MEETING THE MENTAL HEALTH CHALLENGES OF THE ELDER BOOM: AN OVERVIEW FOR ELDER CARE LAWYERS

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As every elder care lawyer surely knows, it is very difficult to find services for older adults with mental problems. How many good geriatric psychiatrists with room in their caseloads do you know? Where can you find a home health aide trained in working with older people who are suspicious, angry, or non-compliant; who hoard to the point that their homes are dangerous; or who just live in sad isolation? Where can you find a place for an older person with a mental disability to live that provides adequate supports but also allows for privacy and autonomy?

Despite vast shortages of decent services—even for people who can pay—and despite the fact that these shortages are likely to grow as the population of people 65+ with mental disorders increases from 7 million to 14 million over the next 25 years, our society pays virtually no attention to geriatric mental health.

What needs to be done?

This is not easy to answer because older adults with mental illnesses are a diverse population. Some people develop dementia as they age—often combined with depression and/or anxiety. Some are people with lifelong, severe psychiatric disabilities who are aging in a mental health system that is not prepared to deal with their health, housing, or rehabilitation needs. Some people have severe anxiety and/or depression and are at great risk of social isolation, suicide, and removal from the community because of behaviors that service providers have not been trained to manage. Some people have comparatively minor—but still very painful—anxiety or depressive disorders. Some people abuse substances. Very few abuse illegal substances, but many abuse alcohol and/or medications. And a great many people find it difficult to make the transition from working age to old age. Retirement, diminished (but usually not lost) physical and mental skills, deaths of friends and family, and maintaining a sense of meaning in the face of our mortality define a set of critical developmental challenges.

Despite the heterogeneity of the population, there are a number of common issues.

- **Aging in the community**: Most older adults want to live in the community not necessarily in the home they lived in most of their lives but in a place where they have freedom to shape their own day-to-day existence. Mental and behavioral problems are among the most common reasons why people are put into institutions. Community-based services could reduce unwanted institutionalizations.

- **Access**: Fewer than half of older adults with diagnosable mental disorders get treatment at all, and of those fewer than half get services from mental health professionals. Why? In large part because there are too few services. And those that

exist are often difficult to access because of location, shortage of home and community-based services, unaffordable cost, and the lack of bi-lingual providers.

- **Outreach and public education**: Low utilization of professional mental health services also reflects stigma, ignorance, and ageism. Outreach to engage older adults who need help and public education to encourage them to seek help are very hard to fund.

- **Quality**: The quality of available services is very uneven. Many people with mental illness go to primary care physicians, most of whom are not trained to identify or treat mental illness. Even mental health professionals generally lack training regarding treating older adults. Most health and aging service providers in the community are not equipped to deal with mental illness. And mental health services in nursing homes and other institutional settings are of very uneven quality.

- **Integration of health and mental health services**: Most older adults with mental illnesses also have chronic physical illnesses—in part because older adults usually have chronic illnesses and in part because of the link between mental and physical illness. There are evidence-based models of integration, but few integrated services are available.

- **Integration of aging and mental health services**: Activity and social involvement are essential for good mental health. This is just one reason why it is critical to integrate mental health services with services provided through the "aging" system.

- **Cultural competence**: The increase of minority older adults makes it more and more important to develop bi-lingual and culturally competent services.

- **Family support:** Families provide 80% of the care for people with disabilities. They experience great stress and are at high risk of mental and physical illness. They need support.

- **Positive aging**: Ageist preconceptions notwithstanding, there are great opportunities for older adults to shape satisfying, creative, productive, and useful lives. Yet little is done to promote positive aging or to prevent mental illness.

- **Workforce**: There is a vast shortage of mental health, health, and aging services providers equipped to serve older adults with mental illness. Recruitment and retention of clinically and culturally competent personnel will become more and more difficult as the elder boom unfolds. Part of the solution will be to forge a workforce of elders to help elders.

- **Research:** To date, research has not produced ultimate insights or cures for mental illnesses among older adults. More research is critical.

- **Funding** for mental health services is inadequate and discriminatory. For example Medicare reimburses less for mental illnesses than physical illnesses, limits access to prescription drugs, and does not cover the non-traditional services that are often critical to older adults with mental illness.

These issues define a set of challenges that will not be easy to meet.

Small, but important, steps have been taken recently. Addressing mental health issues was one of the top ten recommendations of the White House Conference on Aging, and the reauthorized Older Americans Act includes some new provisions for mental health. New York State enacted the Geriatric Mental Health Act in 2005, establishing an Interagency Geriatric Mental Health Planning Council and a services demonstrations grants program with $2 million to begin the program. Grants for nine projects were announced in April 2007. All good news!

But it is just a beginning. It will take a lot more advocacy to build an array of services sufficient to meet the needs that elder care lawyers encounter every day and will encounter more and more over the next 25 years. Hopefully, you will decide to join the advocacy effort. We need your help.

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