MHA OF NYC
your link to health

MHA The Mental Health Association of Westchester

THE GERIATRIC MENTAL HEALTH ALLIANCE OF NEW YORK

BARRIERS TO MEETING THE MENTAL HEALTH NEEDS OF OLDER ADULTS

Written by

Michael B. Friedman, LMSW
Chairman

Kimberly A Steinhagen, LMSW
Project Manager

Supported by

The van Ameringen Foundation

Mental Health Association of New York City, Inc.
50 Broadway, 19th Floor • New York, NY 10004
(212) 614-5753

Mental Health Association of Westchester
2269 Saw Mill River Road • Elmsford, NY 10523
(914) 686-2886

Email: center@mhaofnyc.org
www.mhawestchester.org/advocates/geriatrichome.asp

Dedicated To Improving Geriatric Mental Health Practice and Policy

BARRIERS TO MEETING THE MENTAL HEALTH NEEDS OF OLDER ADULTS

INTRODUCTION

Numerous reports[1] have pointed to significant inadequacies in the current state of service provision for older adults with mental health needs. These inadequacies include:

- Overuse of institutions
- Limited access to services
- Uneven service quality in both institutions and the community
- Very limited integration of mental health, health, and aging services
- Very limited capacity to serve cultural minorities
- Lack of adequate family support
- Stigma, ageism, and ignorance about mental illness and its treatment
- Workforce shortages
- Vast financing problems – both of amount and of structure
- Lack of readiness to meet the mental health challenges of the coming elder boom.

These inadequacies have been noted for more than a decade. Why do they persist? What gets in the way of establishing a system of services to meet the mental health needs of older adults?

This document provides an overview of major barriers.

BARRIERS THAT CONTRIBUTE TO OVERUSE OF INSTITUTIONS

There is widespread agreement that a large number of people in nursing and adult homes could live in the community,[2] were it not for the failure to address:

- the mental health needs of people with dementia and/or physical disabilities
- the health needs of people with long-term psychiatric disabilities and

---

[1] Bazelon Center for Mental Health Law. (2003). *Last in Line: Barriers to Community Integration of Older Adults with Mental Illnesses and Recommendations for Change.* Washington DC: Author

Friedman, M. & Steinhagen, K. (2004). "Issues in Geriatric Mental Health Policy." *Community Mental Health Report,* 4 (4), 49-50, 58-64.

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

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

U.S. Department of Health and Human Services: SAMHSA (2005). Community Integration for Older Adults with Mental Illnesses: Overcoming Barriers and Seizing Opportunities. Rockville, MD:Author.

[2] Friedman, M. & Steinhagen, K. (2006). "Geriatric Mental Health: The Need for Change - Focus Group Findings." To be published.

➢emotionally strained family caregivers.

Barriers to remaining in or returning to the community include:

Limited access to home and community-based mental health services: There are a variety of barriers to access to home and community-based mental health services. (See below.)

Lack of ability to serve people with difficult behavioral problems: Home health and other workers who attempt to help people remain in their homes often are at a loss with people with behavioral problems such as wandering, belligerence, and hoarding. As a result many of these people end up in nursing homes. In many cases this would not be necessary if the workers had greater skills in dealing with mental and behavioral problems.

Inability of the mental health system to adequately address chronic health conditions of people with long-term psychiatric disabilities: Many people with long-term psychiatric disabilities develop complex chronic health problems and/or dementia as they age. The mental health system does not have the capacity to address these problems and as a result many of these people end up in nursing or adult homes.

Shortage of family support services: Families are the primary caregivers for older adults with mental and/or physical disabilities. They are themselves at high risk for depression, anxiety disorders, and physical illnesses. But the mental health system generally does not provide funds for family support services, which, as a result, are in very short supply.

Lack of housing alternatives to nursing homes and adult homes: Some older adults who have mental disorders and are socially isolated would probably do better in congregate housing. However, there are few home-like residential programs that combine the virtues of free access to the community with on-site supports, activities, social opportunities, and health and mental health services. And many of these are accessible only to people who can afford the typically high costs of private assisted living or lifecare communities.

In addition, community housing provided by the mental health system does not provide the kinds of supports needed for people with limited activities of daily living skills (ADLs) and/or complex chronic health conditions.

Also, many people who could return to the community cannot because there is no system in place to help them move into alternative settings.

BARRIERS THAT CONTRIBUTE TO UNDERSERVICE

Fewer than 25% of older adults with mental disorders receive treatment from mental health professionals. Another quarter receives treatment from primary care physicians. More than 50% get no treatment whatsoever.[3] Why is there so much underservice?

[3] U.S. Department of Health and Human Services: Administration on Aging. (2001). *Older Adults and Mental Health: Issues and Opportunities.* Rockville, MD: Author.

Individual and Family Barriers

One of the reasons for underservice of older adults with mental disorders is that they do not seek service from mental health professionals. This reflects:

Preference for primary care practitioners: Most older adults who seek professional help for their emotional problems go to their primary care physicians, who typically have not been trained to identify and treat mental disorders.

Stigma: Many older adults and their families regard it as shameful and embarrassing to be mentally ill and therefore may deny that they have a mental illness.

Ageism: Some older adults and their families think that mental disorders, especially depression and anxiety, are a normal part of the aging process—it is not—and that there is no hope of improvement in their emotional state.

Ignorance regarding mental illness and its treatment: Many older adults and their families are not knowledgeable about mental illness and don't know that effective treatment exists.

Ignorance about resources: Many older adults and their families do not know where to go for affordable, effective treatment.

Cultural Barriers

Many older adults also do not seek traditional mental health services because such services are alien to their cultures. For example:

Mental health may not be part of the conceptual and linguistic framework of the culture: Some cultures do not have a concept of mental health. This particularly affects new immigrants and those who acculturate slowly. As a result, many who could benefit from treatment fail to consider it as an option.

Identification of mental illness with being "crazy": Many cultures associate mental illness exclusively with psychosis. Therefore, some members of these cultures will only seek treatment under the most extreme circumstances.

Preference for other forms of help: People from many cultures follow traditional pathways to help, turning to families, friends, faith healers, herbalists, religious leaders, community service providers, and primary care physicians. In addition, in many cultures there are indigenous community settings where people go for a mix of camaraderie, activities, and help. Sometimes these sources of help are successful, but often people with mental disorders could benefit from professional treatment.

Tensions between traditional forms of help and mental health approaches: Traditionally mental health providers have expected older adults to come to a clinical setting for

treatment; however, many people are more comfortable seeking help in non-clinical settings from trusted providers who speak their language. In addition, people from many cultures find it strange that talk is an instrument of treatment, and some cultures regard western medicines with suspicion.

Access Barriers

Many older adults who seek mental health services encounter barriers to access. These include:

Shortage of geriatric mental health services: There is a vast shortage of geriatric mental health professionals[4] and of mental health service organizations with expertise on geriatric mental health. This often results in long waiting lists.

Shortage of geriatric substance abuse services: There are few options for substance abuse treatment for older adults. And sometimes residential treatment centers and detox units that generally serve the adult population will refuse to admit older adults because they have mobility problems and/or complex medical problems.

Shortage of home-based services: A significant number of older adults are physically and/or psychologically homebound. Reaching them requires the provision of mental health services in their homes. Unfortunately on-going home-based mental health services are in very short supply. And some home-based services are designed to respond only to crises. Their goals are to stabilize, assess, and refer. Unfortunately, on-going services often are not available.

Shortage of mental health services in community settings: Some older adults participate in community programs such as houses of worship, senior centers, social clubs, and NORC-SSPs. It is possible to provide mental health screening, assessment, and treatment services at these sites; however, few such programs exist, and they are difficult to develop because of financial and regulatory barriers. (See below.)

Expectation that patients go to mental health setting: Shortages of home-based mental health services and mental health services in community settings reflect the fundamental expectation that patients will go to offices for treatment. As noted above, this is problematic for older adults who are homebound, for those who do not want to be associated with a place labeled "mental health", and/or for those who seek out non-traditional places for help.

Lack of services in some neighborhoods: Geriatric mental health services are simply unavailable or are in exceedingly short supply in some neighborhoods—especially minority neighborhoods.

[4] Halpain, Maureen C.et al. (1999). Training in Geriatric Mental Health: Needs and Strategies. *Psychiatric Services*. 50:9, 1205-1208.
Jeste, Dilip V. et al. (1999). Consensus Statement on the Upcoming Crisis in Geriatric Mental Health. *Archives of General Psychiatry*, 56, 848-853.

Shortage of transportation: The shortage of transportation in some settings, particularly rural areas, makes it extremely difficult for older adults to get to treatment. Even in urban settings, public transportation may be beyond walking distance or extremely time-consuming and, therefore, effectively unavailable.

Problems of affordability: The out-of-pocket costs associated with outpatient mental health services are unaffordable for some older adults. In particular, Medicare usually pays only 50% of the Medicare rate for outpatient mental health services. (It pays 80% for physical health care.) And some psychiatrists in private practice will not accept Medicare because it pays rates they regard as too low.

Lack of cultural competence: Many mental health professionals are not culturally competent. Problems include not speaking a client's primary language, lack of competent interpreters, and lack of understanding of cultural expectations regarding behavior and of cultural nuances. This contributes to poor engagement, inaccurate diagnoses, and ineffective treatment.

BARRIERS TO EFFECTIVE ENGAGEMENT

Because many older adults do not know about mental illness and its treatment, experience stigma, or regard depression and anxiety as normal consequences of aging, they often do not seek, and cannot be engaged in treatment without substantial, culturally sensitive outreach efforts including education about mental health. Unfortunately, very little funding is made available for outreach and education. (The exception was Project Liberty, which was mounted after the terrorist acts of 9/11/2001. And providers report that they were able to engage many more people typically resistant to treatment because they met them on their own ground and on their own terms.)

BARRIERS THAT CONTRIBUTE TO UNEVEN QUALITY OF CARE

There is widespread agreement that the quality of treatment and other services for older adults with mental health problems is quite uneven. There are some very good providers, but most older adults do not get clinically and/or culturally competent service.[5] Reasons include:

Reliance on inadequately trained primary care providers: As noted above, most older adults who seek professional treatment for emotional problems turn to their primary care physicians for help. However, most are not adequately trained to recognize signs of mental illness (even risks of suicide.) And for the most part, they have not been trained about mental health treatment, whether it is evidence-based psychotherapy or proper use

[5] Wang, et al. (2005).Twelve-month use of mental health services in the United States. *Archives of General Psychiatry*, 62, 629-640.

of medications. In addition, the economics of primary care create a powerful incentive discouraging physicians from spending much time in direct interaction with patients.

Reliance on generic mental health professionals: Many older adults who seek service from mental health professionals end up in care with providers who do not have expertise in treating older adults. This is unfortunate because there are a number of critical physical and mental differences between older adults and younger adults. These create diagnostic and treatment challenges that generic mental health professionals usually have not been trained to meet.

Failure to use evidence-based practices: Evidence-based treatments exist for older adults with depression and there is a quickly growing body of evidence on effective treatment of anxiety disorders. There are also evidence-based treatments that slow the progress of dementia. In addition, there are evidence-based practices that improve outcomes when people with depression are treated in primary care settings. There is also substantial evidence regarding the value of outreach, home-based care, screening, and family support.

Unfortunately, it appears that many—if not most—mental health and health professionals do not use evidence-based approaches.

Limited translation of research into practice: Failure to use evidence-based practices reflects a continuing problem translating research findings to the world of practice.

Lack of evidence-based practices to meet critical needs: Unfortunately, an evidence base has not yet been developed for practices to respond to many critical needs of older adults with mental disorders. For example, there are no evidence-based treatments for people with schizophrenia who are aging, for interventions that address social issues such as social isolation, for housing models, etc.

Lack of evidence-based interventions for minority populations: It is of particular concern that research that supports the use of evidence-based interventions generally has not been done with subjects from minority cultures. This leaves doubt about whether interventions that are effective with white, middle-class, frequently suburban populations are also effective with cultural minorities, especially those living in crowded urban areas and/or who are poor.

Lack of adequate research: Compared to research on other matters, geriatric mental health has been neglected by NIMH and other organizations that fund mental health research.

Lack of recognition of issues of substance misuse: As many as 17% of older adults drink to excess or take prescription or over-the-counter drugs in ways not recommended by their physicians[6]. The dominant image of a substance abuser as a hard core addict or

[6] Blow, Frederic C. et al. (1998). *Substance Abuse Among Older Adults Treatment Improvement Protocol.* U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental

alcoholic is a barrier to developing appropriate services for older adults who misuse substances.

Lack of integrated treatment for people with co-occurring mental and addictive disorders and for people with co-occurring mental illnesses and mental retardation: Despite widespread knowledge that integrated treatment is critical to successful treatment of people with co-occurring disorders, such programs are few and far between. This reflects a complex combination of factors related to treatment ideology, protection of turf, and the fragmentation of service systems generally.

Inadequate recognition of, and attention to, the mental health problems of people living in nursing homes, assisted living facilities, and lifecare communities: Although more than half of nursing home residents have mental health problems, they frequently are not recognized. Nursing home staff are generally not trained how to interact with residents with mental or behavioral problems and access to high-quality treatment is limited. The same is true for assisted living facilities, and lifecare communities.

Inadequate attention to "recovery" in adult homes: Recent scandals about the quality of care for people with serious, long-term psychiatric disabilities in adult homes have focused on the failure to use "recovery" models that would promote greater independence and help people make a transition to living in the community. There are also recurrent questions about the quality of mental health treatment services in adult homes, particularly about the extensive use of the clinic model and the very limited use of rehabilitation models. This may be driven by a funding structure that relies on billing for clinic and continuing day treatment services.

Lack of basic knowledge about mental health among providers of health and aging services: Older adults with mental disorders get services and supports from a broad range of providers such as primary care providers, home health workers, nursing homes, other residential programs, senior center workers, case managers, and adult protective service workers. Unfortunately most of these providers have had virtually no training in the recognition and management of mental disorders.

BARRIERS TO INTEGRATION OF MENTAL HEALTH, HEALTH, AND AGING SERVICES

Virtually all older adults with mental disorders also have chronic physical conditions, in part because most people who are old have chronic physical conditions, in part because people with serious mental illnesses are at high risk for physical illnesses as well and in part because people with serious physical illnesses are at high risk for depression and/or anxiety disorders. For this reason it is critical to integrate mental health and health services including primary care, specialty care, home health care, and residential care.

Health Services Administration**.** http://www.health.org/govpubs/BKD250/26b.aspx

In addition, many older adults with significant mental health problems get services and supports through the aging system. This includes senior centers, NORC-SSPs, case management, adult day care, adult protective services, etc. Use of these services creates opportunities for screening, assessment, and treatment of mental disorders.

General Barriers to Integration

Lack of cross-systems knowledge: People who work in mental health, health, or aging typically know very little about the services available in other systems, resulting in difficulties finding appropriate services for their clients.

Lack of working networks: In addition, there are few working networks of mental health, health, and aging service providers even in neighborhoods where services are available. Not only is there a lack of formal local networks, there is also a lack of informal networking of the kind that is needed to facilitate referrals and coordinated service plans.

Barriers to Integrating Mental Health and Health

There are a number of models for integrating mental health and health services including: training primary care providers in mental health, co-locating health and mental health services, using integrated treatment teams of health and mental health professionals, using care managers or "disease" managers to follow up with patients outside the office, developing primary care centers that specialize in serving people with mental disabilities, and establishing health satellites at mental health centers. Unfortunately, there are a number of major barriers to using these approaches, including:

Lack of knowledge about models of integration: Many providers are simply unaware of the various models of integration of mental health and health services.

Integration runs counter to the current service culture: Currently providers expect to work independently rather than in close collaboration. Collaboration between health and mental health providers is particularly unusual.

Private practice makes collaboration especially difficult: Many older adults get treatment for health and/or mental health from private practitioners. The economics of private practice make it especially difficult for them to take the time necessary to collaborate with other providers.

Poor integration of mental health discharge planning: When older adults leave acute care hospitals, mental health needs are poorly integrated into a patient's overall discharge plan. Thus, mental health problems picked up in the hospital setting are often not pursued in the community.

Cost: Medicare, Medicaid, and private insurance generally do not cover the additional costs of some of these models of collaboration, especially the use of integrated treatment teams or care managers.

In addition, it seems unrealistic to expect primary care physicians to take the time needed to provide psychotherapy because of the income they would lose.

Regulatory Limits: Current regulations prohibit mental health organizations from providing physical health care and limit the amount of mental health care that can be provided by health clinics.

Barriers to Integrating Mental Health and Aging Services

There are a number of models for integrating mental health and aging services including cross-system training, collaborative linkages, on-site services in senior centers and other community settings, etc. Unfortunately there are barriers to using these models. In addition to those noted above, barriers include:

Shortage of training opportunities: There are too few opportunities for cross-system training, particularly for training that brings together personnel from mental health, aging, and health systems.

Overloaded providers: Many front line workers including case managers in the aging services systems and adult protective system are overworked with too many cases and have a laundry list of issues they must confront in dealing with older adults with complex cases. Asking them to identify and deal with mental health issues is often just too much.

Financial and regulatory impediments: It is difficult to develop mental health services on-site in community settings in New York State because licensing of outpatient mental health providers is site-specific. To be eligible to bill Medicaid for services in community settings, the provider must establish a licensed satellite. This is limited by the "Medicaid neutrality" requirement that new services cannot be supported by new Medicaid funding without approval by the State. (See page 12.)

Ignorance of fiscal alternatives: Some providers have found innovative ways to finance mental health services in community settings. However, many others are unaware of these approaches.

BARRIERS TO THE DEVELOPMENT OF AN ADEQUATE WORKFORCE

From the preceding discussion of barriers, it is clear that the short supply of clinically and culturally competent geriatric mental health providers and mental health savvy health and aging providers are major obstacles to providing adequate services to older adults with mental disorders. As previously noted, workforce problems include shortages of:

- Mental health professionals with competence in geriatrics
- Providers of health and aging services who are able to identify and respond appropriately to older adults with mental disorders
- Culturally competent providers, especially those who are bilingual and bicultural

- Competent interpreters

These problems will only get worse over time, because the proportion of working age adults is going to decline by 5% while the proportion of older adults rises by 7% and because the minority portion of the population of older adults will grow from about 15% to about 25%[7].

Barriers to addressing workforce problems include:

Shortage of people interested in careers in geriatrics: Many students chose not to specialize in geriatrics for a variety of reasons, including lack of prestige, the ageist view that older adults are not worth helping, and lower salaries.

Financial disincentives to serve older adults: Salaries are often exceedingly low in mental health, health, and aging services organization. In addition, low rates for private practitioners, coupled with struggles with bureaucracy and managed care organizations, often discourage them from providing services for those in greatest need. And for both those who work in organizations and those in private practice the cost of education and the repayment of loans creates an incentive to serve as wealthy a clientele as possible at the highest possible fees or to choose another career altogether.

Inadequate professional education: Professional schools of medicine, nursing, social work, and psychology do not provide adequate basic education about geriatrics, let alone specialized courses on geriatrics. Those few that do provide specializations in geriatrics often have trouble recruiting students. Despite this lack of training, many providers will find themselves working with the older adult population at some point in their careers.

Lack of training in mental health for long-term care providers: Most health care providers in long-term care settings lack training on how to identify signs and symptoms of mental disorders. Some think that mental health problems are a normal part of the aging process (ageism). Even those who can recognize a mental health problem often do not know how to obtain appropriate treatment.

Lack of training in mental health among workers in senior centers, NORCs and the like: Senior centers, case management services, home care services, friendly visiting, social adult day centers, and the like are ideal venues to identify older adults with mental health problems because the staff of these services have regular contact with their clients. However, typically staff are not trained to identify mental health disorders, and the services are not adequately funded to provide such training. Nor are the staff salaries adequate to hire clinical social workers to provide mental health services.

Rigidity about roles: The growth of the aging population, while the proportion of working-age adults declines, suggests that our society will need to rely on older adults to provide help to other older adults. However, this will mean developing roles that can be

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

played effectively by older adults in paraprofessional or volunteer positions. Currently, there is often resistance to this idea because of the perception that services to help older adults with mental disorders need to be provided by professionals. This rigidity about roles could be a major impediment to effective restructuring.

SYSTEMS BARRIERS

Fragmentation of mental health, health, and aging systems creates major obstacles to providing integrated services for older adults with mental health problems. In addition to barriers noted above, there are several key problems:

"Silos": It has become common to say that service systems are separate and distinct "silos". Whatever the value of the metaphor, this means that the service systems have distinct goals and service structures, different rules regarding program development, different regulations, and different funding mechanisms. In addition these service systems generally do not collaborate.

Lack of standards/guidelines: Although mental health and health services are heavily regulated in New York State, neither The NYS Office of Mental Health nor the NYS Department of Health has standards or guidelines specific to geriatric mental health.

Program licensing/regulatory restrictions: As noted above, licensing and regulatory restrictions prohibit mental health clinics from providing health services and limit provision of mental health services by health clinics. As also noted above, the fact that sites, rather than services, are licensed contributes to the office-based character of mental health service delivery.

In addition, OMH licensing of separate programs on the same site—such as a clinic and a continuing day treatment program—requires that each have a distinct space and a distinct staff. OMH regulations also prohibit enrollment in more than one outpatient program. This creates significant problems for clients who need a mix of services.

Lack of recognition of the importance of the private sector: The private sector plays two critical roles in meeting the mental health needs of older adults. (1) Private practitioners provide treatment services to most older adults who get treatment from mental health professionals or from primary care physicians. (2) Employer-based insurance, employee assistance programs, employer provided elder care supports, and retirement planning are key benefits and services for many older adults with mental health problems and their families.

Unfortunately, most thinking about systems of care focuses virtually exclusively on service organizations and on programs funded by government and philanthropy. This misses an important part of the picture.

FINANCIAL BARRIERS

There are two kinds of financial barriers to meeting the needs of older adults with mental health problems—(1) inadequate amounts of funding and (2) financing structures that create disincentives to serve older adults, do not support innovation, or do not support the use of the best practices.

In addition some, and we suspect a great many, providers do not fully understand what Medicare will pay for. As a result they do not take full advantage of funding opportunities.

Inadequate funding:

There are many sources of funding for mental health services including Medicare, Medicaid, governmental mental health grants and contracts, governmental funding for "older Americans", private insurance, self-pay, and philanthropy. All are limited.

Medicare and Medicaid Limit Eligibility and Covered Services: Both Medicare and Medicaid are entitlements without limits on the amount spent to provide covered services for eligible people. But limits on the kinds of services covered, on rates, and on eligibility result in inadequate funding overall. (See below for details on funding restrictions.)

Governmental grants and contracts are limited because geriatric mental health is a low priority: Governmental grants and contracts are limited to the amount appropriated in federal, state, and local budgets. Because geriatric mental health is not a high priority in the United States, appropriations have not been sufficient to meet the growing need for services. In addition, funds are often distributed on the basis of formulas that call for low salaries, do not adequately cover administrative costs or non-personnel items such as rent, and typically fall behind inflation.

Private insurance does not cover full cost or cover all needed service: Although some older adults have some coverage for treatment of mental illnesses, amounts available are sharply limited by co-payment requirements, caps on rates, and caps on the number of reimbursable sessions.

Out-of-pocket payments are unaffordable for all but the affluent: Some people are able to fully cover the costs of treatment and care from personal income, but most people are not able to pay full costs and may have to struggle to cover co-payments.

Philanthropy is often time-limited: Many organizations that provide services for older adults with mental health problems rely on contributions and grants to fund innovative services and to supplement inadequate governmental funding. Grant funding, however, is usually time-limited and thus is not a reliable source of support for services that are not fully covered by government.

Restrictive funding structures

The most fundamental structural financing problem is that most financing mechanisms are built on a medical model. That is, financing structures are built on the assumptions that the core service is traditional treatment, provided during visits with a mental health or medical professional, usually in the provider's office. Thus, funding is available only to a limited extent for outreach, education, screening in community settings, and wrap-around support services. In addition, funding is available for a very limited range of residential services.

Funding structures also create some disincentives to serve older adults who cannot afford to pay the full cost of care.

Medicare limits: Problems with Medicare include:

- Lack of parity (Co-pays are usually 50% compared to 20% for physical health services)
- Limited drug formularies
- Below market rates for psychiatrists lead many to not accept Medicare because they can fill their practices with people able to pay full fee.
- No coverage for case management
- Limited in-home mental health services
- No coverage for wrap-around, outreach, education, family support, and other non-traditional services
- Coverage for transportation only in an emergency
- No coverage for community residences
- Lifetime cap on inpatient coverage
- Limited mental health coverage under Medicare managed care and Medigap

Medicaid limits: Medicaid problems include:

- Reliance on Medicaid to fund outpatient mental health programs in NYS has forced programs to focus on those who are Medicaid eligible to the neglect of those who are not.
- Although Medicaid permits unlimited home-based services, it does not pay a higher rate, creating a de facto disincentive to serve older adults in their homes.
- Medicaid permits limited amounts of "off-site" services, i.e. services outside of an outpatient program site. But when visits are made regularly to a community setting such as a senior center, a formal satellite must be licensed, a difficult process designed to slow program expansion.
- Program development is limited by what is known as "Medicaid neutrality", which requires that the state decide to allow increased Medicaid expenditures before a new program is started. (This is not a requirement for the development of new physical health care programs.)
- The growth of Medicaid managed care has created some problems, especially regarding access to inpatient care. Not only are managed care entities often reluctant to authorize a hospital stay; they also do not contract with all local hospitals.

- Medicaid covers mental health services in health clinics and health services in mental health clinics to a very limited extent, effectively blocking major opportunities to integrate health and mental health services.
- Medicaid pays very low fees to clinicians in private practice, which effectively eliminates their availability to serve people who cannot get care elsewhere.
- Rules regarding Medicaid funding for nursing homes make it virtually impossible for nursing homes to provide adequate social work services.
- Rules regarding nursing homes also make it difficult to cover the costs of the newest psychiatric medications.

Private insurance limits: Problems with private insurance include:

- Lack of parity of health and mental health benefits
- Lack of coverage for non-medical model services

Ignorance about Financing Opportunities

Ignorance about what is reimbursable and how to bill appears to be a major barrier to funding geriatric mental health services. For example, it appears that Medicare could be used more extensively in NYS if more providers understood that co-pays vary from 20% to 50% depending on the billing code, that sliding fee scales for co-pays are acceptable to Medicare, and that Medicare can be used to cover off-site services without establishing satellite clinics, etc.

READINESS FOR THE ELDER BOOM

Both the governmental and the private sector will soon have to confront the elder boom—the concomitant increase of the proportion of older adults and the decrease in the number of working age adults. There have been headline-making debates about the future viability of Social Security and Medicare, about the paucity of savings by most Americans, about increasing life expectancy, and about health. But issues of mental health barely rise to the surface of social concern. Why? Largely this reflects the fact that mental illness is still a matter of discomfort for most people. In addition, most people don't understand what mental illness is and how prevalent and treatable it is.

As a result, neither the public nor the private sectors in the United States have developed the leadership, the structures, or the plans that will be needed to meet the mental health challenges of the elder boom.

Lack of leadership: At the federal, state, and local levels there is a lack of dedicated, full-time leadership on geriatric mental health. In the private sector, mental health generally is a neglected dimension of human resource management, viewed at best as a subset of health issues.
Lack of planning: Although some good reports and recommendations have emerged from governmental agencies in Washington, they have not resulted in the implementation of major programs or the development of a geriatric mental health plan for the nation.

In New York State, the recent passage of the Geriatric Mental Health Act has led to the development of an Interagency Geriatric Mental Health Planning Council. This body is charged with the responsibility of developing a long-term geriatric mental health plan for New York. We hope that it will be strongly supported by the incoming administration and result in the development of a plan that will drive program expansion and redesign.

Lack of interest in geriatric mental health: Lack of interest in geriatric mental health in both the governmental and private sectors has been the major barrier to bringing about essential changes in geriatric mental health practice and policy. We hope rapidly growing advocacy on behalf of older adults with mental disorders will bring that barrier down soon.