY 10021
(212) 308-1414
Fax: (212) 832-8646
<http://www.americangeriatrics.org>

The American Geriatrics Society (AGS) is a nonprofit organization of physicians and other health care professionals committed to providing quality health care to older persons. AGS provides leadership for professionals, policymakers and the public. To ensure the delivery of quality health care to older persons, AGS develops, implements, and advocates for programs in patient care, research, professional education, public policy, and public information.

American Managed Behavioral Healthcare Association

700 13th Street NW, Suite 950
Washington, DC 20005
(202) 434-4565
Fax: (202) 434-4564
<http://www.ambha.org>

The American Managed Behavioral Healthcare Association (AMBHA) is a nonprofit trade association representing managed behavioral healthcare organizations. The Association's primary objectives are to: promote accountability of health plans; manage behavioral healthcare organizations and providers through performance measurement; promote nondiscriminatory coverage of mental illness and substance use disorders in health benefits; and support consumer rights and protections.

American Mental Health Counselor's Association

801 N. Fairfax Street, Suite 304
Alexandria, VA 22314
(703) 548-6002
(800) 326-2642
Fax: (703) 548-4775
<http://www.amhca.org>

The American Mental Health Counselor's Association seeks to enhance the profession of mental health counseling through advocacy, education, and professional development. The Association focuses on public policy and legislation that will protect its members' right to practice. It also develops national standards for clinical training and practice and present professional development programs, including an annual conference. The web site includes information on membership, public policy, publications, and programs.

American Nurses Association

600 Maryland Avenue, SW, Suite 100 W
Washington, DC, 20024-2571
(202) 554-4444
(800) 274-1262
Fax: (202) 651-7001
<http://www.nursingworld.org>

The American Nurses Association (ANA) is a full-service professional organization representing the Nation's 2.6 million registered nurses through its 53 constituent State associations and 13 organizational affiliate members. Its vision is to ensure quality health care for all people by protecting and enhancing professional nursing practice in all environments. The ANA offers continuing education programs, studies health care needs and practices, lobbies Federal and State governments for appropriate legislation, collects and distributes data pertaining to the nursing profession, and sets standards for gerontological nursing.

American Psychiatric Association

1400 K Street, NW
Washington, D. C. 20005
(202) 682-6220
Fax: (202) 682-6850
<http://www.psych.org>

The American Psychiatric Association is a professional society of psychiatrists, medical doctors who specialize in treating people with mental and emotional disorders.

The APA supports research to improve diagnosis, treatment, and rehabilitation of people with mental or emotional illness, sets standards for facilities that provide psychiatric care, and offers continuing education programs for psychiatrists. Its Council on Aging evaluates psychiatric care for older patients and offers training programs in geriatric psychiatry. Issues of particular concern include the use of

medicines by older people, nursing home care, and treatment of patients with Alzheimer's disease and other dememntias.

American Psychiatric Nurses Association

1200 19th Street NW, Suite 300
Washington, D.C. 20036-2401
(202) 287-1133
Fax: (202) 847-1102
<http://www.apna.org>

The American Psychiatric Nurses Association (APNA) provides leadership to advance psychiatric-mental health nursing practice; improves mental health care for culturally diverse individuals, families, groups, and communities; and shapes health policy for the delivery of mental health services. The APNA facilitates the professional development of psychiatric-mental health nurses through programs related to the creation, exchange, and engineering of new knowledge skills. The Association promotes established standards of clinical practice, participates in implementing and evaluating delivery systems in psychiatric-mental health care, and represents psychiatric-mental health nursing in the health care community.

American Psychological Association

750 First Street NW
Washington, D.C. 20002
(202) 336-5500
Fax: (202) 842-1150
<http://www.apa.org>

The American Psychological Association (APA) is a professional society of psychologists, health professionals who counsel people with mental, emotional, or behavioral problems. APA offers continuing education programs, establishes professional qualifications, and supports mental health research. Its Division of Adult Development and Aging conducts

research on the psychosocial aspects of aging. Psych Abstracts, a computerized database, provides references to journals, books, technical reports, and other publications dealing with psychology. State chapters help individuals locate a psychologist for consultation and investigate complaints about individual counselors.

American Society on Aging

833 Market Street, Suite 511
San Francisco, CA 94103
(415) 974-9600
Fax: (415) 974-0300
<http://www.asaging.org>

The American Society on Aging (ASA) is a nonprofit, membership organization that informs the public and health professionals about issues affecting the quality of life for older people and promotes innovative approaches to meet those needs. The ASA publishes a journal, newspaper, and newsletter. Members of the network also plan and participate in educational programs addressing mental health and aging concerns.

The American Society on Aging (ASA) Learning Center carries out programs including: the Summer Series on Aging, web-enhanced teleconferences and computer-based training, and an online store and searchable databases that provide a one-stop shop for education and training resources in aging. ASA's web site has information on conferences, programs, publications, and membership.

Anxiety Disorders Association of America

11900 Parklawn Drive, Suite 100
Rockville, MD 20852-2624
(301) 231-9350
Fax: (301) 231-7392
<http://www.adaa.org>

The Anxiety Disorders Association of America (ADAA) promotes the prevention and cure of anxiety disorders and works to improve the lives of all people who suffer from them. The association is made up of professionals who conduct research and treat anxiety disorders and individuals who have a personal or general interest in learning more about such disorders. Its web site contains information on membership, anxiety disorders, and consumer and professional resources.

ARCH National Respite and Resource Center

Chapel Hill Training-Outreach Project
800 Eastowne Drive, Suite 105
Chapel Hill, North Carolina, 27514
(919) 490-5577
Fax: (919) 490-4905
(888) 671-2594
<http://chtop.com/archbroc.htm>

The ARCH National Respite and Resource Center provides a National Respite Locator service; a lending library of relevant books, journals, and audiovisual materials; and an informative web site with downloadable factsheets on respite. Professional staff offer training and telephone technical assistance to State and local agencies to develop and maintain effective respite programs; jointly-sponsored training events with other organizations; presentations at professional conferences; technical assistance visits; and products including quarterly newsletters, and other training materials.

Association for Adult Development and Aging

5999 Stevenson Avenue
Alexandria, VA 22304
(703) 823-9800
Fax: (703) 823-0252
<http://www.counseling.org>

The Association for Adult Development and Aging provides leadership and information to gerontological counselors and others on matters related to the development and needs of adults across the lifespan. The Association serves as a focal point within its parent organization, the American Association for Counseling and Development, for information dissemination, service, and professional development related to adult development and aging. It also provides a forum for discussion of ethnical, social, and technical issues related to counseling adults across the lifespan and seeks to improve the standards of professional service to adults throughout life.

Bazon Center for Mental Health Law

1101 15th Street NW, Suite 1212
Washington, DC, 20005-5002
(202) 467-5730
Fax: (202) 223-0409
<http://www.bazon.org>

The Bazon Center acts as a legal advocate for people with mental illness and mental retardation. The Center's current work is focused on reform of public systems to serve adults, children, and older people with mental disabilities in their communities; access to housing, health care, and support services; services to help children with disabilities; and protections against discrimination in housing, employment, and public services.

Brookdale Center on Aging

425 East 25th Street
New York, NY 10010
(212) 481-4426
Fax: (212) 481-5069
<http://www.brookdale.org>

The Brookdale Center on Aging of Hunter College offers professional training and

support to those who provide services to older people. The Center offers up-to-date research and information on aging to policymakers and practitioners in the field of aging.

The Center's Institute on Law and Rights of Older Adults advocates for the legal rights of older people, conducts conferences and seminars for lawyers and social workers, and publishes free and low-cost materials on elder law issues. The Center's Training Division offers workshops and professional development programs, as well as videos, books, and curriculum materials. Technical assistance is available to local groups starting respite care services for caregivers of those with Alzheimer's disease.

Center for the Study of Aging of Albany

705 Madison Avenue
Albany, NY 12208-3604
(518) 465-6927
Fax: (518) 462-1339
<http://members.com/iapass>

The Center for the Study on Aging of Albany is a nonprofit organization dedicated to improving the quality of life for older people through research, education, and training.

The Center offers expert technical assistance to researchers; conducts a variety of leadership training seminars; publishes books and manuals; and sponsors national and international conferences on health, fitness, and disease prevention. The Center also functions as a small think-tank to develop creative programs and policy papers; provides information and referral services to assist professionals and lay people to locate resources for research and practice; and provides consulting services to professionals in areas such as adult day services, mental health, housing, nutrition, physical and mental fitness, disease prevention, and retirement.

The Coalition on Mental Health and Aging

AARP
601 E Street NW
Washington, D.C. 20049
(202) 434-2263
Fax: (202) 434-7683
<http://www.aarp.org>

The Coalition on Mental Health and Aging includes more than 40 organizations, as well as several Federal agencies. Information exchange occurs on a regular basis on policy matters including research funding, reimbursement issues, and barriers that inhibit efficient, cost-effective interventions to prevent or treat mental disorders. The Coalition also serves as a model for State and local coalitions. Its "How-To-Guide", published in 1994, has encouraged formation of such groups.

Depression and Related Affective Disorders Association

Johns Hopkins Hospital
Meyer 3-181, 600 North Wolf Street
Baltimore, MD 21287-7381
(410) 955-4647
Fax: (410) 614-3241
<http://www.med.jhu.edu/drada>

The Depression and Related Affective Disorders Association's (DRADA) mission is to alleviate the suffering arising from depression and manic depression by assisting self-help groups, providing education and information, and lending support to research programs. Its web site includes information on support groups, research studies, membership, research reports, and book reviews. An order form and information on books and videos sold by the organization is also online.

Family Caregiver Alliance

690 Market Street, Suite 600
San Francisco, CA 94104
(415) 434-3388
Fax: (415) 434-3508
<http://www.caregiver.org>

The Family Caregiver Alliance (FCA) supports and assists caregivers of brain-impaired adults through education, research, services, and advocacy. Its information clearinghouse covers research findings and trends, information on specific diagnosis of cognitive disorders, statistics on long term care, recommended readings, and a full listing of FCA publications, and fact sheets. The FCA assists organizations in all parts of the Nation to establish new programs for caregivers and helps government agencies to develop legislation and determine resources needed for the future. FCA works with Human Resources Programs and Employee Assistance Programs to establish cost-effective programs that support employees juggling the dual demands of work and eldercare. And, FCA conducts caregiver workshops, state-of-the art research presentations, professional training, and public policy conferences. The web site offers information on a wide range of caregiver issues, services and support.

Gerontological Society of America

1030 15th Street NW
Washington, D.C. 20005-1503
(202) 842-1275
Fax: (202) 842-1150
<http://www.geron.org>

The Gerontological Society of America (GSA) is a professional organization that promotes the scientific study of aging in the biological and social sciences. The Society works to improve the well being of older persons by promoting the study of the aging process. To encourage the exchange of

scientific information about aging, the Society sponsors conferences and information programs and distributes professional education materials. The GSA information service is a computerized database geared toward professionals and researchers in the field that provides sources of information on aging and identifies experts in aging research.

John Douglas French Foundation for Alzheimer Research

11620 Wilshire Boulevard, Suite 270
Los Angeles, CA 90025
(310) 445-4650
(800) 477-2243
Fax: (310) 479-0516
<http://www.jdfaf.org>

The mission of the French Foundation for Alzheimer Research is to generate funds for Alzheimer's research in order to delay the onset or find a cure within the next decade. Funding is targeted to areas of research not supported by government agencies. The Foundation, through its International Scientific Advisory Board, funds scientific projects throughout the world. It also shares research advances at local, regional, and international conferences and workshops. Additionally, the Foundation sponsors programs to foster public awareness, education, and improved patient care including providing educational information to families of Alzheimer's victims, health professionals and the general public; funding and coordinating an intergenerational Alzheimer's educational program; and supporting patient care programs at local care facilities.

The National Adult Day Services Association

National Council on Aging, Inc.
409 3rd Street SW, Suite 200
Washington DC, 20024
(202) 479-6682
Fax: (202) 479-0735
<http://www.ncoa.org/nadsa>

The National Adult Day Services Association (NADSA), a nonprofit unit of The National Council on the Aging, offers consumer guidelines for selecting adult day services. NADSA is the national voice for adult day services practitioners and consumers.

Its purpose is to promote the concept of adult day services as a viable community-based option for disabled older persons; to collect, prepare and disseminate information on all aspects of adult day services; and to provide assistance and guidance to adult day service programs and planners of new programs through consultation services, publication of instructional materials, and the formulation of standards.

National Alliance for Caregiving

4720 Montgomery Lane, Suite 642
Bethesda, MD 20814
(301) 718-8444
Fax: (301) 652-7711
<http://www.caregiving.org>

The National Alliance for Caregiving (NAC) is a nonprofit venture created to support family caregivers of the elderly and the professionals who serve them. There are three NAC partners: the American Society on Aging, the Department of Veteran's Affairs, and the National Association of Area Agencies on Aging, and founding sponsor Glaxo Wellcome. There are also 11 affiliate organizations. Recognizing that family caregivers provide important societal and financial contributions toward

maintaining the well-being of older Americans, the Alliance was created to conduct research, develop national projects, and increase public awareness of the issues of family caregiving. The Alliance is developing projects to support employed caregivers, to educate caregivers of those in managed care, and to establish a network of caregiving training programs available around the country.

National Alliance for the Mentally Ill

Colonial Place Three
2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042
(703) 524-7600
(800) 950-6264
Fax: (703) 524-9094
<http://www.nami.org>

The National Alliance for the Mentally Ill (NAMI) is a nonprofit self-help and family advocacy organization dedicated to improving the lives of people with severe mental illnesses such as schizophrenia, bipolar disorder, major depression, obsessive-compulsive disorder, and panic disorder. Working on the national, State and local levels, NAMI provides education about severe brain disorders, supports increased funding for research, and advocates for adequate health insurance, housing, rehabilitation, and jobs for those with serious psychiatric illnesses. NAMI has State and local affiliates in the United States and other countries. Its web site includes information on the Program of Assertive Community Treatment (PACT), support groups, membership, NAMI's helpline, and mental health information.

National Alliance for Research on Schizophrenia and Depression

60 Cutter Mill Road, Suite 404
Great Neck, NY 11021
(516) 829-0091
(800) 829-8289
Fax: (516) 487-6930
<http://www.narsad.org>

The National Alliance for Research on Schizophrenia and Depression (NARSAD) is an organization which was formed from four major citizens' groups (National Alliance for the Mentally Ill, National Mental Health Association, National Depressive and Manic-Depressive Association, and the Schizophrenia Research Foundation). NARSAD raises and distributes funds for scientific research into the causes, cures and treatments, and prevention of severe mental illness, primarily schizophrenia and depression. Its web site includes information on NARSAD's educational materials, mailing list, grants, and Infoline, a service that provides referrals, answers questions, and sends free materials on psychiatric illnesses.

National Association of Area Agencies on Aging

927 15th Street NW, Sixth Floor
Washington, DC 20005
(202) 296-8130
Fax: (202) 296-8134
<http://www.n4a.org>

The National Association of Area Agencies on Aging (NAAAA) represents the interests of Area Agencies on Aging (AAAs) across the country. The AAAs plan, implement, coordinate, monitor, and evaluate home and community-based services such as transportation, legal aid, nutrition programs, housekeeping, senior center activities, shopping activities, employment counseling, preretirement advising, and information and

referral programs. NAAAA provides the communication, training, and technical assistance necessary to enable the network of AAAs to serve older people. NAAAA also conducts an annual training conference and exposition that showcases innovative program developments in services to older persons.

The National Association of Professional Geriatric Care Managers

1604 North Country Club Road
Tucson, AZ 85716-3102
(520) 881-8008
Fax: (520) 325-7925
<http://www.caremanager.org>

The National Association of Professional Geriatric Care Managers (GCM) is an organization of professional practitioners whose purpose is the development, advancement, and promotion of humane and dignified social, psychological, and health care for the elderly and their families through counseling, treatment, and the delivery of concrete services by qualified, certified providers. GCM is committed to working towards the highest quality of care for the elderly and their families through education, advocacy, and high standards of professional practice. Association members assist older people and their families in coping with the challenges of aging.

National Association of Psychiatric Health Systems

325 Seventh Street, NW, Suite 625
Washington, DC 20004-2802
(202) 393-6700
Fax: (202) 783-6041
<http://www.naphs.org/index.html>

The National Association of Psychiatric Health Systems (NAPHS) promotes quality mental health and substance abuse care in behavioral healthcare systems. NAPHS

represents delivery systems working to coordinate a full spectrum of treatment services, including inpatient, residential, partial hospitalization, and outpatient programs as well as prevention and management services. NAPHS advocates for behavioral health and represents provider systems targeted on the prevention and treatment of mental and substance use disorders for all age groups. The Association has a wide variety of members including integrated health systems, hospitals, units of general hospitals, community mental health centers, and behavioral group practices located in all regions of the country.

National Association of Social Workers

750 1st Street NE, Suite 700
Washington, DC 20002-4241
(202) 408-8600
(800) 638-8799
Fax: (202) 336-8331
<http://www.socialworkers.org>

The National Association of Social Workers (NASW) is a membership organization of professional social workers that works to enhance the professional growth and development of its members, to create and maintain professional standards, and to advance sound social policies. Social workers seek to enhance the psychosocial functioning of people through direct services or assistance in obtaining services. The NASW web site includes information on membership, publications, educational programs, advocacy efforts, and a chapter directory.

National Association of State Alcohol and Drug Abuse Directors, Inc.

808 17th Street, NW, Suite 410
Washington, DC 20006
(202) 293-0090
Fax: (202) 293-1250
<http://www.nasadad.org>

The National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD) is a private, nonprofit, educational, scientific, and informational organization. NASADAD's basic purpose is to foster and support the development of effective alcohol and other drug abuse prevention and treatment programs throughout every State. Information on research and program applications, publications, and public policy is available on its web site.

National Association of State Mental Health Program Directors

66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
(703) 739-9333
Fax: (703) 548-9517
<http://www.nasmhpd.org>

The National Association of State Mental Health Program Directors (NASMHPD) organizes to reflect and advocate for the collective interests of State Mental Health Authorities and their directors at the national level. The association identifies public mental health policy issues, appraises its members of research findings and best practices in the delivery of mental health services, fosters collaboration, provides consultation and technical assistance, and promotes effective management practices and financing mechanisms adequate to sustain its mission.

National Association of State Units on Aging

1225 I Street NW, Suite 725
Washington, DC, 20005
(202) 898-2578
Fax: 202-898-2583

The National Association of State Units on Aging (NASUA) is a National public

interest organization that provides information, technical assistance, and professional development support to its members—the State and territorial Government Units on Aging. These Units offer services to improve the social and economic well-being of older persons. Member services include reports on current legislative and regulatory issues and policies affecting State programs; training and technical assistance; and an annual membership meeting. Also, NASUA regularly communicates with Congress and the Administration, as well as national aging organizations and other human services networks representing business, industry, and philanthropic interests.

National Center on Elder Abuse

1225 I Street, NW, Suite 725
Washington DC, 20005
(202) 898-2586
Fax: (202) 898-2583
<http://www.gwjapan.com/NCEA>

The National Center on Elder Abuse (NCEA) is operated jointly with the National Association of State Units on Aging, the National Committee for the Prevention of Elder Abuse, and the University of Delaware to serve the information, knowledge and skill development needs of professionals concerned with elder abuse/neglect. NCEA operates the Clearinghouse on Abuse and Neglect of the Elderly, provides technical assistance, disseminates information about best practices, conducts training and research, and disseminates training and research materials.

National Citizens' Coalition for Nursing Home Reform

1424 16th Street NW, Suite 202
Washington, DC 20036-2211
(202) 332-2275
Fax: (202) 332-2949
<http://www.nccnhr.org>

The National Citizens' Coalition for Nursing Home Reform defines and achieves quality for people with long-term-care needs through the use of informed consumers and effective citizen and ombudsman programs; promotion of best practices in care delivery; advocacy of public policy responsive to consumer's needs; and enforcement of consumer-directed health and living standards. Consumer/citizen action and long-term-care ombudsman groups around the country, supported by the Coalition, work on behalf of older people and people with disabilities who are institutionalized. The Coalition conducts advocacy training on nursing home and other long-term-care issues, holds an annual education and membership conference, and serves as a clearinghouse of current information on institutional-based, long-term care.

The National Council on Aging, Inc.

409 3rd Street SW, Suite 200
Washington, DC 20024
(202) 479-1200
Fax: (202) 479-0735
<http://www.ncoa.gov>

The National Council on the Aging (NCOA) is a private, nonprofit organization that serves as a resource for information, training, technical assistance, advocacy, and leadership in all aspects of aging. NCOA seeks to promote the well-being and contributions of older persons and to enhance the field of aging. NCOA provides a national information and consultation center, offers conferences, conducts

research, supports demonstration programs, and maintains a comprehensive library of materials on aging. NCOA's special areas of interest include healthy aging and spirituality, older worker employment, lifelong learning, senior center services, adult day services, long-term care, financial issues, senior housing, rural issues, advocacy, intergenerational programs, and volunteers in aging.

National Council on Alcoholism and Drug Dependence

12 West 21st Street
New York, NY 10010
(800) 622-2255
Fax: (212) 645-1690
<http://www.ncadd.org>

The National Council on Alcoholism and Drug Dependence (NCADD) is a voluntary health organization with a nationwide network of affiliates. The affiliates provide objective information and referral for individuals, families, and others seeking intervention and treatment; community prevention and education programs; presentations to raise community awareness at schools, businesses, and community organizations; and advocacy for alcoholics and other drug dependent persons and their families in State and local governments. Its web site includes information on affiliates, research, factsheets, treatment programs, and advocacy.

National Depressive and Manic Depressive Association

730 North Franklin, Suite 501
Chicago, IL 60601-3526
(312) 642-0049
(800) 826-3632
Fax: (312) 642-7243
<http://www.ndmda.org>

The mission of the National Depressive and Manic Depressive Association (National DMDA) is to educate patients, families, professionals, and the public concerning the nature of depressive and manic-depressive illnesses as treatable medical diseases; to foster self help for patients and families; to eliminate discrimination and stigma; to improve access to care; and to advocate for research toward the elimination of these illnesses. The organization is patient-run and has a grassroots network of 275 support groups.

National Family Caregivers Association

10400 Connecticut Avenue, Suite 500
Kensington, MD 20895-3944
(800) 896-3650
Fax: (301) 942-2302
<http://nfcacares.org>

Through its services in the areas of education and information, support and validation, public awareness and advocacy, the National Family Caregivers Association (NFCA) strives to minimize the disparity between a caregiver's quality of life and that of mainstream Americans. The Association sponsors the Caregiver Community Action Network, a State-based system of volunteer representatives who serve as the link between the NFCA members in the State, State policymakers and professionals, and the NFCA national office to promote membership growth and strengthen community outreach. The Association also is involved in providing a service, National Resource Referrals, to help caregivers locate the help they need.

National Foundation for Depressive Illness, Inc.

P.O. Box 2257
New York, NY 10116
(212) 268-4260
(800) 239-1265
<http://www.depression.org>

The Foundation was established to educate the public about depressive illness; to provide information to physicians, professionals, and all those who make requests; to encourage professionals to enter the field; and to translate public awareness into programs of research, education, and treatment innovation. Ongoing activities include educating business leaders about the costs of depressive illness in the workplace, providing speakers and materials for workshops and seminars in the mental health community, providing information through a toll-free number, and working with the news media to increase public awareness.

The National Institute on Senior Centers

National Council on Aging, Inc.
409 3rd Street SW, Suite 200
Washington DC, 20023
(202) 479-1200
Fax: (202) 479-0735
<http://www.ncoa.org/nisc>

The National Institute on Senior Centers (NISC) is a network of professionals who represent the senior center field, which serves nearly 10 million older Americans each year through community-based senior centers nationwide. These professionals and their centers serve as effective agents for the provision of services and opportunities to older people. The Institute provides NISC accreditation, coordination and guidance, and technical assistance materials to the senior center field on a national level. NISC is also involved in promoting the growth, development, and expansion of senior

centers; developing professional senior center leadership; and working to improve the quality of activities and services in senior centers.

National Mental Health Association

1021 Prince Street
Alexandria, VA 22314-2971
(703) 684-7722
Fax: (703) 684-5968
(800) 969-6642
<http://www.nmha.org>

The National Mental Health Association (NMHA) is dedicated to promoting mental health, preventing mental disorders, and achieving victory over mental illness through advocacy, education, research, and service. NMHA established the National Mental Health Information Center to meet the needs of the general public, consumers of mental health services and their families, and other concerned individuals and groups. The Center, through the toll-free number, utilizes professionally trained employees and is a resource for written information on mental illnesses and treatments as well as referrals for local treatment services. The organization has a network of 340 affiliates that implement national initiatives and develop programs geared toward the mental health needs of their communities; for example, support groups, public education campaigns, rehabilitation, and socialization.

National Mental Health Consumers' Self-Help Clearinghouse

1211 Chestnut Street
Suite 1000
Philadelphia, PA 19107
(800) 553-4539
FAX: (215) 636-6310

The National Mental Health Consumers' Self-Help Clearinghouse is supported by the Center for Mental Health Services. It

provides information and referral, on-site consultation, training events, teleconferences and national conferences, and a consumer library.

National Policy and Resource Center on Women and Aging

Heller Graduate School
Brandeis University, Mail Stop 035
P.O. Box 9110
Waltman, MA 02254-9110
(781) 736-3866
Fax: (781) 736-3865

<http://www.brandeis.edu/heller/National/ind.html>

The National Policy and Resource Center on Women and Aging serves as a national focal point for issues related to older women. The Center conducts research, provides policy analysis to those working in the field, and provides training and technical assistance to the aging network, women's organizations, and policymakers. The Center's objectives include: identifying issues and expanding knowledge on income security, health, caregiving, housing, and the prevention of crime and violence as they relate to older women; educating and empowering women themselves; and promoting greater national understanding of older women's issues.

Recovery, Inc.

Association of Nervous and Former Mental Patients
802 North Dearborn Street
Chicago, IL 60610
Phone: (312) 337-5661
Fax: (312) 337-5756
<http://www.recovery-inc.com>

Recovery, Inc. is a mental health self-help program based on the work of the late Dr. Abraham Low, founder and neuropsychiatrist. By studying Dr Low's practical method of mental health through

will training, members learn techniques for handling everyday situations. It is a nonprofit, nonsectarian group and completely member-managed. Recovery, Inc. has groups meeting every week around the world.

SPRY Foundation

10 G Street NE, Suite 600
Washington, DC 20002
(202) 216-0401
Fax: (202) 216-0779
<http://www.spry.org>

The SPRY Foundation is a nonprofit foundation whose mission is to provide leadership to encourage, support, conduct, and coordinate research and education programs to assist mature adult Americans to plan for and enjoy a healthy, financially secure, and satisfying future. The Foundation focuses on ways to achieve successful aging in four areas: finances, health and wellness, mental health and social environment, and intellectual pursuits. It has been active in establishing working relationships with top organizations in the field of aging, disseminating information to consumers worldwide, and conducting applied research that has implications for older adults and their families.

Schizophrenics Anonymous

Mental Health Association of Michigan
15920 West 12 Mile Road
Southfield, MI 48076
(800) 482-9534
Fax: (248) 557-5995
<http://www.sanonymous.org>

Schizophrenics Anonymous (SA) is a self-help support group for persons with schizophrenia or related disorders. It is organized and managed by persons with the illness. SA groups exist across the United State and abroad. Materials regarding SA, the group development process, local chapters, and schizophrenia are available upon request and on the web site.

Suicide Prevention Advocacy Network USA

5034 Odins Way
Marietta, GA 30068
(770) 998-8819
Fax: (770) 642-1419
(888) 649-1366
<http://www.spanusa.org>

The Suicide Prevention Advocacy Network (SPAN USA) is dedicated to creating an effective national suicide prevention strategy. SPAN links the energy of those bereaved by suicide with the expertise of leaders in science, business, government, and public service to achieve the goal of reducing the national rate of suicide by the year 2010. Its web site includes information on how to be an advocate, updates on federal and State activities, sample advocacy letters, and links to related sites.