HOUSING IN THE MENTAL HEALTH SYSTEM FOR AGING PEOPLE WITH SERIOUS PSYCHIATRIC DISABILITIES

The Geriatric Mental Health Alliance of New York

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The Geriatric Mental Health Alliance of New York

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ABOUT THE GERIATRIC MENTAL HEALTH ALLIANCE OF NEW YORK

The Geriatric Mental Health Alliance of New York (GMHA-NY) was founded in January 2004 with the goal of advocating for changes in mental health practice and policy that are needed to improve current mental health services for older adults and to develop an adequate response to the mental health needs of the elder boom generation. The Alliance's goals are to: 1) advocate for improvements in public policy regarding geriatric mental health and 2) provide information, public education, professional and paraprofessional training, and technical assistance regarding state-of-the-art practices in geriatric mental health. The Alliance works primarily in New York State, but it also offers training and technical assistance in geriatric mental health service, funding, and advocacy nationwide.

ABOUT THE MENTAL HEALTH ASSOCIATION OF NEW YORK CITY

The Mental Health Association of New York City (MHA of NYC) is a private, not for profit, organization whose mission is to provide direct services, access to services, community education, and advocacy for the benefit of people with mental illness. MHA of NYC works to change attitudes about mental illnesses; to improve services for children, adults, and older adults with mental disorders; and to promote mental health in the community. MHA of NYC serves as the mental health information hub for New York City via LifeNet, the 24/7, multilingual, multicultural information and referral hotline and website staffed by mental health professionals. Through a subsidiary corporation, MHA of NYC also operates the National Suicide Prevention Lifeline. For help in NYC, call 1-800-LifeNet or visit www.800lifenet.org. For help nationwide, call 1-800-273-TALK.

GMHA-NY FUNDERS

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Introduction

- As the elder boom unfolds over the next *25* years and the number of older adults with mental disorders doubles nationally and increases by 50% in New York State, the mental health system in the U.S. and in NYS will need to make significant changes to meet the needs of people with severe, long-term psychiatric disabilities who are aging.

- Because a primary goal of older adults is to live where *they* choose—generally in the community—the availability of appropriate housing and residential supports will be critical components of the emerging system of care needed for older adults with mental disorders.

- In order to clarify what is needed to help older adults with severe and persistent mental disorders to live in the community, The Geriatric Mental Health Alliance of New York convened a consensus group consisting of advocates, housing providers, representatives of the NYS Office of Mental Health (OMH), the NYS Office for the Aging (OFA), and others. (See attached list).

- The goals of the workgroup were to develop recommendations for policy changes that will:
  — **Avoid institutionalization** of older adults with serious mental illnesses in adult homes or nursing homes.[1]
  — **Increase the life expectancy** of people with serious mental illness.
  — **Promote recovery and improve quality of life** for this population.

- The workgroup reached a consensus that:

  1. The mental health system should increase the number of residential units that it provides for older adults with psychiatric disabilities and that it should develop new models of residential care—both congregate and supported[2]—suitable for older adults with co-occurring serious physical health conditions and for those with diminishing self-care skills.

  2. The mental health, aging, and health systems should work together to develop supports that will enable older adults with serious mental illness to remain in their own homes[3] or to live in a variety of alternatives such as senior housing, supportive housing, assisted and assistive living facilities, etc.

- This document addresses only the need to increase and remodel housing through the mental health system.

- A subsequent document will address models of residential support outside of the mental health system.

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[1] In some of its long-term care reform proposals, NYS maintains that large adult homes are community settings. The Workgroup regards them as institutional settings.

[2] "Supported housing" is permanent, housing subsidized by OMH and offering visiting case management services. It is a form of "supportive housing", a generic term that refers to several different kinds of subsidized housing for people with disabilities or a history of homelessness.

[3] Some older adults live in naturally occurring retirement communities (NORCs), apartment houses or neighborhoods made up of mostly older adults. Some NORCs have supportive service programs (NORC-SSPs), which provide a mix of activities, supports, and health care that enable older adults to live well in a natural community setting.

Historical Background

- Since the middle of the 20th century helping people with serious psychiatric disabilities to live in the community has been the major goal of the mental health system in the United States.
- The first effort to shift from an institution-based mental health policy to a community-based policy was deinstitutionalization.
- Although beneficial to some, for hundreds of thousands of people around the nation and ten's of thousands in NYS, deinstitutionalization was a disaster.
- People with psychiatric disabilities needed support in order to manage in the community.
- Instead of living independently, upwards of two-thirds moved from hospitals into their parents' homes.
- A great many were transinstitutionalized to adult homes, nursing homes, or prisons.
- Many people with psychiatric disabilities who might have lived in state hospitals prior to deinstitutionalization did go on to live independently. Some lived quite well. But a great many lived—with other poor people—in squalid and sometimes dangerous settings. In NYC a very large number moved into single-room occupancy hotels (SROs) that became notorious because people with psychiatric disabilities were frequent victims of crimes, including a number of highly publicized murders.
- In response to the clear failures of deinstitutionalization, the nation and NYS developed a new mental health policy called "The Community Support Program" (CSP).
- This policy is based on understanding that a great many, if not most, people with long-term psychiatric disabilities need a range of supports to lead satisfying lives in the community.
- In its original form CSP expanded the kinds of interventions provided by the mental health system from treatment alone to a combination of housing, rehabilitation, outpatient treatment, and inpatient treatment in local general hospitals. It also provided case management to coordinate various services and supports.
- Over subsequent years there have been a number of significant modifications, including more independent housing models, peer support services, and more.
- Community support policy has been quite successful. In NYS, for example, there are now over 27,500 units of housing for people with serious mental illnesses with 7,500 more committed for development by 2016.
- There are also hundreds of rehabilitation programs. There has been a vast increase in outpatient treatment services, some of which have been re-modeled to focus on rehabilitation. In addition, general hospitals have picked up much of the inpatient load that had previously been handled by state hospitals.
- Ten's of thousands of people who prior to CSP would have been warehoused in state hospitals or left to their own devices in the community are now reasonably well-served in treatment, rehabilitation, and community-based housing programs, including housing outside the mental health system.
- But there still is not enough housing, rehabilitation, treatment, case management, or assertive outreach to meet the needs of all people with serious, long-term psychiatric disabilities.

Demographic Changes

- CSP was created at a time when there had been a great increase in the population of young adults with psychiatric disabilities; therefore, it has focused primarily on working age adults.
- With the flow of time, however, people who were in their 30s in the 1980s are in their 50s today, and—if they survive—will be in their 70s in 25 years—at the peak of the elder boom.
- The total number of older adults (65+) in the U.S. will double over the next quarter century from 35 million to 70 million. In NYS the number will increase over 50% from 2.4 million to 3.9 million.[4]
- The proportion of older adults will increase from about 13% to approximately 20% of the total population, while the proportion of working age adults will decline by 5%. [5]
- The proportion of older adults from minority cultures will increase from 16% to 25%.[6]
- During the elder boom, the number of older adults in the U.S. with mental illnesses of any kind—mild, moderate, or severe—will double from 7 million to 14 million and will increase more than 50% in NYS from 480,000 to 780,000.[7,8]
- The number of older adults with serious, long-term psychiatric disabilities in the U.S. will double from at least 900,000 to 1.7 million [9] and will increase in NYS from 65,000 to 95,000.[10]
- In NYS the proportion of older adults with serious, long-term psychiatric disabilities of all adults with serious, long-term psychiatric disabilities will grow from about 12% to about 20%.[11,12]
- The number may be higher due to the people with mental disabilities "hidden" by their parents.

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[4] 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*, pp. 25-1130. Washington, D.C.: Author.

[5] Ibid.

[6] Ibid.

[7] U.S. Department of Health and Human Services. (1999). *Mental health: A report of the surgeon general.* Rockville, MD: Author.

[8] 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*, pp. 25-1130. Washington, D.C.: Author.

[9] McAlpine, D. (2003). Patterns of care for persons 65 years and older with schizophrenia. In C. Cohen (Ed.), *Schizophrenia Into Later Life* (pp. 3-17). Washington, D.C.: American Psychiatric Publishing, Inc.

[10] The number of older adults with serious and persistent mental illness is a matter of some debate because it depends on the age used—50,55,60, or 65—and because it depends on the estimate of the portion of the population with serious and persistent mental illness, which ranges from 0.6% to 2.6%. For people with serious mental illness we have set the age of being an older adult at 55. We have estimated that 1.6% of the population has a serious and persistent mental illness not including dementia.

[11] U.S. Department of Health and Human Services. (1999). *Mental health: A report of the surgeon general.* Rockville, MD: Author.

[12] 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*, pp. 25-1130. Washington, D.C.: Author.

Mental Status

- Aging people with serious mental illness include both those who have had psychiatric disabilities most of their lives and those who have developed serious mental illnesses as they have aged.

- Although some people with long-term psychiatric disabilities experience improved mental status and functioning as they age, many continue to have compromised cognitive and functional abilities throughout their lives, even if the primary symptoms of severe mental illness are controlled with medication.

- Although late-onset schizophrenia is relatively rare,[13] some older adults—especially those who have experienced moderate mental illness when they were younger—develop severe mental disorders when they are older and experience the same sort of compromised cognitive and functional abilities as people who have had psychiatric disabilities most of their lives.

- Older adults with severe mental disorders are as vulnerable to dementia as the general population.[14] (The prevalence of dementia, of which Alzheimer's is the most common but not the only form, doubles every five years beginning at age 60.[15])

- Therefore, some people with serious psychiatric disabilities experience additional cognitive impairment and, as a result, find it increasingly difficult to manage basic activities of daily living.

- In addition, there is increasing evidence that people with long-term psychiatric disabilities frequently become depressed as they age,[16] compounding emotional and cognitive problems. To some extent, their depressions may be linked to severe, chronic physical conditions—especially cardiac conditions.

- A small number of the people with serious mental illness who survive into old age have co-occurring substance abuse disorders.[17] Some of them stop abusing illegal drugs as they age, but some do not. In addition, like other older adults, some people with serious mental illness overuse alcohol and medications. There is an expectation that "levels of substance abuse will increase dramatically in the upcoming generation…."[18]

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[13] Desai, A.K., & Grossberg, G.T. (2003). Differential diagnosis of psychotic disorders in the elderly. In C. Cohen (Ed.), *Schizophrenia Into Later Life* (pp. 60). Washington, D.C.: American Psychiatric Publishing, Inc.

[14] Ibid.

[15] U.S. Department of Health and Human Services. (1999). *Mental health: A report of the surgeon general*. Rockville, MD: Author.

[16] Meeks, S. & Depp, C. (2003). What are the service needs of aging people with schizophrenia? In C. Cohen (Ed.), *Schizophrenia Into Later Life* (pp. 179). Washington, D.C.: American Psychiatric Publishing, Inc.

[17] Schoos, R. & Cohen, C.I. (2003). Medical comorbidity in older persons with schizophrenia. In C. Cohen (Ed.), *Schizophrenia Into Later Life* (pp. 128-138). Washington, D.C.: American Psychiatric Publishing, Inc.

[18] Patterson T.L. & Jeste D.V. (1999). The potential impact of the baby boom generation on substance abuse among elderly persons. *Psychiatric Services, 50*, 1184-1188.

- There are a couple of formally sanctioned evidence-based practices for the treatment of older adults with schizophrenia—cognitive behavioral social skills training and functional adaptation skills training. Cognitive behavioral social skills training teaches cognitive coping techniques, social skills functioning, problem-solving, and supports for neurocognitive impairments. Functional adaptation skills training teaches social and independent skills functioning in areas of everyday living.[19]

- There is also a consensus that atypical anti-psychotics are effective (albeit in different doses than for younger adults).[20]

- There is also consensus that depression in older adults with schizophrenia can be treated effectively with anti-depressant medications and with cognitive behavioral therapy.[21]

- Poly-pharmacy is common for older adults with mental disorders. Several medications may be used to treat psychiatric disorders and memory loss. And several medications will likely be used for physical ailments.

- A number of experts on schizophrenia in old age believe that family psycho-education—an evidence-based practice for younger adults—could also be effective for older adults but that the technique would need to be modified for this population (C. Cohen and W. McFarland, personal communication, 2006).

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[19] SAMHSA. (2007). *SAMHSA's national registry of evidence based programs and practices*. Retrieved from http://nrepp.samhsa.gov/.

[20] Bartels et al. (2002). Evidence-based practices in geriatric mental health care. *Psychiatric Services*, *53* (11), 1419-1431.

[21] Liberman, R.P. (2003). Biobehavioral treatment and rehabilitation for older adults with schizophrenia. In C. Cohen (Ed.), *Schizophrenia into Later Life*. (pp.238-9) Washington D.C.: American Psychiatric Publishing, Inc.

Health and Life Expectancy

- Although some older adults with serious psychiatric disabilities remain healthy and vigorous throughout their lives, most have chronic physical conditions including obesity, hypertension, diabetes, heart disease, and pulmonary disease as well as dementia.

- Sadly, people with serious psychiatric disabilities generally have limited access to quality health care[22] because health care providers generally do not understand their psychological problems and are often uncomfortable caring for them.

- Poor health and poor health care contribute to the low life expectancy of people with serious psychiatric disabilities, whose lives on average are at least ten years shorter than the general population.[23,24] A recent study puts it at about 25 years.[25]

- Lower life expectancy is also due to suicide and accidents.[26] (Falls are a major cause of disability and death among older adults, but drug or medication overdoses may be the major causes of "accidental" death.[27])

- In addition to driving down life expectancy, co-occurrence of these conditions and severe mental illness combined with lack of appropriate treatment drive up the costs of care for this population.

- People with long-term psychiatric disabilities are also just as likely to develop dementia[28] (which doubles every five years beginning at age 60) as the general population, resulting in increased cognitive impairment and reduced activities of daily living (ADL) skills.

- As a result of the increasing co-occurrence of physical and mental disorders and of dementia and psychiatric disorders as people age, there is an increasing number of people who need complex, continuing physical health care and ADL supports as well as treatment and rehabilitation for mental illness.

- Currently the housing and rehabilitative day programs provided through the mental health system for people with serious psychiatric disabilities are designed primarily for working age adults and are not geared to respond to the developmental and health challenges faced by those who are aging.

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[22] Horvitz-Lennon, M., Kilbourne, A., & Pincus, H. (2006). From silos to bridges: Meeting the general health care needs of adults with severe mental illnesses. *Health Affairs*, *25*(3), 659-669.

[23] Friedman, M. (2005, Fall). Baby boomers with schizophrenia and other long-term psychiatric disabilities: Prepare now. *Mental Health News*, pp.13, 43.

[24] Bartels, S. (2004). Caring for the whole person: Integrated health care for older adults with severe mental illness and medical comorbidity. *American Geriatrics Society*, *52* (12), 249-257.

[25] Colton, C.W. & Manderscheid, R.W. (2006). Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing Chronic Disease*, *3* (2), Available from: URL: http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm.

[26] Dembling, B.P., Chen, D.T. & Vachon, L. (1999). Life expectancy and causes of death in a population treated for serious mental illness. *Psychiatric Services*, *50* (8), 1036-1042.

[27] Ibid.

[28] Alzheimer's is the most common but not the only form of dementia.

- As a result, many aging people with psychiatric disabilities are served in nursing homes or adult homes rather than housing programs that are more integrated into community life. Some also shift to adult medical day care programs while continuing to live in the community.[29]

- Sadly, the inability of the mental health system to address the needs of people with complex, co-occurring physical and mental disorders often results in separating people with serious, long-term psychiatric disabilities from the communities to which they have often been attached for many, many years. In addition, it appears that separation from the community also results in many people with serious, long-term psychiatric disorders being alone as they reach the end of life.

- There is a need for alternative housing and day program models that take these needs into account. The physical plants of these programs also need to be accessible to people with physical disabilities and designed to prevent falls and other accidents.

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[29] Friedman, M., & Williams K. (2006). *Geriatric mental health –The need for change: Focus group findings*. Retrieved from http://www.mhaofnyc.org/gmhany/FocusGroup12_2008.pdf.

Housing

- Currently in NYS the Office of Mental Health serves 36,000 people with serious mental illness in 28,500 units of housing annually,[30] at most 17% of all adults with serious and persistent mental illness.[31] 5,875 are older adults 55+, approximately 9% of all older adults with serious mental illness.

- Obviously, most older adults with long-term psychiatric disabilities do not live in community-based housing funded by OMH. Some live independently and are satisfied with their housing. Some live in squalid or dangerous housing. Many live with their families, many in adult homes and nursing homes, and some in prisons. Many also live in naturally occurring retirement communities (NORCs), in senior housing, or supportive housing. Some are homeless.

- OMH housing is based on three different primary models—community residences, SROs, and supported housing.

COMMUNITY RESIDENCES

- "Community residences," which may be congregate living settings or scatter-site apartments, are designed to be transitional living situations. Residents are expected to move on to live independently or with limited supports.

- Most residences work on the assumption that residents need very limited assistance with basic activities of daily living and that they can leave the residence during the day to work, go to school, or attend rehabilitation or day treatment programs.

- Funded staffing levels are based on these assumptions.

- Currently 6.1% of people in community residences are 65 or over, but few of them are in facilities designated for older adults.[32]

- And most facilities for older adults are, unfortunately, not funded to provide additional staffing needed to provide ADL supports and medication management or to adapt the residential setting to the needs of people with physical disabilities or at risk of falls.

SROS

- SROs provide single room occupancy apartments in buildings that also have minimal on-site services. There are two types of SROs—either licensed (CR-SRO) or unlicensed (SHP-SRO).

- CR-SROs are licensed in the same way as a group home and designed on the assumption that residents will have an "extended stay," but they do not formally provide "permanent" housing. SHP-SROs are permanent.

- Older adults in SROs are eligible for a variety of home-based services such as home health care. But virtually none of these services are designed to meet the mental health needs of older people with serious and persistent mental illnesses.

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[30] NYS Office of Mental Health. (2007, May 16). *Guiding principles for the redesign of the Office of Mental Health housing and community support policies*. Retrieved from http://www.omh.state.ny.us/omhweb/News/housing_policy.html

[31] Estimates of the number of adults with serious and persistent mental illness range from 210,000 to 380,000.

[32] NYS Office of Mental Health. (2007). *2007 Patient Characteristics Survey*. Retrieved from http://www.omh.state.ny.us/omhweb/pcs/survey07/index.htm

SUPPORTED HOUSING

- "Supported housing" is permanent housing in the community subsidized by OMH. Case managers visit residents as needed. Most case managers do not have the training to deal with chronic medical illnesses.

- Few supported housing units are accessible to people with physical disabilities.

ALTERNATIVE DESIGN

- There is a need for alternative housing models to take into account the complexity of co-occurring disorders, the need for more ADL supports, and the need for safe and accessible housing.

- There is also a need for congregate housing that is home-like and located in local communities but that is not officially transitional. At some point it simply makes no sense to establish an expectation for an older adult to move from a congregate, supportive setting to independent living.

- Such models are key to avoiding unnecessary use of adult and nursing homes.

- A number of organizations have developed model programs for older adults with long-term psychiatric disabilities, including Rehabilitation Support Services (RSS), Fountain House, and The Bridge.

- In addition, 30-40% of people with serious, long-term psychiatric disabilities live with their parents.[33] As their parents die or become disabled, they need alternative housing and sources of care and support.

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[33] Grosser, R. & Conley, E. (1995). Projections of housing disruption among adults with mental illness who live with aging parents. *Psychiatric Services*, 46, 390-394.

Recommendations

GOALS

- **Help aging people with serious psychiatric disabilities to live in the community**, i.e. avoid institutionalization in adult homes or nursing homes.[34]
- **Increase the life expectancy** of people with serious and persistent mental illness.
- **Promote recovery and improved quality of life for** this population.

RECOMMENDATIONS

The recommendations in this document focus only on actions that the mental health system should take to provide appropriate housing for older adults with psychiatric disabilities—whether life-long or late life. The workgroup believes that there are other actions that the mental health, aging, and health systems should take in concert so as to develop support services that will help older adults with serious mental illness to age in the settings in the community that they prefer. We will address the need for residential supports in another document.

1. **Develop Additional Housing for Older People with Serious Mental Illnesses**
   There is a shortage of housing for older adults with long-term psychiatric disabilities.

2. **Modify Housing Programs in the Mental Health System**
   Most current housing programs in the mental health system are not suited for older adults with serious psychiatric disabilities and chronic physical conditions. There are a number of ways in which OMH housing programs should be modified for older adults.

   a. **Permanence:** For some people with long-term psychiatric disabilities, congregate housing is preferable to supported, scatter-site housing. But for older adults some congregate housing needs to be permanent; these residents need to be in the place they will stay for the rest of their lives.

   b. **Alternatives to Family Care:** A large percentage of adults with serious, long-term psychiatric disabilities live at home with their parents. When their parents become disabled or die, alternative housing needs to be made available.

   c. **NORC-SSPs:** Some NORCs have on-site supportive services programs that provide opportunities for activities, socialization, voluntary assistance to neighbors, on-site primary care by nurses, and on-site social work services. OMH could locate relevant supported housing in such sites and develop arrangements with the on-site supportive services programs to provide support to these residents. It would combine strong support oriented to older adults with an opportunity to live in the mainstream.

   d. **Accessibility:** Many older adults cannot manage stairs and may need walkers or wheel chairs to get around. For these older adults housing needs to be handicapped accessible with wide enough corridors and large enough bathrooms to accommodate walkers and wheel chairs.

[34] NYS regards adult homes as community settings. The Workgroup regards them as institutional settings.

e. **Safety:** Since falls are a major risk for older adults, housing needs to be constructed to try to reduce falls—for example, by providing grab bars—and to minimize the risks of injuries when people fall—for example, by using soft floor surfacing.

f. **ADL Supports:** For those older adults whose activities of daily living skills are deteriorating due to cognitive impairments, housing needs to be available that provides assistance with activities of daily living. This does not necessarily mean round-the-clock skilled nursing. By building ADL supports into OMH housing programs and/or by providing access to homecare services in these programs, nursing home placements could be averted.

g. **Health Care:** Congregate, mental health housing programs also need to be able to address the complex health care needs of their residents. This includes:
—Medication management
—Health maintenance via good nutrition, exercise, and smoking cessation
—Disease management, particularly using peer medical care managers
—Trained care coordination and medical management personnel
—Health care personnel on-site
—Linkages to good health care providers
—Integrated treatment for mental illness and substance abuse

h. **Home Health Care:** Helping people with serious long-term psychiatric disabilities to remain in scatter-site, supported housing may depend on the development of specialized home health care providers, who are knowledgeable about mental illness and working with people with psychiatric disabilities as well as with the physical conditions to which they are prone.

i. **Suicide Prevention:** Housing providers have frequent opportunities to observe their clients. Screening for depression as well as sensitivity to mood swings could help to identify suicide risks and to intervene.

j. **Deal with Death and Dying:** Apparently it is rare for service programs to deal openly with issues of death and dying. All providers should:
—Assist people with serious long-term psychiatric disabilities with future care directives
—Develop ways to maintain contact with clients who have become terminally ill so that they do not die alone.

3. **Future Care Planning**

Many aging adults with serious mental disabilities who live with their families will suffer housing disruptions when their parents die or become disabled. Many of these families have assets (usually their own home) that they can leave to their disabled child. NYS law enables parents to establish supplemental needs trusts. Establishing housing with parental assets has still not been developed in the mental health system even though there are examples of it in the mental retardation system. Developing mechanisms and providing guidance for parents to do this could relieve some of the current housing need.

4. **Workforce Development**

There is a great shortage of staff qualified to work with older adults with serious psychiatric disabilities. A number of efforts should be undertaken to increase the supply of qualified workers including:
—The development of incentives to enter the field
—Improved education in professional schools
—The development of volunteer and paraprofessional roles that could be filled by older adults and by people with psychiatric disabilities. These roles could include providing respite, home visiting, providing home health care, serving as medical care managers, and more.
—Staff training regarding aging, health, and cultural competence

5. **Long-Term Care Reform Should Include a Focus on Mental Health**
   New York State currently is pursuing a vision of long-term care restructuring, which is unfortunately narrow. It focuses exclusively on services provided under the aegis of the health care system—nursing homes, adult homes, home health, adult medical day care, etc. In fact the mental health system is also a long-term care system and one that feeds into the health-based long-term care system, causing disruptions in the lives of people with mental illness and driving up the cost of long-term care.

   New York State should include the mental health system in its pursuit of long-term care restructuring[35] and develop services responsive to its aging population with serious mental illness.

6. **Financing Models**
   There is a need to develop new financing models to support the recommendations above.

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[35] The Geriatric Mental Health Alliance has a paper entitled *Mental Health is Key to Long-Term Care*.

HOUSING IN THE MENTAL HEALTH SYSTEM FOR AGING PEOPLE WITH SERIOUS PSYCHIATRIC DISABILITIES

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