services, and, in some cases, medical care. In short, more resources must be devoted to programs that integrate mental health rehabilitative services into long-term care in both community and institutional settings.

Financing Services for Older Adults

Financing policies furnish incentives that favor utilization of some services over others (e.g., nursing homes rather than state mental hospitals) or preclude the provision of needed services (e.g., mental health services in nursing homes). Details on financing and organizing mental health services, with a special focus on access, are presented in Chapter 6. Selected issues germane to older adults are addressed here.

Historically, Federal financing policy has imposed special limits on reimbursement for mental health services. Medicaid precluded payment for care in so-called "institutions for mental diseases," Medicaid's term for mental hospitals and the small percentage of nursing homes with specialized mental health services. This Medicaid policy provided a disincentive for the majority of nursing homes to specialize in delivering mental health services for fear of losing Medicaid payments (Taube et al., 1990). Under Medicare, the most salient limits were higher copayments for outpatient mental health services and a limited number of days for hospital care. Medicare's special limits on outpatient mental health services were changed over the past decade, resulting in significantly increased access to and utilization of such services (Goldman et al., 1985; Rosenbach & Ammering, 1997). The concern, however, is that the gains made as a result of policy changes easily could be eroded by the shift to managed care (Rosenbach & Ammering, 1997).

Increased Role of Managed Care

Projections are that 35 percent of all Medicare beneficiaries will be in managed care plans by the year 2007, amounting to approximately 15.3 million people (Komisar et al., 1997). Although the managed care industry has the potential to provide a range of integrated services for people with long-term care needs, managed care's awareness of and response to chronic care are rudimentary (Institute for Health and Aging, 1996). Despite the potential of systems of managed health care, such as HMOs, to provide comprehensive preventive, acute, and chronic care services, their current specialized geriatric programs and clinical case management for older persons tend to be inadequate or poorly implemented (Friedman & Kane, 1993; Pacala et al., 1995; Kane et al., 1997). In addition, older patients are likely to be poorly served in primary care settings (including primary care HMOs) because of minimal use of specialty providers and suboptimal pharmacological management (Bartels et al., 1997). Further, current systems lack the array of community support, residential, and rehabilitative services necessary to meet the needs of older persons with more severe mental disorders (Knight et al., 1995). These shortcomings are unlikely to be remedied until more research becomes available demonstrating cost-effective models for treating older people with mental illness.

Carved-In Mental Health Services for Older Adults

The types of mental health services available within managed care organizations vary greatly with respect to how services are provided. In some organizations, mental health care is directly integrated into the package of general health care services ("carved-in" mental health services), while it is provided in others through a contract with a separate specialty mental health organization that provides only these services and accepts the financial risk ("carved-out" mental health services).

Proponents of carved-in mental health services argue that this model better integrates physical and mental health care, decreases barriers to mental health care due to stigma, and is more likely to produce cost-offsets and overall savings in general health care expenditures. These features are particularly relevant to older persons, as they commonly have comorbid somatic disorders for which they take multiple medications that may affect mental disorders, often avoid specialty mental health settings, and incur significant health care expenses related to psychiatric

symptoms (George, 1992; Paveza & Cohen, 1996; Moak, 1996; Riley et al., 1997). Unfortunately, mental health specialty services for older persons tend to be a low priority in managed health care organizations, by comparison with medical or surgical specialty services (Bartels et al., 1997). More importantly, carved-in mental health care may have superior potential for individuals with diagnoses such as minor depression and anxiety disorders but tends to shortchange older patients with SPMD who require intensive and long-term mental health care (Mechanic, 1998). The range of outreach, rehabilitative, residential, and intensive services needed for patients with SPMD is likely to exceed the capacity, expertise, and investment of most general health care providers.

Economic factors also may limit the usefulness of mental health carve-ins in serving the needs of older individuals with SPMD. First, evidence from private sector health plans suggests that without mandated parity, insurers offer inferior coverage of mental health care (Frank et al., 1997b, 1997c). Furthermore, if providers or payers compete for enrollees, there is strong incentive to avoid enrollees expected to have higher costs from mental health problems (e.g., older persons with SPMD). To avoid such discrimination, equal coverage of mental health care would have to be mandated through legislation on mental health parity or through specialized contract requirements with managed care organizations.

Carved-Out Mental Health Services for Older Adults

Proponents of mental health service carve-outs for older persons argue that separate systems of financing and services are likely to be superior for individuals needing specialty mental health services, especially those with SPMD. In particular, advocates suggest that carved-out mental health organizations have superior technical knowledge, specialized skills, a broader array of services, greater numbers and varieties of mental health providers with experience treating severe mental disorders, and a willingness and commitment to service high-risk populations (Riley et al., 1997). From an economic perspective, since competition is largely over the carve-out contract with the payer (generally a public organization or an employer), there is less incentive to compete on risk selection, and risk adjustment becomes unnecessary. In addition, mental health carve-out organizations may be better equipped to provide rehabilitative and community support mental health services necessary to care for older persons with SPMD. Finally, growth of innovative outpatient alternatives could be stimulated by reinvestment of savings by the payer from any decrease in inpatient service use.

Unfortunately, research is lacking on outcomes and costs for older persons with SPMD in mental health carve-outs. A carve-out arrangement could lead to adverse clinical outcomes in older patients due to fragmentation of medical and mental health care services in a population with high risk of complications of comorbidity and polypharmacy. Also, from a financial perspective, the combination of physical and mental comorbidities seen in older adults, especially those with SPMD, may reduce the economic advantages of carved-out services (Bazemore, 1996; Felker et al., 1996; Tsuang & Woolson, 1997). If the provider cannot appropriately manage services and costs associated with the combination of somatic and mental health disorders, anticipated savings may not materialize. Furthermore, fragmentation of reimbursement streams would likely complicate the assessment of cost-effectiveness or cost-offsets. For example, apparent savings of mental health carve-outs under Medicare actually may be due to shifting costs when an individual is also covered under Medicaid. In this situation, Medicaid may cover prescription drugs, long-term care, and other services that are not paid for by Medicare. In order to offer true efficiencies, Medicare mental health carve-outs need to find a way to bridge the fragmentation of financing care for older persons.

Outcomes Under Managed Care

There do not appear to be any studies of mental health outcomes for older adults under managed care. In general, the available research on mental health outcomes for other adults consistently finds that

managed care is successful at reducing mental health care costs (Busch, 1997; Sturm, 1997), yet clinical outcomes (especially for the most severely and chronically ill) are mixed and difficult to interpret due to differences in plans and populations served. Several studies suggest that outcomes under managed care for younger adults are as favorable as, or better than, those under fee-for-service (Lurie et al., 1992; Cole et al., 1994). In contrast, others report that the greater use of nonspecialty services for mental health care under managed care is associated with less cost-effective care (Sturm & Wells, 1995), and that older and poor chronically ill patients may have worse health outcomes or outcomes that vary substantially by site and patient characteristics (Ware et al., 1996). A recent review of health outcomes for both older and younger adults in the managed care literature (Miller & Luft, 1997) concluded that there were no consistent patterns that suggested worse outcomes. However, negative outcomes were more common in patients with chronic conditions, those with diseases requiring more intensive services, low-income enrollees in worse health, impaired or frail elderly, or home health patients with chronic conditions and diseases. These risk factors apply to older adults with SPMD, suggesting that this group is at high risk for poor outcomes under managed care programs that lack specialized long-term mental health and support services. To definitively address the question of mental health outcomes for older persons under managed care, appropriate outcome measures for older adults with mental illness will need to be developed and implemented in the evolving health care delivery systems (Bartels et al., in press).

Other Services and Supports

Older adults and their families depend on a multiplicity of supports that extend beyond the health and mental health care systems. Patients and caregivers need access to education, support networks, support and self-help groups, respite care, and human services, among other supports (Scott-Lennox & George, 1996). These services assume heightened importance for older people who are living alone, who are uncomfortable with formal mental health services, or who are inadequately treated in primary care. Services and supports appear to be instrumental not only for the patient but also for the family caregiver, as this section explains, but research on their efficacy is sparse. The strongest evidence surrounds the efficacy of services for family caregivers. Support for family caregivers is crucial for their own health and mental health, as well as for controlling the high costs of institutionalization of the family member in their care. The longer the patient remains home, the lower the total cost of institutional care for those who eventually need it.

Support and Self-Help Groups

Support groups, which are an adjunct to formal treatment, are designed to provide mutual support, information, and a broader social network. They can be professionally led by counselors or psychologists, but when they are run by consumers[8] or family members, they are known as self-help groups. The distinction is somewhat clouded by the fact that mental health professionals and community organizations often aid self-help groups with logistical support, start-up assistance, consultation, referrals, and education (Waters, 1995). For example, self-help support groups sponsored by the Alzheimer's Association use professionals to provide consultation to groups orchestrated by lay leaders.

Support groups for people with mental disorders and their families have been found helpful for adults (see Chapter 4). Participation in support groups, including self-help groups, reduces feelings of isolation, increases knowledge, and promotes coping efforts. What little research has been conducted on older people is generally positive but has been limited mostly to caregivers (see later section) and widows (see below), rather than to older people with mental disorders.

Despite the scant body of research, there is reason to believe that support and self-help group participation is as beneficial, if not more beneficial, for older people with mental disorders. Older people tend to live alone

[8] Consumers are people engaged in and served by mental health services.

and to be more socially isolated than are other people. They also are less comfortable with formal mental health services. Therefore, social networks established through support and self-help groups are thought to be especially vital in preventing isolation and promoting health. Support programs also can help reduce the stigma associated with mental illness, to foster early detection of illnesses, and to improve compliance with formal interventions.

Earlier sections of this chapter documented the untoward consequences of prolonged bereavement: severe emotional distress, adjustment disorders, depression, and suicide. Outcomes have been studied for two programs of self-help for bereavement. One program, They Help Each Other Spiritually (THEOS), had robust effects on those who were more active in the program. Those widows and widowers displayed the improvements on health measures such as depression, anxiety, somatic symptoms, and self-esteem (Lieberman & Videka-Sherman, 1986). The other program, Widow to Widow: A Mutual Health Program for the Widowed, was developed by Silverman (1988). The evaluation in a controlled study found program participants experienced fewer depressive symptoms and recovered their activities and developed new relationships more quickly (Vachon, 1979; Vachon et al., 1980, 1982).

Education and Health Promotion

There is a need for improved consumer-oriented public information to educate older persons about health promotion and the nature of mental health problems in aging. Understanding that mental health problems are not inevitable and immutable concomitants of the aging process, but problems that can be diagnosed, treated, and prevented, empowers older persons to seek treatment and contributes to more rapid diagnosis and better treatment outcomes.

With respect to health promotion, older persons also need information about strategies that they can follow to maintain their mental health. Avoiding disease and disability, sustaining high cognitive and physical function, and engaging with life appear to be important ways to promote mental and physical health (Rowe & Kahn, 1997). The two are interdependent.

Established programs for health promotion in older people include wellness programs, life review, retirement, and bereavement groups (see review by Waters, 1995). Although controlled evaluations of these programs are infrequent, bereavement and life review appear to be the best studied. Bereavement groups produce beneficial results, as noted above, and life review has been found to produce positive outcomes in terms of stronger life satisfaction, psychological well-being, self-esteem, and less depression (Haight et al., 1998). Life review also was investigated through individualized home visits to homebound older people in the community who were not depressed but suffered chronic health conditions. Life review for these older people was found to improve life satisfaction and psychological well-being (Haight et al., 1998).

Another approach to promoting mental health is to develop a "social portfolio," a program of sound activities and interpersonal relationships that usher individuals into old age (Cohen, 1995b). While people in the modern work force are advised to plan for future economic security—to strive for a balanced financial portfolio—too little attention is paid to developing a balanced social portfolio to help to plan for the future. Ideally, such a program will balance *individual* with *group* activities and *high mobility/energy* activities requiring significant physical exertion with *low mobility/energy* ones. The social portfolio is a mental health promotion strategy for helping people develop new strengths and satisfactions.

Families and Caregivers

Among the many myths about aging is that American families do not care for their older members. Such myths are based on isolated anecdotes as opposed to aggregate data. Approximately 13 million caregivers, most of whom are women, provide unpaid care to older relatives (Biegel et al., 1991). Families are committed to their older members and provide a spectrum of assistance, from hands-on to monetary help (Bengston et al., 1985; Sussman, 1985; Gatz et al., 1990; Cohen,

1995a). Problems occur with older individuals who have no children or spouse, thereby reducing the opportunity to receive family aid. Problems also occur with the "old-old," those over 85 whose children are themselves old and, therefore, unable to provide the same intensity of hands-on help that younger adult children can provide. These special circumstances highlight the need for careful attention to planning for mental health service delivery to older individuals with less access to family or informal support systems.

Conversely, a large and growing number of older family members care for chronically mentally ill and mentally retarded younger adults (Bengston et al., 1985; Gatz et al., 1990; Eggebeen & Wilhelm, 1995). Too little is known about ways to help the afflicted younger individuals and their caregiving parents. Families are eager to help themselves, and society needs to find ways to better enable them to do so.

There is a great need to better educate families about what they can do to help promote mental health and to prevent and treat mental health problems in their older family members. Families fall prey to negative stereotypes that little can be done for late-life mental health problems. They need to know that mental health problems in later life, like physical health problems, can be treated. They need to understand how to better recognize symptoms or signals of impending mental health problems among older adults so that they can help their loved ones receive early interventions. They need to know what services are available, where they can be found, and how to help their older relatives access such help when necessary.

The plight of family caregivers is pivotal. As noted earlier, the burden of caring for an older family member places caregivers at risk for mental and physical disorders. Virtually all studies find elevated levels of depressive symptomatology among caregivers, and those using diagnostic interviews report high rates of clinical depression and anxiety (Schultz et al., 1995). Ensuring their mental and physical health is not only vital for their well-being but also is vital for the older people in their care. Support groups and services aimed at caregivers can improve their health and quality of life, can improve management of patients in their care, and can delay their institutionalization.

Communities and Social Services

Family support is often supplemented by enduring long-term relationships between older people and their neighbors and community, including religious, civic, and public organizations (Scott-Lennox & George, 1996). Linkages to these organizations instill a sense of belonging and companionship. Such linkages also provide a safety net, enabling some older people to live independently in spite of functional decline.

While the vast majority of frail and homebound older people receive quality care at home, abuse does occur. Estimates vary, but most studies find rates of abuse by caregivers (either family or nonfamily members) to range up to 5 percent (Coyne et al., 1993; Scott-Lennox & George, 1996). Abuse is generally defined in terms of being either physical, psychological, legal, or financial. The abuse is most likely to occur when the patient has dementia or late-life depression, conditions that impart relatively high psychological and physical burdens on caregivers (Coyne et al., 1993). A recent report by the Institute of Medicine describes the range of interventions for protection against abuse of older people, including caregiver participation in support groups and training programs for behavioral management (especially for Alzheimer's disease) and social services programs (e.g., adult protective services, casework, advocacy services, and out-of-home placements). While there are very few controlled evaluations of these services (IOM, 1998), communities need to ensure that there are programs in place to prevent abuse of older people. Programs can incorporate any of a number of effective psychosocial and support interventions for patients with Alzheimer's disease and their caregivers—interventions that were presented earlier in this section and the section on Alzheimer's disease.

Communities need to ensure the availability of adult day care and other forms of respite services to aid caregivers striving to care for family members at home. They also can provide assistance to self-help and other support programs for patients and caregivers. In the

process of facilitating or providing services, communities need to consider the diversity of their older residents—racial and ethnic diversity, socio-economic diversity, diversity in settings where they live, and diversity in levels of general functioning. Such diversity demands comprehensive program planning, information and referral services (including directories of what is available in the community), strong outreach initiatives, and concerted ways to promote accessibility. Moreover, each component of the community-based delivery system targeting older adults should incorporate a clear focus on mental health. Too often, attention to mental health services for older people and their caregivers is negligible or absent, despite the fact, as noted earlier, that mental health problems and caregiver distress are among the leading reasons for institutionalization (Lombardo, 1994). Important life tasks remain for individuals as they age. Older individuals continue to learn and contribute to society, in spite of physiologic changes due to aging and increasing health problems.

Conclusions

1. 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.
2. Continued intellectual, social, and physical activity throughout the life cycle are important for the maintenance of mental health in late life.
3. 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.
4. 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.
5. 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:
   a. Dementia produces significant dependency and is a leading contributor to the need for costly long-term care in the last years of life;
   b. Depression contributes to the high rates of suicide among males in this population; and
   c. Schizophrenia continues to be disabling in spite of recovery of function by some individuals in mid to late life.
6. 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.
7. 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.
8. 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.
9. 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.
10. 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.

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