Older Adult Workgroup Report

Report of the Older Adult Workgroup of the Florida Commission on Mental Health and Substance Abuse

prepared on behalf of the workgroup by:

Co-Chairs:

Sallie Parks, Palm Harbor
Jeremiah Singleton, West Palm Beach
Larry Dupree, Tampa

Commission Members:

David McCampbell, Pembroke Pines
Mary McKinnon, Orlando

EXECUTIVE SUMMARY

The Number and Percent of Older Floridians Is Increasing As Is Their Need for Mental Health and Substance Abuse Services

Florida faces the challenge of a steadily increasing and steadily aging population. Besides being demographically the oldest state in the nation in 1997 (median age of 38.4 versus 34.9 for the nation), Florida's percentage of elders exceeded that for the nation (18.5% versus 12.7%). Florida's percentage represents more than 2.7 million persons age 65 and above, and approximately 46% are age 75 or older (U.S. Census Bureau, 1998). Florida's percent of increase for adults age 65+ from 1990 to 1998 was15.2%. Due to Florida's attractiveness and in-migration, population aging is likely to continue (Treas, 1995)

Even though most elders are emotionally robust despite the social, economic, and physical changes they face, the prevalence of mental illness is approximately 22%. Mental and substance abuse disorders among older adults are major factors in increasing health care costs and, tragically, the highest suicide rate of any age-group in America. Depression and anxiety disorders suppress immune system functioning, compromising resistance to, and recovery from, serious medical conditions. These risks are only beginning to receive the appropriate recognition and attention necessary to prevent and reduce hospitalization and re-hospitalization. Improved assessment and treatment of older persons is likely to have significant impact on their quality of life, as well as their loved ones, and on the costs associated with their health care.

Depression is the most frequent mental disorder among the elderly. It occurs in 8%-20% of community-based elders, up to 37% of older primary care patients, and up to 22% of nursing homes residents. It is associated with high rates of physical illness, disability, hospitalizations, alcohol abuse, and suicide. Depression is also related to increasing homicide-suicide rates. Homicide-suicides are tragedies that appear to be occurring more frequently in the U.S. In these circumstances, usually a man kills a victim, usually a wife or intimate, and then commits suicide. Older adults have homicide-suicide rates that are twice as high as younger adults, with nearly 20 older Americans dying each week. Depression is related to the increase in both homicide-suicide and suicide rates for elders.

It has been estimated that nationwide 2%-10% of community-based older adults abuse alcohol. Applied to Florida's age 60 and older population, it suggests that 71,354 to 356,773 abuse alcohol. Research at the University of South Florida has demonstrated that older drinkers typically drink in response to depression and social isolation, yet remained "hidden" from traditional service delivery systems. According to the National Longitudinal Alcohol Epidemiologic Survey, alcoholics age 65 and older are three times more likely to exhibit a major depressive disorder than those without alcoholism. In Florida, elders (age 60+) represented more than a third of the 1,006 alcohol-related deaths from mid 1996-98, 19% of all alcohol related hospital discharges, 4% of DUI arrests, and 7% of alcohol-related crashes. Elders constituted 8% of 488 drug induced deaths and one quarter of drug related hospital discharges.

Another form of substance misuse among elders is the misuse of medications. As a result, elders experience adverse drug reactions and interactions more than other age groups. Also, polypharmacy complicates effective treatment of both physical and mental disorders, and results in a higher rate of medication related hospital admissions for elders.

Older Floridians Are Significantly Under Served

Despite the major consequences and costs associated with mental health (MH) and substance abuse (SA) problems among older adults, they are rarely served by the traditional mental health and substance abuse treatment systems. In Florida, older adults use public sector mental health services substantially less than elders in the rest of the nation, including those from poorer states. Lower use of these services by older Floridians also holds true in comparison to individuals 18-64 in Florida, nationally and regionally. Also, the 1997 National Nursing Home Study, reported that more

than half of the residents in Florida's nursing homes had some diagnosable mental illness, but less than one quarter of those in need received mental health services. In assisted living facilities (ALFs), it is estimated that between 31%-56% of ALF residents have some form of mental disorder. This is noteworthy in that Florida leads the nation in assisted living facilities with nearly 2,300 ALFs and 79,000 beds. In all of these examples, few elders are provided mental health care due to lack of assessment and recognition of the problems, and also due to lack of in-home and in-facility services. For older substance abusers, the picture is worse. In 1998-99, only 676 of Florida's 30,000 adult substance abuse admissions were age 60 and older. Using estimates of alcohol problems among community-based elders of 2% to 10%, this suggests that only approximately 1 out of every 100 elders in need of treatment for alcohol problems actually receive treatment (using the 2% prevalence rate), and about 2 of every 1000 using the 10% prevalence rate.

A significant proportion of older adults with mental illnesses and substance abuse disorders remain unrecognized and untreated, often overshadowed by problems of the young. Mental health priorities, resources, and targeting largely center on younger generations. Thus, older adults who seek care for mental health and substance abuse problems are likely to do so outside the traditional MHSA sectors via primary care settings. Community care is delivered largely by non-psychiatric physicians more than by professionally trained mental health providers. Unfortunately, most primary care physicians are not prepared to identify and/or treat older adults with mental and substance use disorders. Even among state and local aging services, identification and assessment of depression and substance abuse have low priority. In Florida, such data are collected by field workers and case managers assessing Medicaid eligibility for nursing homes or assessing elders for supportive/in-home services, but are not coded or reported within the state's central data system. Also, a very small percentage of community mental health providers conduct elder outreach, signaling a relatively low level of commitment toward the aged. Outreach activities are important in educating older adults, their family members, and the general public. In addition, most community mental health centers do not have elder-appropriate programs, and very few of them have staff trained in geriatric service delivery.

Lack Of Mental Health and Substance Abuse Policy for Elders

Mental health policy in Florida has not kept abreast of the service needs of elders, advances in understanding of aging, or the demographics of aging. Although the efficacy of age-appropriate interventions relative to mental health and substance abuse problems among elders is well established, and the need for elder MHSA services well documented, policies affecting access to services, service system coordination, the financing of care, and the training of professional and nonprofessional providers and caregivers, lag far behind. As a result, elder Floridians manifesting emotional and substance abuse problems appropriate for professional care will not receive services.

Elders Develop Dependency on Intensive Services

Older adults are more likely to use inpatient than outpatient services, are more likely to use general hospitals than other treatment sites, and are highly likely to be treated by general medical practitioners than mental health professionals. Important factors constraining utilization of mental health services by older adults are stigma and general misinformation about mental health problems, and payment for services. Both Medicare and private insurance reimburse more substantially for hospitalization; however, outpatient care is only partially covered, providing major incentives for the use of hospital care.

A System of Care Is Lacking

Provision of an age appropriate system or continuum of MH and SA care is seen as an

answer to the interrelated physical, cognitive, emotional, social, economic, and support system needs of older adults. However, the notion of a continuum of care presupposes available, accessible, and affordable resources that are well coordinated. Florida's service delivery system relative to MHSA care for elders is fragmented, varies by geographical area, and is meagerly supported. Failures to collaborate and coordinate meaningfully among service organizations are noted, and dictated more often by economic pressures than by failures in planning or personal failings of providers. Insuring appropriate care for older adults with mental health and substance abuse problems becomes a matter of securing appropriate services from a multiplicity of competing systems, each with its own internal operating principles and funding streams. Because of the different constraints often placed upon resource utilization by the different funding streams within Florida's service delivery systems, the needs are being addressed in piecemeal fashion. In the absence of comprehensive mental health policy for elders, older adults will continue to be overlooked in an increasingly fragmented service delivery system.

High Cost is Associated with Not Serving Elders

Mental stress and mental illness take a significant toll on the health, costs of care, and productive functioning of older Floridians. Also, there is significant caregiver burden. "Caregiver burden" is well documented and understood relative to caring for elders with physical and cognitive disorders (e.g., Alzheimer's Disease), as well as substance use disorders. It also applies to emotional disorders. Liptzin, Groh, and Eisen (1988) compared perceived burden among family members of elders experiencing either depression or dementia, and determined burden was equal in the two groups, emphasizing that caregiver burden is not restricted to any one diagnostic category. Meeks, Carstensen, Stafford, and Brenner (1990) found that two- thirds of elderly psychiatric patients in their investigation of chronically mentally ill elders were living in the community and were relying on family support; and most caregivers of elders are elderly themselves. Also, Mellins, Blum, Boyd-Davis, and Gatz (1993) report that major life events, such as MH and SA episodes experienced by older family members, have effects that radiate throughout the family system, whether or not a particular family member is directly involved in caregiving.

Caregiver burden often results in clinical depression, as well as physical, financial, and vocational hardships (particularly for younger caregivers). Employment may be disrupted, attendance sporadic and less certain, with heavy reliance on annual and sick leave benefits. Employers lose billions annually in productivity. Also, as caregiver burden continues, and depressive symptoms increase, there is an often concomitant increase of physical symptoms, and use of physical health resources by the caregiver.

The inadequacy of mental health services for older Floridians continues to be a concern. There are instances of sensitive and imaginative treatment and service programs around the state, but significant problems and weaknesses have been noted by previous committees established to study elder mental health and substance abuse issues. The Older Adult Workgroup findings are highly consistent with those reported in 1997 by the Florida Elder Mental Health Task Force. Thus, little appears to have changed, and probably won't until statewide policy and comprehensive planning specific to elders are established. Committee findings thus far have had little impact, effected little change.

SPECIFIC FINDINGS

Findings common to the 1997 report and the Older Adult Workgroup include:

- There continues to be an absence of state policy and a comprehensive plan regarding the mental health and substance abuse needs and care of older Floridians.
- The absence of leadership and effective

advocacy for the mental health needs of older Floridians continues.

- Public funds are not dedicated to the broad mental health and substance abuse needs and care of older Floridians.
- The unique, age-related needs and circumstances of older adults necessitating specialized services have not been addressed.
- The capacity, scope, accessibility, and continuity of mental health services for older Floridians are inadequate.
- Older adults continue to not receive their proportional share of limited mental health resources.
- The number of trained and skilled clinical gerontological providers is inadequate, as are training opportunities. Providers involved with elders need continuing training programs, and higher education professional training programs need to develop curricula content that is more congruent with the requirements and requisite skills necessary to provide quality care to older persons with MH and SA problems.
- Outreach, education and prevention efforts specific to elders are inadequate, stigma associated with mental illness and SA deters elders and family from seeking treatment; and ageism continues to be a barrier to resource allocation, casefinding, and intervention.
- There continues to be a lack of outreach, casefinding and alternative service modalities in nontraditional settings (e.g., senior sites, home, primary care settings, and other settings where elders congregate). Services need to be taken to elders rather than anticipate use of traditional MH and SA settings.
- Prevention and wellness efforts designed for elders, families and professionals are inadequate.
- The continued fragmentation of efforts by state and local agencies whose responsibilities for older adults may overlap. The continued lack of interagency collaboration and planning relative to elder MH and SA issues, as well as the lack of collaborative/joint training opportunities.
- The need for increased "advocacy" regarding MH and SA issues from DOEA and the MHSA program offices both jointly and separately.
- Relative to outreach and identification, the inclusion of the Department of Elder Affairs (DOEA) as an MHSA partner would benefit elders, and is greatly needed. Thus, there is a need for greater involvement and commitment to elder MH and SA issues and services by the various aging programs; and enhanced collaboration with MH and SA agencies.

RECOMMENDATIONS

Older people with emotional and substance abuse problems should be recognized as having the same basic needs and responsibilities as all other people. They have the need for acceptance, belonging, dignity, self-determination, and caring for others; to be a help rather than a burden. Any continuum of care must include elements that work in unison to provide environments of opportunity to continue one's personal development. In response to these principles, as well as to the above findings, the Older Adult Workgroup generated a number of recommendations. Each of the recommendations is discussed in greater detail in the body of the report.

The Older Adult Workgroup recommendations include:

1. **Establish statewide policy directing attention to older adults with mental health and substance abuse problems.**

The lack of elder specific policy is a major barrier to MHSA service delivery to elders. Policy would require state agencies to address the MHSA

problems of elders, not being restricted just to the more severe conditions.

The policy should also establish a comprehensive service plan that addresses the mental health and substance abuse needs of older adults, as well as provide strategies to meet those needs through interagency coordination of services.

2. **Employ statewide a public health approach to mental health, mental illness, and substance abuse.**

The public health model extends beyond narrower models that provide treatment only for those who request care, to include systematic case finding approaches, facilitating access to care, ensuring the delivery of quality care, and assessing outcomes relative to changes in symptom behavior and other outcomes of public significance.

3. **Enhance the existing elder MHSA system of care.**

Older adults are likely to continue not seeking care from traditional MHSA services, appearing to prefer receiving any such related care in combination with medical care and support provided by their family physicians. It would seem reasonable that for older adults to receive increased MHSA care, public resources should be directed toward provision of this care in primary healthcare settings. Costs of delivering MHSA care are likely, in part, to be offset by reductions in the costs of medical care as a result of behavioral interventions.

Access to care for elders is an essential issue. Since most elders (90%) see their physicians at least once a year, access would be assured for most older persons via use of primary care settings. Also, provision of effective MHSA care in combination with medical care would be a benefit. A recommended integrated model of care is described.

4. **Establish collaborative outreach and recognition efforts.**

Staff development plans within the aging network, as well as the MH and SA networks, regarding the recognition of MH and SA signs in elders should be developed and implemented on a continuing basis. Also, aging and MHSA staff should conduct joint in-service training and education events. In addition, there should be a collaborative plan, including methods of information dissemination, designed to overcome barriers to treatment among elders.

5. **Individuals treating and/or serving older Floridians should have appropriate and ongoing training in aging and mental health, and substance abuse.**

An aging, MH and SA "consortium" should work with providers, licensure boards, professional organizations and educators to establish appropriate, age-specific education and training.

6. **Establish a recommended effective older adult MH and SA system of care.**

Obviously there is little value in outreach programs if referral/treatment resources are either not available or inappropriate. A critical task of the Older Adult Workgroup was to process and describe what it considered to be an effective system of care for older adults with MH and SA problems. Such a system is described through responses to questions. Implementation would be on a phased, as needed, basis.

There needs to be one authority, with the associated funding for elders, responsible for assuring quality services appropriate to elders' needs, as well as continuity across multiple systems. That authority would determine and monitor the standards (protocols) for all providers.

7. **Establish an integrated data collection and storage system.**

The lead agency should review annually, and adjust as needed, the specific performance measures and outcomes to assess the effectiveness of the intervention system and programs.

In order to make better policy, planning and monitoring use of available data currently housed in separate organizations, it is recommended that an integrated data system be developed by DOEA and MHSA; to be housed in one agency or organization.

8. **DOEA and the MHSA programs of DCF should jointly commit to establishing a coordinated and comprehensive policy for addressing the mental health and substance abuse needs of older Floridians, and act on that policy.**

Also recommended is collaboration on legislative budget requests regarding MHSA services for elders. Such action should have system integration value, as well as indicate multiple support for budget initiatives.

9. **DOEA, MH, and SA should each appoint (full time) staff to be responsible for elder MH and SA Issues.**

Previously, staff in MH and SA program offices were designated to promote elder initiatives, and the results were positive. Also, by having identifiable, designated staff responsible for elder MH and SA issues in each of the programs, the likelihood of cross-network collaboration markedly increases.

10. **The Legislature should provide funds for the development of new services within traditional and nontraditional settings.**

In order to enhance innovation in elder MH and SA services, it is recommended that demonstration models be proposed and funded via an RFP process. The RFP process is to be developed and monitored via a "consortium" of DOEA, DCF mental health and substance abuse program offices, AHCA, and the Department of Health.

11. **Require public sector agencies serving elders to conduct brief MHSA screening.**

These would include DOEA and its network, DCF and its providers, and the Department of Health.

12. **Judges, general masters, assistant state attorneys, and assistant public defenders should be adequately trained and educated on general mental health and elder issues, including community resources.**

They should also be educated on the issues identified in the Florida Supreme Court Commission on Fairness report on the Judicial Administration of the Baker Act and its Effect on Florida's Elders, prior to being assigned to Baker Act proceedings.

13. **Mandate specific strategies to enhance service attractiveness, access and use.**

The recommended actions relate to: location of services; education and prevention; gatekeeper, caregiver, and staff training; standardized systems of care; multiple collaborative relationships; enhanced aging expertise in treatment settings; staff longevity; basic screening of elders; case management; and staff placement.

CONCLUSIONS

Florida's current MHSA services for older adults are inadequate, and true need far exceeds actual services provided. This is related to limited resources, prioritization of other age groups, outreach efforts to elders being rarely undertaken, and case identification typically not given much emphasis. This is costly in terms of human

suffering and financial loss. Mental stress and mental illness, and substance abuse and misuse, take a significant toll on the health, costs of health care, and productive functioning of older Floridians.

As would be expected when there is a lack of available MHSA services, continuity of care is also lacking. Gaps in integrated care are noted within and between the MHSA and aging systems, and community based private sector providers. These gaps are the result of both minimal resources, and the lack of a guiding policy or plan. Thus, there isn't a unified, integrated system of care. As the Older Adult Workgroup focused on case identification, access, quality care, tracking and monitoring, and outcomes, it became apparent there were many gaps in the "system," meager support for existing programs, and little encouragement or prospect for improvement. Even though quality programs can be noted, they are too few, and center in just a few geographic areas. In fact, members of OAWG report that the availability of MH and SA services has drastically diminished in the last 10 years; all the while the numbers of elders in Florida have dramatically increased. Currently, care for elders is not a priority for state and local governments, nor community facilities.

Just as comprehensive child and adolescent mental health planning and policy have progressively served our younger citizens, we would expect newly established policy specific to elders to assist in countering the problems noted in this report, promoting adequate, accessible, quality care provided by appropriately educated/trained staff that could be relied upon on a continuing basis.

MISSION OF THE OLDER ADULT WORKGROUP

In order to promote a more detailed look at Florida's public sector mental health and substance abuse systems, the Florida Commission on Mental Health and Substance Abuse established four workgroups relative to: data compilation and analysis, children and adolescents, adults, and older adults. The purpose and values of each of the groups are congruent with the Vision Statement of the Commission:

> "All Floridians shall have access to a mental health and substance abuse system that works, with integrated treatment and prevention services that are affordable, client sensitive, high quality and outcomes focused, available within an unimpeded continuum of care."

To facilitate opportunity for public education and testimony, the Commission met monthly in different locales around the state. Each meeting had a theme and provided opportunity for open public testimony. Early meetings also included facilitated group discussion and invited speakers on selected themes. Meeting topics included: law enforcement / legal system, children's mental health, the state of the science in mental health, emergency behavioral health care, substance abuse, mental health / substance abuse needs of older adults, and system architecture / organization and financing.

The workgroups convened at times apart from and during full Commission meetings. The Older Adult Workgroup had an agenda for each time that it met, and functioned much like a focus group defining issues or problems currently negatively impacting the availability and quality of MH and SA services for elders (age 60 and above). The discussion of "problems" was preparatory to discussions centering on defining an effective MH and SA delivery systems for older adults. Elements of an effective system were established by the Commissioners, and were employed as a guide for discussions and decisions during the workgroup meetings. Those guiding elements (which also suggest a continuum of care) were: access, assessment, quality care, tracking/outcomes/feedback. Other elements suggested by the Commissioners included stigma and funding.

Issues other than those on the agenda were also open for discussion, allowing a freedom to contribute, while attempting to gain information about specific continuum elements each meeting. Notes were taken during each of the workgroup sessions, and were usually distributed the week after the meeting.

The Older Adult Workgroup (OAWG) was chaired by Commissioners Sallie Parks and Jeremiah Singleton, and Larry Dupree. At least one of the chairs was present at all OAWG meetings. The workgroup consisted of Commissioners (Sallie Parks, Jeremiah Singleton, Mary McKinnon, David McCampbell), an Advisory Committee (initially established by the Commission, but expanded as we continued), consumers/family members, USF-FMHI faculty and staff, DCF representatives, and AHCA representatives.

The workgroup meetings were publicly announced in advance, and open to all wishing to attend. The announcements also invited those not able to attend to link to the group via conference calling. Input was encouraged from both group members and nonmembers. The workgroup was open and receptive to whomever (including organizations) wished to contribute, either in person, the telephone, or written communications. Because there was great consensus in the perception of both the strengths and weaknesses of the existing MH and SA service delivery systems, and frequent consensus on ways to remedy the perceived system problems, there was very little group disharmony. The group process was informative, and positive. Generally, members were tired of rehashing the past, and appreciated the opportunity to be future oriented and positive. Thus, they surfaced problems/issues, but progressed to elaborating on ways to resolve those problems.

Core values guiding the discovery and recommendation process of the Older Adult Workgroup included:

- Older people having, or at risk of developing mental illnesses and substance abuse disorders, should be considered a priority population, with the MH and SA of elders promoted in policy, resource allocation, program development, cost effective service delivery, and staff development.
- Awareness and acknowledgement of the unique MH and SA needs of older adults and the necessity of specialized services, and specialized training of staff.
- The development of policy, programs and services relative to elders should foster independence, as appropriate, with an emphasis on the empowerment of older adults to help themselves to the maximum extent possible.
- Mental health and SA services should be both preventive and rehabilitative in nature, and seek to build on the strengths of the individual. Services should be inclusive and not exclusive.
- Services should be designed with the participation of older people so that available services are appropriate and acceptable to older consumers, considering both their needs and preferences.
- Older people should be served in an environment maximizing the personal rights, dignity and uniqueness of each older person, with sensitivity to ethnic and cultural diversity.
- Older people having, or at risk of developing MH and SA disorders, should have access to quality services which are well-coordinated by the service providers, and, when appropriate, linked to other agencies serving the needs of older people.
- MH and SA services (including prevention efforts) for elders should be readily accessible through appropriate delivery settings, including nontraditional settings (two of many examples: the home and senior resource centers).
- Family, consumers, the general community, and those providing services for elders must have ready access to information, education and training to promote quality care responsive and appropriate to older adults.

THE CASE FOR NEEDED SERVICES

THE NATION Data from the U. S. Bureau of Census and the National Center for Health Statistics indicate that persons 65 years or older numbered 34.4 million in 1998, representing approximately 13% of the U.S. population, or about one in every eight Americans. Since 1990, the number of older Americans increased by 3.2 million or 10.1%, compared to an increase of 8.1% for the under 65 population. Also, since 1900, the percentage of Americans 65+ has more than tripled (4.1% in 1900 to 12.7% in 1998), with the absolute number increasing eleven times (from 3.1 million to 34.4 million).

With this increase in number and percentage of elders, the median age of the country has increased. In 1998, the 65-74 age group (18.4 million) was eight times larger than in 1900, but the 75-84 group (12.0 million) was 16 times larger and the 85+ group (4.0 million) was 33 times larger. Additionally, as the nation ages, the ratio of women to men grows more disparate. In 1998, there were 20.2 million older women and 14.2 million older men, or a sex ratio of 143 women for every 100 men, with a high of 241 women to 100 men for persons 85 and over.

The older population will continue to grow significantly in the future, particularly when the "baby boom" generation reaches age 65. In 2030 elders will represent about 20% of the national population (projected to be 70 million, or double the 1998 number), and there will be proportionally more elders than young people (Hobbs & Damon, 1996). The over 85 age group is projected to grow at a rate nearly seven times faster than any other age group, and the

"baby boom" cohort (projected to exceed 55 million by the year 2020) will impact the nation's health care resources, including mental health and substance abuse resources (Jeste, et al., 1999; Koenig, George and Schneider, 1994).

FLORIDA Florida, in particular, faces the challenge of a steadily increasing and steadily aging population. Besides being demographically the oldest state in the nation in 1997 (median age of 38.4 versus 34.9 for the nation), Florida's percentage of elders exceeded that for the nation (18.5% versus 12.7%). Florida's percentage represents more than 2.7 million persons age 65 and above, and approximately 46% are age 75 or older (U.S. Census Bureau, 1998). Florida's percent of increase for adults age 65+ from 1990 to 1998 was15.2%. Due to Florida's attractiveness and in-migration, population aging is likely to continue (Treas, 1995).

Based upon data provided by Florida's Department of Elder Affairs (DOEA), the current (year 2000) elder population of the state is predominantly Caucasian (92%). African Americans represent 6.97%, Hispanics represent 9.17%, and other minorities represent less than one percent. Women in the state outnumber men in the age 65+ population. For every 100 men age 60+, there are 133 women, and for every 100 men age 75+, there are 153 women.

MENTAL HEALTH AND SUBSTANCE ABUSE NEEDS

Other than through anecdotal reports that provide a substantial collective body of information, little is known about the mental health problems and needs of older adults in Florida. The same can be said for most other states within our nation. Typically, we rely on data based on national studies and research done elsewhere to provide indications of mental health needs of Florida's elders. The consistency of findings from numerous studies around the nation are "aggregated" and used as guidelines for need as well as intervention. Many of those findings are well catalogued in Chapter 5 (Older Adults and Mental Health) of the recent U. S. Surgeon General's Report on Mental Health. Using those collective national findings as guidelines, projections of mental health and substance abuse needs of older Floridians are offered.

Most older adults are satisfied with their lives and are adapting well to the many changes that they experience. However a significant portion of elders have mental health needs that have major impact on individuals, their families and their communities. The U.S. Surgeon General reports that almost 20% of the population 55 and older experience specific mental disorders that are not part of "normal" aging. A report prepared by an elder mental health task force jointly commissioned by Florida's Departments of Children and Families and Elder Affairs indicates that approximately 22% of older adults have a mental disorder, with highest rates being found among older adults in institutional settings, such as nursing homes (typically estimated at over 50%, but considered to be much higher by some experts) (Strahan and Burns,1991; Tariot, et al.,1993; German et al.,1992; Cohen,1990). These percentages reflect that one in five of Florida's elders may have mental health and substance abuse needs (and dramatically higher in institution-like settings). However, elders with mental health problems are more likely to be undiagnosed and untreated (Unutzer et al., 1997; Blazer, 1996; Callahan et al., 1992). Thus, the prevalence rates are likely to be even higher. The unmet need for treatment services is a national problem, and reflects barriers to care: patient barriers, provider barriers, and mental health and substance abuse delivery system barriers.

Unrecognized or untreated depression, alcohol and drug misuse/abuse, anxiety, late-life schizophrenia, and other conditions can be severely impairing, even fatal (Hoyert et al., 1999). For example, suicide is frequently a consequence of depression; and the rate of suicide is highest among older adults relative to all other age groups. The suicide rate for older persons is 50% higher than that of the young or the nation as a whole. Also, the impact of

untreated mental health and substance abuse disorders experienced by older adults can pose difficulties for the growing numbers of family members who assist in caretaking tasks for their loved ones (Light & Lebowitz, 1991).

Depression and anxiety disorders suppress immune system functioning, compromising resistance to, and recovery from, serious medical conditions. These risks are only beginning to receive the appropriate recognition and attention necessary to prevent and reduce hospitalization and re-hospitalization (Florida Elder Mental Health Task Force, 1997).

Mental health treatment has demonstrated its effectiveness in decreasing health care costs overall. For example, a study of federal employees insured by Blue Cross/Blue Shield found that health care costs for patients with heart disease, respiratory problems and diabetes who received mental health counseling were reduced by 57% by the end of the second year and 66% by the end of the third year. An 18-year study by Kaiser Permanente concluded that a 12% reduction in total medical care costs and a 68% reduction in hospital days were realized following mental health treatment for those that needed it.

Available assessment and treatment of older persons is likely to have an even more significant impact on their quality of life and health care costs, as well as the quality of life of loved ones. Mental stress and mental illness take a significant toll on the health, costs of care, and productive functioning of older adults (EMHTF, 1997). Yet, that need not be the case. We know how to effectively treat elders with MH and SA problems.

SPECIFIC ELDER MENTAL HEALTH AND SUBSTANCE ABUSE ISSUES

DEPRESSION Depressive symptoms are an important indicator of general well-being and mental health among older Americans. Higher levels of depressive symptoms are associated with higher rates of physical illness, greater functional disability, and higher health care resource utilization. The Surgeon General's report indicates that depression is very prevalent among older adults, its symptom profile is different from that in other adults, and very difficult to disentangle from the many other disorders that affect older people. From eight to 20% of older adults in the community and up to 37% in primary care settings are experiencing depressive symptoms. "Minor depression" is more frequent than major depression, 8 -20% of community residing elders displaying symptoms (Alexopoulos, 1997; Gallo and Lebowitz, 1999). The rate of depression in nursing homes is even higher. Estimates range from 12 to 22.4% for major depression, and an additional 16.5 to 18% of the residents have "minor depression" (Lombardo et al, 1995). Mental health problems are the rule rather than exception in long-term care settings (up to 80%)(Florida Elder Mental Health Task Force, 1997; Gatz and Smyer, 1992; Lichtenberg, 1998).

LOSS AND BEREAVEMENT Many elders experience multiple losses with aging: changes in social status, personal control and self-esteem; financial changes; physical changes; and loss of loved ones. About 800,000 elders are widowed each year, and bereavement is a natural response. However bereavement is an established risk factor for depression (U.S. Surgeon General, 1999) Ten to 20% of those widowed develop clinical depression during the first year of bereavement, and, without care, the depression tends to persist and become chronic. This bereavement induced depression leads to further disability and impairments in physical health, including alterations in endocrine and immune function (Zisook and Shucter, 1993; Zisook, et al., 1994).

ANXIETY Flint (1994), reporting on community-based prevalence estimates in elders age 55 and over, estimated 11.4%. Himmelfarb and Murrell (1984) note that up 17% of elderly men and 21% of elderly women experience anxiety

symptoms that do not meet full criteria for formal diagnosis. However, Jeste et al. (1999) report that aging baby boomers are expected to have a higher risk of anxiety disorders, as well as depressive and substance abuse disorders, than the current cohort of older adults.

ALZHEIMER'S DISEASE Often, victims of Alzheimer's Disease (AD) are not only experiencing memory problems , but also other cognitive problems, as well as depression and anxiety. Eight to 15% of elders (over age 65) are victims of Alzheimer Disease (Ritchie and Kildea, 1995). The prevalence of dementia increases as age increases. Behavioral problems are a frequent concomitant, and create tremendous burden and stress for caregivers. Often, caregivers develop mental health problems of their own as their quality of life deteriorates in response to caring for the AD victim.

SCHIZOPHRENIA The prevalence rates for depressive syndromes and symptoms, as well as anxiety disorders, substantially exceed that for schizophrenic disorders in elders (Regier et al., 1988; Wetherell, 1998). One year prevalence is about 0.6%, about one-half that for populations 18 to 54. However, the economic burden of late-life schizophrenia is high.

SUBSTANCE ABUSE/MISUSE

Illicit Drug Use Older adults (age 65+) infrequently use illicit drugs (a lifetime prevalence of illegal drug use of 1.6 %)(Anthony & Helzer, 1991). However, this may change as baby boomers age. Patterson and Jeste (1999) recently compared prevalence estimates of those born during the baby boom with an older non-baby-boomer cohort. The researchers concluded that the baby boomer excess use, combined with their sheer numbers, means that more drug use is expected as this cohort ages, placing greater pressures on treatment programs and other resources.

Alcohol Abuse Often, older alcohol abusers are referred to as "hidden abusers." Just as the signs and assessment instruments for depression are not appropriate to elders, so it is relative to recognizing alcohol abuse in elders; particularly late-life onset alcohol abusers. Thus, abuse and dependence among older adults may be underestimated (Ellor & Kurz, 1982; Miller et al., 1991; King et al., 1994). Also, data from the National Longitudinal Alcohol Epidemiological Survey demonstrate that, among persons older than 65, those with alcoholism are approximately three times more likely to exhibit a major depressive disorder than are those without alcoholism (Grant and Harford, 1995). Dupree and Schonfeld (1996) also noted that many elders drink in order to soften the impact of experienced negative affect (e.g., depression, sadness, loneliness, grief, anxiety).

Early epidemiological surveys suggested that alcohol problems among the general, elderly population ranged from 2% to 10% (Gomberg, 1980). More recent estimates for problem drinking and heavy drinking among older people support those findings (Adams and Cox, 1997; Beresford, 1995). Among health care settings, the estimates are alarming. A Congressional Report in 1992 stated that 2.5 million older adults have alcohol problems, and that 21% of hospitalized people age 60 or older have a diagnosis of alcoholism, with related hospital costs as high as $60 billion (HR Report, No. 852, 1992). Other reports have had the percentages even higher (up to 60%). Whereas the National Institute on Alcohol Abuse and Alcoholism (1998) reports the following: six to 11% of elderly patients admitted to hospitals exhibit symptoms of alcoholism, as do 20% of elderly patients in psychiatric wards and 14% of elderly patients in emergency rooms. In acute-care hospitals, rates of alcohol-related admissions for older adults are similar to those for heart attacks Yet hospital staff are significantly less likely to recognize alcoholism in an older person than in a younger one. Also reported is that the prevalence of problem drinking in nursing homes is as high as 49% in some studies, depending in part on survey methods (Joseph, 1997). The high prevalence of problem drinking in this setting may reflect a trend

toward using nursing homes for short-term alcoholism rehabilitation stays (Adams and Cox, 1997). High estimates have also been obtained in veterans hospitals (Moos, Mertens, and Brennan, 1993).

Between July 1996 and July 1998, there were 1006 alcohol induced mortality cases across the state of Florida, and 38% of the alcohol related deaths were age 60 and above (compared to 1% of individuals ages 18-20). Those over 60 also represented 19% of all alcohol-related hospital discharges, 4% of DUI arrests, and 7% of alcohol-related crashes. Relative to drugs, those over 60 represented 7.8% of 488 drug induced deaths, and 0.6% of drug arrests; but 24.4% of drug related hospital discharges.

The conclusions generally drawn are: 1) that alcohol problems among older adults are more likely to be identified through less traditional means than those used to identify younger substance abusers, 2) that alcohol abuse or dependence will likely increase as baby boomers age, since that cohort has a greater history of alcohol consumption than current cohorts of older adults (Reid & Anderson, 1997), and 3) individuals are more likely to visit physician offices and require hospitalization. For many, especially older males, alcohol problems are likely to be observed secondarily to other health problems.

Misuse of Prescription Medications

People 65 and older consume more prescribed and over-the-counter medications than any other age group in the United States. Older adults fill an average of 13 prescriptions a year which is approximately three times the number filled by younger individuals (Chrischilles et al., 1992). Not surprisingly, substance abuse problems in older adults frequently may result from the misuse - that is, underuse, overuse, or erratic use - of such medications; such patterns of use may be due partly to difficulties older individuals have with following and reading prescriptions (Devor et al., 1994), as well as polypharmacy. In its extreme form, such misuse of drugs may become drug abuse. Benzodiazepine use represents an area of particular concern for older adults. Also, polypharmacy (use of multiple compounds, both prescription and nonprescription) complicates effective treatment of both physical and mental disorders.

Table 1 translates the above national prevalence rates into numbers relative to Florida. These are only estimates for Florida, but, in the absence of Florida-specific data, may be considered reasonable indicators of MHSA service delivery need.

ESTIMATES OF MENTAL DISORDERS OF COMMUNITY - BASED ELDERS IN FLORIDA

Disorder	Prevalence Rate	Total Number
All Mental Disorders	22% *	784,903
Depression	8 - 20% *	285,419 - 713,547
Anxiety - Symptoms not Diagnoses	11.4% of 55+ (4,175,604) 17% men 21% women	476,018 260,171 4217,836
Alzheimer's Disease	8 - 15% over age 65 **	227,991 - 427,484
Schizophrenia	0.6% *	21,406
Illicit Drug Use	1.6% lifetime prevalence	45,598
Alcohol Abuse	2 - 10% *	71,354 - 356,773

* Estimates based on age 60 and older
** Estimates based on age 60 and older

Table 1

OLDER ADULT WORKGROUP YEAR 2000 FINDINGS

SYSTEM OF CARE

First thing to note is that there is not a unified, integrated system of MHSA care for older adults. As the Older Adult Workgroup focused on case identification, access, quality care, tracking and monitoring and outcomes, it became apparent there were many gaps in the "system," and meager support for existing programs. Even though quality programs can be noted, they are too few, and center in just a few geographic areas. In fact, members of OAWG report that the availability of MH and SA services have drastically diminished in the last 10 years; while the numbers of elders in Florida have dramatically increased. MH and SA care for elders is not a priority for state and local governments, nor community facilities.

This dearth of elder services is a result of a number circumstances. Central is the lack of mental health and substance abuse policy for elders. The only mental health "policy" for older Floridians has been the drive to deinstitutionalize older state hospital patients. In mid-1969, the number of older persons in the Florida state hospital system peaked at 4,950. By January 1997, this number had been reduced to 478.

Several factors contributed to fewer elders in the state hospital system: 1) the passage of amendments to the federal Social Security Act in 1965, 2) the federal Community Mental Health Act of 1963, implemented in the mid to late 1960s, 3) the passage of the Florida Mental Health Act (the "Baker Act") in 1972, 4) the appropriation of funds in 1974 to establish 13 special community mental health projects for people over 55 years of age (providing a valuable background for the development of subsequent geriatric programs), and, 5) in 1980, another pilot project was funded to provide mental health care to discharged older adults in the community. Subsequently, 11 Geriatric Residential and Treatment System Programs (GRTS) were established across the state and helped to reduce the number of older patients in state hospitals from 2,032 in 1980, to 823 in 1990 (EMHTF, 1997).

All of the GRTS programs for elders suffering from mental disorders have struggled to survive in an environment of state fiscal constraint. Funds previously dedicated to the GRTS Programs have been, and continue to be, shifted to services for youth and young adults. This reduction in funds via shifting was permitted in 1990 by the elimination of categorical funding for elders. The result is that in 2000 only three GRTS programs exist, and none of the 13 specialized projects exist. This redirection of funds was possible in that Florida has never established a comprehensive mental health policy for older adults; and there have been few advocates on behalf of elder services. The same holds true for substance abuse services. Yet, elders (age 60 and above) represent approximately a quarter of Florida's population.

There have been prior efforts to review, improve and plan for mental health services for older adults, but with little impact. The most recent attempt began in 1994, and resulted in an excellent report in 1997 by the Elder Mental Health Task Force. The findings of that report are consistent with those of earlier review groups, as well as consistent with the Older Adult Workgroup year 2000 findings. The OAWG findings are next summarized across categories, and subsequently elaborated on in various sections of the text.

POLICY AND FUNDING ISSUES

In Florida, there is an absence of:

- A comprehensive mental health and substance abuse services policy for older Floridians.
- Leadership and effective advocacy on behalf of elders.
- Public funds dedicated to the broad (including SA) mental health needs of older Floridians.
- Collaboration, cooperation, and knowledge of

each other by state and local agencies whose responsibilities for older adults may overlap, but differ in service, and

- Involvement and advocacy relative to elder MHSA needs and services by the various aging programs, and enhanced collaboration of MH, SA and aging networks.

An Underserved Population

- 12% of all adults in need receive mental health services (Florida Senate Report, 1999), and
- 16.4% of all adults with substance abuse problems receive services.
- Only about 2% of adults who receive substance abuse services are age 60 and older. and less than one percent of adults age 60 and older in need of treatment for alcohol problems ever receive services
- Older adults are poorly represented among those receiving care.

Services are Meager

- Age-related needs and circumstances necessitating specialized services have not been addressed.
- Availability, accessibility and continuity of MHSA services for older Floridians are inadequate.
- MH & SA outreach and case finding efforts are minimal.
- Elders continue to not receive a representative share of limited MHSA resources.
- There is a lack of alternative service modalities for those unlikely to seek traditional MHSA services.

Lack of Training and the Consequences

- Few professionals receive training related to:
  - age-appropriate assessment and intervention
  - normal or abnormal aging issues

As a result ...

- identification, access, and resources are geared toward younger people
- MHSA providers in general feel less prepared to deal with issues associated with aging, including total case management
- primary care physicians lack the appreciation and understanding of MH problems, and overlook them in elders
- few staff in MH and SA programs are assigned to outreach and case identification for elders

Ageism, Bias, and Stigma

- Cultural and professional ageism, as well as stigma associated with mental illness and SA, impacts accessibility to care.
- Lack of information campaigns to counteract stigma; ageism; and elders', family members', professionals', and general public's beliefs that elder mental health problems are just an outgrowth of poor physical health and/or aging.
- There is a general lack of understanding by elders and families about mental health and substance abuse.
- Professionals lack recognition of the need for age-appropriate screening, assessment, and treatment.

MENTAL HEALTH ISSUES IN AGING SERVICES

- No routine screening for MH and SA problems using valid, age-appropriate assessment instruments.
- Not familiar with available referral resources, and not trained to recognize or resolve MHSA problems.
- Despite the fact that case managers employed by the various Area Agencies on Aging collect data on elders with respect to mental health and emotional problems, these data are not entered into the Florida Department of Elder Affairs' data system, and therefore are not reported.

In summary, Florida's current MHSA services for older adults are inadequate, and true need far exceeds actual services provided. This is related to limited resources, prioritization of other age groups, outreach efforts to elders being rarely undertaken, and case identification typically not given much emphasis. This is costly in terms of human suffering and financial loss. Mental stress and mental illness, and substance abuse and misuse, take a significant toll on the health, costs of health care, and productive functioning of older Floridians.

Relative to outreach and identification, the inclusion of DOEA as an MHSA partner would benefit elders. Thus, there is a need for greater involvement and commitment to elder MH and SA needs and services by the various aging programs; and enhanced collaboration with MH and SA agencies.

The latter point is not only reflective of the OAGW, but also reflective of a 1994 agreement. In April 1994, Florida's Alcohol, Drug Abuse and Mental Health Program Office and the Department of Elder Affairs recognized that service delivery to elders needed review and improvement. Thus, they signed a Statement of Cooperation. Excerpts from that agreement are offered because of the noted appropriateness, sense of combined responsibility, and values relative to Florida's elders, and because it reminds us of the cooperation and collaboration needed in order to succeed in establishing quality MH and SA services for Florida's elders.

Those excerpts are:

...We collaboratively commit our energies and resources to increase the choice, and community inclusion of elder persons who have mental illness or substance abuse problems. In addition, we agree to develop a joint strategy to advocate for the comprehensive services for elder persons who have mental illness or substance abuse problems.

We affirm a mutual responsibility for the development and promotion of stronger linkages between mental health, substance abuse and elder agencies at the federal, state and local levels. It is our hope that the effort of these agencies will foster such partnerships throughout Florida.

This collaborative attempt underscores an important, overlooked fact. Just because a person is over age 60 or 65, the MH and SA network should not presume that aging networks are solely responsible for his/her care; nor should the aging network presume that an older person with MH and/or SA problems solely be the responsibility of the MHSA network. DOEA's role in MH and SA care needs to be considered, if only as "gatekeepers" or referrers of elders with problems. "Case identification" is obviously an important part of an elder MHSA service delivery system. However, the potential to do more than identify also seems feasible.

THE CURRENT MENTAL HEALTH AND SUBSTANCE ABUSE SYSTEM

As a result of a lack of available MHSA services, continuity of care is not feasible. Gaps in integrated care are noted within and between the MHSA and aging systems, and community based private sector providers. These gaps are the result of both minimal resources, and a

lack of a guiding policy/plan relative to interagency collaboration. Obviously, gaps in the service delivery systems are not planned, but result from different operating principles, goals, eligibility criteria, funding sources, and pressures to respond to immediate, more acute, issues.

IDENTIFICATION AND ACCESS

More often than not, elders with MH and/or SA problems are "overlooked". This may be the result of many factors: inadequate "education" of older adults, family members, the general public, and professionals interacting with elders in various settings; and ageism. Ageism reflects a personal revulsion to and distaste for growing old, disease, disability; and fear of powerlessness, 'uselessness' and death (Butler, 1969, p243)." These beliefs are reinforced by our culture, and can express themselves in insidious ways via policy makers, care providers, and family (as well as elders). In the MH and SA field, "professional ageism" refers to the negative attitudes of MHSA professionals toward older adults. It includes a belief that aging means inevitable decline, pessimism about the likelihood and speed of change, and the belief that it is futile to invest effort (as well as resources) in a person with limited life expectancy. Such beliefs are rarely verbalized, but still guide the behavior of professionals. Elders are undiagnosed, or misdiagnosed as untreatable when noted problems are assumed to be irreversible consequences of aging. Lack of attention to the problem then confirms the "prophecy." Age has also been shown to affect both the diagnosis and treatment recommended for elders. In a number of studies, professionals have been presented with identical cases, with exception of the age of the persons. The "elder" case examples were more often diagnosed as having underlying organic conditions rather than psychosocial problems, and treatment recommendations were more often drug related, demanding institutionalization; and recommending less community-based service. For the identical "younger" cases, more often the recommendations included community based care, with less drug use.

Regarding under reporting of mental disorders among older adults, Kip (2000) has determined that often reported Epidemiologic Catchment Area (ECA) prevalence rates based on formal DSM diagnoses gave little consideration to the frequency of formal DSM *symptoms*. Also, he reports a seemingly paradoxical feature. When between 2 to 5 DSM symptoms were present, older persons were less likely to receive a DSM diagnosis. "For example, when 4 DSM symptoms were present, 19% of persons ages 31 to 40 and 15% of persons ages 41 to 50 were considered cases (at least 1 DSM diagnosis). This compares to only 6% or less being considered cases among the age groups 51 and older." It seems apparent that given the same number of DSM symptoms, the likelihood of receiving a DSM diagnosis was somewhat lower in older adults; again, supporting a diagnostic bias relative to age. It also reaffirms that a formal DSM diagnosis alone is not the only determinant of true need.

Kip, using methodology incorporating less age bias, has also calculated 1-year (1998) Florida prevalence rates for persons age 55 and older. His prevalence rates were 24.2% for mental disorders, 11.0% for substance abuse, 5.2% for co-occurring disorders, with an estimated 17.3% of all prevalent cases 55 and older estimated to have severe mental illness (SMI). Kip indicates that the estimated rate of SMI can be used as a basis for establishing "definite" need for mental health services.

All of us, as a result of both cultural and professional ageism, may be the barriers to identification of elders needing MHSA care, barriers to accessing care, and barriers in providing appropriate care. Thus enhanced recognition of elders with MHSA problems is going to require both content regarding age-specific signs and symptoms and attention to ageism issues. "Community gatekeepers" can be helpful to the identification process only if adequately prepared.

Availability versus Accessibility

Speer and Demmler (2000) have differentiated availability from accessibility of healthcare services.

> "Historically, utilization rate information has been thought of as one way to consider the availability and accessibility of services. "Availability" can be thought of as the amount of service or number of service providers or sites available in a particular area. 'Accessibility' has included: how easily these services can be located by those in need, the financial affordability of the services (including fee charges and insurance coverage), how easy it is for those in need to enter and engage the service system, transportation to service sites, attractiveness and safety of service sites, 'friendliness' of providers and the organization, and knowledge of providers about the characteristics of the group under consideration. Deficits on these variables have often been considered potential 'barriers' to obtaining services by those in need (p.1)."

Also, the stigma which older adults appear to attach to mental health or emotional problems and services is a significant barrier to seeking and using MH and SA services. Nationally, older adults have tended to constitute only 4-6% of publicly funded community mental health center total (all ages) caseloads while constituting 13-18% of the population (Speer and Demmler, 2000); whereas in Florida during 1994, 14% of the mental health outpatient consumers 18 and over were 65 and older. This older age group accounted for 24% of the total population of Floridians in 1994 of those 18 and older (Demmler, 1998). As Speer and Demmler suggest, the 1994 information may best be thought of as a recent historical "snapshot" of elder mental health services use. In their report, they present elder Floridian mental health service use in comparison to elders in other states both nationally and regionally (10 southeastern states). They determined that Florida's older adults used public sector mental health services substantially less than elders in the rest of the nation, including those from poorer states. Lower use of these services by older persons also holds true in comparison to individuals 18-64 in Florida, nationally and regionally. The rate of outpatient use for younger adults (18-64) was more than twice that for individuals 65-74, and about three times for those over age 75. Inpatient use rates were lower and more similar with the youngest age group having a use rate of 39 per 100,000 members of that age group, and the two elder groups had inpatient use rates of 22 and 25. The lower use rate of elders cannot be a function of lower prevalence rates in that for many disorders they are similar for both young and old people.

Based on national prevalence rates for elder alcohol abusers, it is likely that between 83,000 and 412,000 older adults in Florida age 60+ abuse alcohol. However in 1996, only 552 of Florida's almost 19,000 substance abuse admissions were age 55+. This suggests that only 7 out of every 1,000 elders in need of treatment for alcohol problems actually receive treatment (using a 2% prevalence rate), and about 1 of every 1000 elders (using a 10% prevalence rate).

More recent data from DCF records support earlier elder use rates compared to younger populations. 1998–1999 MH and SA service use rates provided via the DCF Integrated Data System (IDS) indicate that elders (age 60+) represented 12.6% of all adult mental health service users (10,999 of 87,028 total adults), 2.2% of adult substance abuse service users (676 of 30,097), and 2.1% of adults using both mental health and substance abuse services (170 of 7,951). Unfortunately, the numbers do not differentiate the kinds of services received, or extensiveness of care.

Nursing Homes In 1998, there were an estimated 82,096 nursing home beds in Florida nursing homes. The rate of mental illness in nursing homes in the 1997 National Nursing Home Study, based on ICD-9 codes of 290.0 through 316.9 and V40.0 through V40.9, was 56.4% (Kip, 2000). This

rate was applied to the estimated 138,575 annual nursing home residents resulting in an estimated 78,156 persons with mental illnesses in Florida nursing homes each year, with 12.5% receiving mental health services. This compares to an estimated 21.5% of residents with a diagnosed mental disorder, and 14.3% without a diagnosis, receiving mental health services in the National Nursing Home Study.

Assisted Living Facilities (ALFs) have become the fastest growing group housing alternative for frail elders; however, there is currently little information available about the prevalence of mental health and/or substance use disorders. Yet, a substantial rate of cognitive impairments has been reported.

In Florida, there were a total of 2,376 licensed ALFs in 1998 with a capacity of 79,043 residents at any point in time (may be underestimated due to possible unidentified facilities). However the annual number of residents is estimated at 133,550. Kip (2000) estimates that the prevalence of mental illness in ALFs lies somewhere between 31% (41,400) and 56% (74,780) with greater likelihood being closer to the latter rate.

Elderly residents in nursing homes and ALF's may be particularly vulnerable to the Baker Act process. The Florida Baker Act requires all receiving facilities to send a copy of every involuntary examination initiation form to the Florida Agency for Health Care Administration on the next working day after the person arrives at the facility. There were 75,828 forms received for involuntary examinations initiated in 1998. Some represented more than one initiation for the same person during the calendar year. The data reflect that 13% of those for whom involuntary examinations were initiated were 60 years and older; 11% were 65 and older. Clients whose forms were completed by mental health professionals were older than those with forms completed by judges or law enforcement officials. Those persons admitted as a result of alleged neglect were older than those alleged to be harmful to self/others or both neglect and harm.

Persons cannot be legally held in facilities as voluntary patients unless they are competent to provide express and informed consent to admission and to treatment. However, it is reported that many older adults are placed into facilities on a "voluntary" basis even though they lack the capacity to make well reasoned, willful, and knowing decisions about their care. This deprives them of the protections guaranteed in the Baker Act.

The Florida Supreme Court Commission on Fairness issued its report on the Judicial Administration of the Baker Act and its Effect on Florida's Elders in December 1999. The following information and recommendations were included in the report: persons providing testimony before the Subcommittee expressed concern about the excessive and inappropriate involuntary examination and placement of elders, especially elders who reside in nursing homes and assisted living facilities. Certain misuses of the Baker Act for elders purportedly involve financial incentives. Others relate to behavioral problems. Some facilities reportedly intentionally use the Baker Act to "dump" residents who are disruptive or require mental health treatment. In those situations, the nursing home or assisted living facility refuses to allow the individual to return when the individual is released from the mental health facility.

The Florida Legislature enacted legislation in 1996 to provide an increased level of protection for certain elders living in licensed facilities. The statute now provides that prior to an elder being sent to a Baker Act receiving facility on a voluntary basis, an initial assessment of their ability to provide express and informed consent to treatment must be conducted by a publicly-funded service. There is consensus that these increased protections have improved the process. Nevertheless, further modifications should be made to provide additional protections for vulnerable elders in both voluntary and involuntary admission situations. For example, some have suggested that the Florida Legislature consider whether the definition of mental illness should be amended to exclude dementia, Alzheimer's disease, and traumatic brain injury.

Access In the face of being stymied by a lack of information about where to seek effective and affordable services, as well as a tendency to interpret the basis for behavioral problems in old age as either physiological or normal aging, elders and loved ones turn to familiar, primary health care settings. Not only are primary care settings familiar to elders, they may act as an important potential portal of entry for elders with mental and substance abuse disorders. Yet primary health care providers vary in their capacity to recognize and manage mental health problems, and rarely do they know referral sources or have the time to help their patients find needed services.

Callahan, Bertakis, and Azari (1996), in a study supported by the Agency for Health Care Policy and Research, found that when physicians did recognize depression, they treated patients differently. They spent less time chatting and taking a physical history and more time on counseling, as well as more overall time with the patient. Physicians who did not recognize depression spent significantly more time taking medical histories, perhaps to clarify confusing data in an effort to explain the patients' symptoms. This additional time may mark the beginning of expensive efforts to diagnose patients using more laboratory tests, more return visits, and more referrals to subspecialists for diagnostic testing, all of which increase depression-related costs of care.

Access to care is not solely a service delivery system issue. Elders and loved ones can act as barriers to care. Most reinterpret psychosocial problems to be medical ones. Many elders hesitate reporting mental disorders fearing the intrusion of others into their lives; and losing independence. Once in, never out. A concomitant fear is placement in more restrictive environments. Whereas younger adults "cries for help" may result in help, the goal is a return to independence and personal control. Elders recognize that a cry for help within our atmosphere of cultural and professional ageism is dangerous. They fear becoming caught in an alien service delivery system that views elders needing continuing care, with someone else determining what that will be (Sussman et al., 1987; Monahan et al., 1999). Thus, the loss of personal control is feared. Also, the stigma associated with mental health and substance abuse issues is a barrier to care for elders.

Other barriers to care include financial obstacles. They discourage people from seeking treatment and from staying in treatment. Concerns about the cost of care are among the major reasons why people do not seek care (Sussman et al., 1987; Sturm & Sherbourne, 1999). There is an enormous disparity in insurance coverage for mental disorders in contrast to other illnesses. Thus, elders are forced to draw on more of their own resources to pay for mental health. This inequity is a deterrent to treatment and needs to be addressed.

The mental health and substance abuse service delivery systems also present barriers to access. Florida has a fragmented mental health system in which shifting policies and economic considerations have largely prescribed the type of care, if any, that the elderly receive. Also, without a systematic outreach effort, a significant proportion of older adults with mental illnesses remain unrecognized and untreated. They are often overshadowed by the problems of younger populations that appear more rehabilitative, more urgent, and more likely to affect public safety. With elders, the focus often is placed on medical illnesses. The result is that mental health priorities, resources, and targeting largely center on younger populations. For example, a very small percentage of community mental health providers conduct elder outreach, signaling a relatively low level of commitment toward the aged. Also, most community mental health centers do not have aging-appropriate programs, and very few of them have staff trained in geriatric service delivery. Yet, it has been demonstrated that mental health centers with both age-specific mental health programs and specifically trained staff attract elders in numbers above the national average for mental health centers, and private care. So did the centers that had either an aging program or staff specifically trained; but they had fewer enrolled elders than centers with both attributes. The facilities with neither aging-specific programs or staff had the lowest elder census.

Lastly, aging organizations and mental health advocacy groups have not advocated for elders with mental health and substance abuse problems, and have not been the sources of identification and referral that they could have been. Strengthening ties or establishing linkages between the aging network and mental health and substance services is warranted. Failures to coordinate among organizations are dictated more often by economic pressures than by failures in planning or personal beliefs of providers. Resources have been scarce. Economic pressures can lead to competition rather than cooperation, and limit services to existing clients rather than do additional casefinding, particularly for elders that may "belong" to some other system. Thus, in Florida , insuring appropriate care for older adults with mental health and substance abuse problems may be one of obtaining appropriate services from a multiplicity of "competing" systems, each with its own internal operating principles. There are gaps because different systems exist for different purposes and have developed in response to different historical pressures (Knight and Kaskie, 1995).

Knight and Kaskie (1995) have identified key features of successful community-based mental health service programs for elders after reviewing exemplary community based programs around the nation. Those programs emphasize accurate diagnosis of older adults, are interdisciplinary and treatment focused, use active case finding methods and community education approaches to attract elderly consumers, collaborate actively with other agencies that serve older adults (including gatekeepers), deliver mental health services to older adults at home, and are affordable. However another potentially overlooked factor (actually predictor) of service provision to elders in local programs in California was the presence of designated staff to serve them.

Relative to Access, What Are the Characteristics of an Effective System?

This question focused attention on outreach via traditional services, as well as community-based "gatekeepers." It was concluded that there needs to be collaboration between community organizations - setting up outreach and referral partnerships, with an organization taking the lead role in establishing and guiding a collaborative effort to define and establish outreach networks (including alternative settings), establish assessment and referral standards, train gatekeepers/network staff (including primary care physicians), and educate the general public. This entry network is to be designed to carry the "system" to the person by offering assessment and case managed service delivery via outreach programs, use of less traditional and primary care sites , as well as in-home services.

Quality Care Within an effective system, the treatment modalities offered should be research substantiated, and relate to nationally recognized "best practices" guidelines. That would also relate to age-appropriate training curricula. Currently, training related to geriatric mental health and substance abuse is virtually nonexistent. Its occurrence is unsystematic and fragmented. Incentives should be established for the development, provision and use of training programs in an effort to train and maintain staff at recognized standards of care. Those conducting the training should have specialization in aging and mental health, as well as substance abuse specific to elders. Also, providers should be required to use assessment protocols, interventions, and tracking and monitoring systems (outcome measures) valid with elders.

What is Quality Care?

Quality care incorporates program responsiveness and consumer appropriateness, continuity, and staffing and training related to the people being served. Also, quality programs have empirical support (are data based) demonstrating that they are relevant and effective. Currently, Florida doesn't have policy or guidelines to address the development of access, intervention, and staff training content appropriate to elders, whether the programs are elder-specific or age blended. Thus, it is left to the discretion of providers. Conscientious providers will look to recognized case identification,

access, quality care, and training standards for elders. Others may rely on using ongoing approaches believed to be effective with younger populations, and assumed to be effective with elders, though not established. The latter may work on an inconsistent, almost random, basis; yet, be interpreted to be effective with "motivated" elders. Consumers would be considered the basis for "failure," rather than the service program. Yet, inappropriate staff techniques and content have been related to both early dropout rates and poorer long term effectiveness for younger and older populations.

The absence of guidelines permits inconsistency in staff training and program content across the existing elder MH and SA programs, as well as an inconsistency in quality. Regardless of the source of funding, use of standardized and validated approaches with elders is likely to generate and maintain higher quality care across the state. This assumes a staff educated in both MHSA and aging issues, as well as being "elder friendly."

A recommended system of care, incorporating quality care issues, is presented in the recommendations section.

Whom should the system serve? The target groups defined by DCF's Older Adult Performance Outcome Measures Task Force, as stipulated in the recommendations section, identify the populations to be served. Individuals with dementia that can be appropriately helped with psychosocial interventions are also included. There will not be any exclusion for services based on income, however, payment will be based at least partially on the ability to pay.

How should the MHSA systems relate to each other, as well as to other elder programs (e.g., DOEA) in striving for quality care? An integrative model of care, with a lead agency, but collaboration around policy, funding program development, and standards and guidelines should be developed. In order to have an effective system, a comprehensive clinical information system must be in place, as well as have one point of responsibility. This system would basically be an integration of three organizations: Mental Health, Substance Abuse, and Elder Affairs; with AHCA and Health as other potential entities. However, it was recognized that integration and collaboration are more likely to function in the presence of a "central authority" with sufficient mandate, leadership, and interest in elders to get the distinct elements (agencies) to work together both at state and local levels. Such a collaboration can effect policy, standards, funding, program development, and advocate for elders with MH and SA needs; establishing elders as a priority population. Also, RFP based incentives (new monies, for new, need-based programs) designed and monitored by the consortium can guide and generate MHSA programs for elders, always requiring across agency cooperation. Additionally, a collaborative effort can require and ensure adequate training within each department, and across agencies (e.g., MHSA staff trained in aging issues, and aging network staff trained in elder MH and SA issues). It would be expected that Florida's aging organizations and mental health advocacy groups, as well as DCF service delivery programs, would play more of an advocacy role for the elderly with respect to MHSA services.

A key element of an effective system is case management, incorporating case managers who are properly trained to work with elders in negotiating for services across many service delivery systems (e.g., food stamps, housing, transportation, medical care, etc.). However, case managers, and organizations, should not be set up for failure by having a system of case-finding without the appropriate referral base and/or service resources. The "systems" currently in place to manage the needs of the older adult population for MHSA are markedly inadequate.

How should ADM services relate to long term care residents needing MHSA services? A current example is "mental health overlay services" for nursing homes (NHs). The "overlay program" provides services to NH residents (often for depression). Nursing staff, psychiatrists and primary care providers make referrals/requests for overlay services. Many professionals recommend that NH residents be screened for MHSA services within the first month of admission. The question becomes who is responsible, and who will pay for the screening, as well as needed services? Screening should be more comprehensive than the MH and SA related items on the MDS. Such screening is actually required by OBRA 1987, but identified needed services may not be provided.

The National Mental Health and Aging Coalition has written the Honorable Donna Shalala, Secretary of Health and Human Services regarding the lack of HCFA enforcement of the Federal requirement that nursing homes must provide or arrange for the provision of services to meet the need of residents. "This has been a particular problem in the effective implementation of the PASARR program. The PASARR process identifies persons with serious mental illness and determines the level of services that are needed. It then becomes the nursing facilities responsibility to provide or arrange for the necessary services. With very few exceptions there is no process in place to ensure that this is actually happening. In fact, anecdotal information indicates that in many cases it is not. This issue affects all nursing home residents whether or not they are those who have been assessed by PASARR. One state study found that residents that had received a PASARR review were fairing far better in terms of receiving services than were other residents.

Currently basic screening for MHSA in NHs, and adequate service delivery based on age-appropriate protocols are almost non-existent. Also, since most MHSA services are not billed through the nursing home, tracking of these services is difficult. Typically, outside licensed practitioners are invited into the institution to provide services, with the older adult being billed directly under Medicare or a Medigap policy. However, those services typically are not monitored or evaluated, and the qualifications of the providers relative to elders are very often overlooked. Often, because nursing homes are not required to monitor, or funded to provide MHSA services, and play a peripheral role in the delivery of such services, the homes do not perceive MHSA as part of their domain.

How should the ADM system relate to those living in ALFs? Mental health overlay services are also provided for ALFs. Currently, physician authorization is required to bill for services in ALFs and nursing homes. However, rather than having an available medical director responsible for all residents (as in NHs), ALF residents may use multiple external physicians. This complicates MH service delivery. It is often not efficient for physicians to provide services in ALFs due to a lack of volume of service (depending on the size of the ALF, as well as the level of care needed by ALF residents). All of this impacts the availability of Medicaid reimbursed services requiring physician referral/consultation. In the in-home and ALF overlay programs in District 5, ADM general revenue pays for mental health services. Medicaid billing occurs only in NH settings. However, it is the obligation of ALFs with a limited mental health license to assure that persons with a mental illness receive the mental health treatment they need from a licensed mental health professional or mental health agency. There are no financial incentives for ALFs to apply for such a license.

Tracking, Monitoring and Outcomes Effective performance measurement systems are necessary elements of management and quality improvement efforts. Thus, they need to address a number of issues: the program's/system's capacity for prevention/early intervention, concerns about access to care, the structure and delivery of services, and consumer performance outcomes.

The Florida Legislature in 1994 established requirements for performance outcome measures.

The mental health and substance program offices of DCF, as part of contracting with providers, implemented a standardized set of (quantitative) performance measures to formalize public accountability. Continued contracting was potentially based upon how well the providers did in terms of the performance measures. It became apparent that some of the required performance measures were more appropriate to younger populations than elders. Examples of irrelevant performance measures for elders were related to employment, school attendance and improvement in school, and involvement in the criminal justice system. Not only does there need to be age-appropriate measures of emotional status and functioning in the environment, outcomes for service are likely to be different for elders as a result of the multiplicity and complexity of physical, emotional, and cognitive conditions.

- In recognition of needing different performance indicators and measures for elders, the Mental Health and Substance Abuse program offices of DCF commissioned a task force to research and develop outcome measures appropriate to older adults. That task force is now in operation. Once appropriate measures have been identified, selected, and implemented, areas needing improvement, as well as continuing quality assurance, can be identified.

In establishing performance indicators for elders, the DCF elder task force identified seven "target groups:"

- Older adults (age 60 and above) with serious and persistent mental illness (SPMI)
- Older adults with serious & acute episodes of mental illness
- Older adults at risk of mental illness
- Older adults with substance abuse problems
- Older adults at risk of substance abuse problems
- Older Adults with Co-Occurring Mental and Substance Use Disorders
- Older Adults with Forensic Involvement

In accord with general principles for developing measures that generate a comprehensive view of performance, data will be derived from multiple sources (assessments). Thus, consumer indicators and measures appropriate for each of the seven elder groups are being defined. Community stability, mental health stability, consumer satisfaction, and goal achievement are among the most frequent indicators thus far considered, but may be measured/defined differently based on the specific elder target group. The task force is aiming at a system that has meaning to consumers, providers, and the mental health program office, making sure it is a useful system of measurements.

RECOMMENDATIONS OF THE OLDER ADULT WORKGROUP

1 Establish statewide policy directing attention to older adults with mental health and substance abuse problems.

The lack of elder specific policy is a major barrier to MHSA service delivery to elders. The absence of policy and shifting of resources to other populations reinforces the appearance that elders are not important in Florida. Policy would require state agencies to address the MHSA problems of elders, not being restricted just to the more severe conditions.

The policy should also establish a comprehensive service plan that addresses the mental health and substance abuse needs of older adults, and provide strategies to meet those needs through interagency coordination of services. The plan should identify the unique service needs of older adults, determine the types of services delivered, project the services needed, and ensure performance outcome measures.

Elements of the comprehensive plan are to be coordinated/integrated with other mental health planning, and with the plans of other state agencies that administer programs or services that are or should be components of a comprehensive mental

health and substance abuse service delivery system for older adults. To this end, state agencies should coordinate the development and integration of elements of the comprehensive plan appropriate to their respective programmatic responsibilities.

The comprehensive plan, established by policy, would also recognize the unique health, social, and mental health/substance abuse needs of elders; which in turn recognizes the need for age-appropriate assessment and intervention, as well as specialized education or training for staff.

The system should include comprehensive screening, assessment, internal case finding and outreach to identify older adults who are in need of mental health or substance abuse services, and should target known risk factors.

Even though priorities setting and minimum standards would be established at the state level to foster consistency throughout the state in mental health and substance abuse services, the system of care would be community based, with accountability, location of services, and the responsibility for management and decision making resting at the local level.

Older adults should receive individualized services, guided by an individualized service plan, in accordance with the unique needs and strengths of each older adult and his or her family or support system. These services should be received within the least restrictive environment appropriate to the service needs and quality of life of the individual. Also, comprehensive services should support and strengthen families and support systems so that the family or support system can more adequately meet the mental health and substance abuse needs of the older adult.

Services should be delivered in a coordinated manner so that the older adult can move through the system of services consistent with his or her changing needs and in a way that meets the needs of the older adult.

With elders there is a given: with any concern for MH and/or SA problems, there should be equal concern for the older adults' physical status. Co-morbid medical conditions are more the norm than the exception, and interact with MHSA problems. Thus appropriate care must be more comprehensive and integrated. Also, policy specific to elder MHSA care should take these interactive conditions into consideration, and permit development of programs in settings enhancing integrated care.

2 Employ a public health approach to mental health, mental illness, and substance abuse.

The public health model extends beyond narrower models that provide treatment only for those who request care, to include systematic casefinding approaches, facilitating access to care, ensuring the delivery of quality care, and assessing outcomes relative to changes in symptom behavior and other outcomes of public significance.

A study by Rabins et al (2000) conducted within public housing, as well as other elder studies (Katz and Coyne, 2000) are causing a reevaluation of current strategies for the delivery of mental health care, as well as the interactions of MH care with medical and longterm care of elders.

Rabins intervened with elders in Baltimore facilities known to have an increased prevalence of mental disorders: public housing. The intervention consisted of training building staff (including managers, social workers, grounds keepers, and janitors) to identify persons at risk for psychiatric disorders. Workers were also trained in how to refer them to a psychiatric nurse. Subsequently, identified elders were both evaluated and provided care, when needed, in their own homes. Results were that the PATCH intervention (Psychogeriatric Assessment and Treatment in City Housing) was more effective than usual care in reducing psychiatric symptoms in elders with psychiatric disorders and elders with elevated levels of psychiatric symptoms.

Via a public health model, case identification,

treatment planning, consumer and family education, implementation of treatment, monitoring of outcomes, and modifications of the treatment plan when necessary are all necessary elements. Also, the effect of interventions on an array of outcomes is tested: interpersonal functioning, general health, health-related quality of life, and health care use.

The public health model suggests the importance of modifying current public policy to support bringing care for elders with mental and substance abuse disorders out of the mental health care system and encouraging its integration with housing, long term care and medical care systems, and other nontraditional settings.

The public health model, in demonstrating the value of interactions between mental health care and general medical care for elders, also demonstrates the problem behind financial models that ignore important interactions with other components of care. This can be a problem with "carve out" approaches to funding mental health services.

3 Enhance the existing elder MHSA system.

Over the last 25 years mental health services for children have been greatly expanded using categorical funding; and, over this same period, the only expansion of services to older persons also occurred with categorical funding. However, when the approximately $20 million for the GRTS programs were no longer protected by categorical funding, the resources began to be directed to younger populations. The result has been a marked reduction of MHSA services for elders.

Someone has said it well: "It's a matter of trust." There must be confidence that the MHSA systems will serve all. Should there be accountable, sound and "equitable" management, fostering trust, legislatively establishing a comprehensive MH and SA services act for older adults (policy) would place elders in a position of being recognized and served. Services would be mandated. In essence, there would no longer be a need for age designated funding. However, categorical funding requests will continue as services and trust are lacking, and policy is not forthcoming. Also, requests for categorical funding are not attempts to return to the past, but are, again, signs of the MHSA systems' failure to respond to elder needs.

Adequate policy, and responsive and accountable system management, have the potential to also diminish the impact of another inflexible aspect of categorical funding: that of partially defining eligibility for services by age rather than in terms of recognized problems. Using noncategorical funding within primary care settings (settings often frequented by elders) would permit and support MHSA care for a broad spectrum of patients, focusing on disorders rather than age. This also assumes that staff would be knowledgeable of lifespan issues.

It would seem reasonable that for older adults to receive increased MHSA care, public resources should be directed toward provision of this care in primary health care settings. Costs of delivering MHSA care are likely, in part, to be offset by reductions in the costs of medical care as a result of behavioral interventions.

For example, research evidence indicates that untreated depressive and anxiety disorders and symptoms among younger and older adult primary care patients are associated with significantly higher rates of outpatient and inpatient utilization, more medical tests, longer lengths of stay, slower recovery, poorer medical outcomes, and overall higher healthcare costs (Speer, 2000a,b).

Older adults are likely to continue not seeking care from traditional MHSA services, appearing to prefer receiving any such related care in combination with medical care and support provided by their family physicians. It would seem reasonable that for older adults to receive increased MHSA care, public resources should be directed toward provision of this care in primary healthcare settings. Costs of delivering MHSA care are likely, in part, to be offset by reductions in the costs of medical care as a result of behavioral interventions.

Access to care for elders is an essential issue. Since most elders (90%) see their physicians at least once a year, access would be assured for most older persons via use of primary care settings. Also, provision of effective MHSA care in combination with medical care would be a benefit. Thus, behavioral health care and medical care would be integrated; also, somewhat softening the stigma often associated with seeking out specialized MHSA care in traditional settings. In addition, the issue of underuse is likely to be reduced in that elders more often turn to medical professionals with their problems and concerns. In fact, older adults, historically, have under-utilized traditional publicly funded mental health care; whereas, elders are disproportional users of medical services. Also, it is estimated that 50-70% of physician visits are for non-medical causes, or for medical reasons exacerbated by psychosocial factors (Speer, 1999).

Medical doctors have long been considered the primary providers of mental health services in the United States. Physicians treat more older adults with mental disorders than do specialty mental health providers. Unfortunately, however, many physicians are ill-prepared to care for older patients with MHSA problems; failing to detect about half of the mental disorders among their patients, and appropriately treating or referring only about 40% of the problems detected. With incentives and training these inadequacies can be resolved.

Clinical experience in integrated behavioral health care settings suggests that older adults more readily accept an in-house (same setting) referral to a mental health provider by their physician than to an external provider. Via such an internal referral process in primary care settings, brief, time-limited, structured, and group mental health or psychoeducational interventions appear effective and cost-effective.

A significant issue is that primary care as currently practiced very rarely provides adequate MHSA care for elders or any age person. It is therefore recommended that Florida, on a demonstration basis, fund the integration of MHSA care into primary care practices with known moderate to high elder representation. Specifically, it is recommended that such integrated models be supported in each district of the state (each continuing for three years), with evaluation regarding effectiveness, costs, and medical cost-offset effects.

England currently uses the integrated approach, with nonmedical professionals specifically trained to perform screenings and interventions in primary care settings for an array of patients. Also, a Partners in Care program in the U.S. has demonstrated how depression care can be improved by primary care physicians. The study was conducted in 46 primary care clinics and used a team based approach including nurse depression specialists. The goal of this approach was in improving the cost-effectiveness of care for depression in managed primary care, and the results included enhanced patient MH care, adherence to treatment components, and reduced co-payments for psychotherapy (Rubenstein, Jackson-Triche, Unutzer, et al, 1999). However, similar integrated approaches have value in primary care practices other than health maintenance organizations.

The Older Adult Workgroup recommends that the integrated pilot programs for Florida include:

1. Placement and support of at least one specially trained and licensed MHSA provider in a practice serving older adults in each district (funded by the state ADM). These providers would conduct on-site informal and formal, as appropriate, training and consultation to medical staff in assessment and detection of MHSA problems; as well as provide brief individual and group MHSA treatment and prevention efforts. Consultation about patient management is also be provided.
2. Brief, structured, and time-limited MHSA care. Elders, and others, not responsive to the briefer interventions, or having needs requiring more intensive or restrictive settings, would be appropriately referred to other elements of the MHSA systems.
3. Competent, well trained staff. It is

recommended that the MHSA staff have a minimum of a Master's degree, and be licensed MHSA providers. There would be at least one MHSA provider per primary care setting, offering 30-35 contact and/or consultation hours per week.

4. Continuing psychosocial programs (often using a group format), either of a restorative or a preventive nature.

5. Response to high frequency problems common to a number of age groups. These might include: depression, anxiety, somatization, grief, crises and stress, family and interpersonal problems, suicide concerns, caregiver support and counseling, and behavior management for dementia patients.

6. Training. The state would contract with an experienced trainer expert in the provision of brief MHSA services in primary care settings. The trainer would design a succinct training program, implement it, and arrange for supervision of the MH providers in primary care settings for one year.

7. Recruitment of primary care settings. To be eligible for participation, a primary care practice will have seen a minimum average of 100 older adults per year during the preceding two years. The practice would also have to agree to the staffing, training, continuing programs, referral and effectiveness evaluation requirements of the model.

8. Financial incentives will be necessary for the development of services in primary care practices, as well as funds to defray overhead and support services costs. It is assumed that billing and cost-recovery mechanisms will be established during the demonstration project that will recover some costs of MHSA related services. Because the integrated MHSA services are likely to prove their value and cost-effectiveness over time, incentives are likely to no longer be necessary beyond the period of demonstration.

9. Evaluation of effectiveness. A Ph.D. program evaluator with MHSA evaluation experience, plus two BA level research assistants will be employed full-time to evaluate the effectiveness and costs of integrated MH services in primary care. In addition to designing the logistics for obtaining utilization, outcome and cost data about primary care patients referred for brief MH services, the evaluator will also design logistics for comparison conditions similar to those generated by Dupree and Speer (2000).

10. Costs and revenue. Suggested three year budgets are available including net costs per district, and total net costs for 14 districts. Net general revenue costs diminish over the three year period as revenue (reimbursement) increases.

4 Establish collaborative outreach and recognition efforts.

Most elders who might profit from MHSA services apparently go unidentified. Yet, many agency staff interact with elders on a daily basis. Often we cannot see what we have not learned to see. Staff development plans within the aging network, as well as the MH and SA networks, in the recognition of MH and SA signs in elders should be developed and implemented on a continuing basis. Also, aging and MHSA staff should conduct joint in-service training and education events.

In addition, there should be a collaborative plan, including methods of information dissemination, designed to overcome barriers to treatment among elders. Innovative outreach programs must be developed and promoted to improve the diversion of older persons from expensive and intensive forms of care. Also, there should be developed a marketing and public education plan on how best to develop prevention and treatment strategies aimed at an older audience .

Aging network organizations, the MH and SA systems, and appropriate community organizations should collaborate to develop training modules designed to help "gatekeepers" identify high risk

older persons and to refer them to the appropriate resource. Major potential gatekeepers (with training) include primary care physicians and their staff, as well as the aging service delivery, NH and ALF staff. Education and training efforts would be directed at increasing professional, staff and lay person skills in accurately assessing the mental health and substance abuse needs of elders, and to increase the rate of appropriate referral to MH and SA service providers, private or public sector.

Community-based systems of MHSA care should become resource and education "centers" for elders, professionals, and the general public about elder MH and SA issues.

5 Individuals treating and/or serving older Floridians should have appropriate and ongoing training in aging and mental health, and substance abuse.

The aging, MH and SA "consortium" should work with providers, licensure boards, professional organizations and educators to establish appropriate, age-specific education and training. The consortium should work with the educational system to develop training, and to train workers in a variety of agencies who deal with older people, as well as professional associations to promote continuing education efforts. Also, at least annually, the consortium should convene an Aging/Mental Health/Substance Abuse Conference, inviting practitioners from all service networks serving elders.

MH, SA and DOEA should consult with legislators and educational leaders regarding formally establishing curricula in Florida's higher education centers, as well as professional schools, focusing on the normal aging process, and behavioral needs sometimes associated with aging.

6 Establish an effective older adult MH and SA system of care.

Obviously there is little value in outreach programs if referral/treatment resources are either not available or inappropriate. A critical task of the Older Adult Workgroup was to process and describe what it considered to be an effective system of care for older adults with MH and SA problems. Such a system is described through responses to questions.

Many of the questions and responses are colored by an underlying assumption that elders are only likely to gain resources and access to care via categorical funding. It colors certain aspects of defined eligibility, but other elements are appropriate to various funding sources. See recommendation #2 for an alternative to categorical funding.

At what age does an individual qualify for specialized elder behavioral health care?
Quite a bit of discussion centered on whether the minimum qualifying age for specialized elder behavioral health care should be age 55 or 60. The Older Adult Workgroup settled on age 60; however, it was also suggested that the elder care system be flexible so that persons ages 55 -59 who are emotionally or physically fragile, and would benefit from elder care services, might be "enrolled." Persons who are 60 should be "enrolled" as an older adult so that they may be tracked in the system. Enrollment, however, should not limit an older adult's ability to access any services that they need whether in the "regular" adult system or specialized older adult services.

The 2000 session of the Florida Legislature directs DCF to revise its target groups for substance abuse and mental health services approved pursuant to s. 216.0166, Florida Statutes, to include "older adults in crisis," "older adults who are at risk of being placed in a more restrictive environment because of their mental illness or substance abuse," "older adults with severe and persistent mental illness," and "older adults in need of substance abuse treatment." Thus, elders other than those with severe and chronic conditions are eligible for services. The department is also directed to track and report specifically on substance abuse and mental health services provided to older adults.

Who are eligible to receive services? Individuals within the noted age criteria experiencing:

- Severe and persistent mental illness
- Serious and acute episodes of mental illness
- At risk of mental illness and/or suicide
- Substance abuse problems
- At risk of substance abuse problems
- Co-occurring mental and substance abuse disorders
- Forensic involvement, and
- Older adults experiencing dementia associated with MHSA conditions that can be helped via psychosocial interventions.

Income should not limit services; however, payment for services would be based at least partially on the ability to pay.

What is an effective geriatric model of care? A good geriatric model must incorporate both medical and MHSA services within a "specialized case management" system. The "case manager" would be responsible for assisting the individual in arranging for whatever care was needed in whatever systems of care (i.e., medical, MH, SA, nursing home, etc) he or she may be involved, or needed to become involved.

The quality of care system should be as seamless as possible so that admission to a hospital, nursing home, ALF, or SA treatment etc. does not break the continuity of the MHSA care. Ongoing contact by the case manager and possible overlay services should be maintained as needed as well as in-home services to persons confined to their home. Multiple funding mechanisms should be available to cover the costs of appropriate services such as general revenue for services not reimbursed by Medicare or Medicaid or third party insurance.

What is the array of services and what are the differences? Many services should be separate or distinct from the adult service delivery system. However, this may be difficult in residential and CSU/inpatient services. Plans and safeguards for frail elders need to be in place. For example, although older adults could be housed with younger adults, their safety may need to be protected by having separate bedrooms (as is done for children under age 14). Thus, in order not to have duplicate residential settings, concrete plans and/or unit configurations protective of the safety of elders on a multi-age unit need to be in place, and specially trained staff need to be available. Mixed age settings should still comply with standards appropriate to elders in terms of staff requirements, assessment and intervention.

The service array should include elder crisis response programs; mental health overlay services in long term care settings such as nursing homes and ALFs; a continuum of residential services such as group homes, therapeutic foster homes and other alternative housing options; day treatment programs; programs in nontraditional, alternative settings (e.g., in-home and aging network sites); outreach, elder education and MHSA prevention programs; individual and group psychotherapy; and psychoeducational programs such as assertiveness training, grief and loss education, and healthy aging.

Where should the development of an older adult service system begin? Implementation should occur in phases for the development of a specialized treatment system for older adults.

Phase One needs to simultaneously include assessment, early intervention, and coordination of care services. This phase could begin with aggressive outreach services to begin to identify older adults currently in need of, but not receiving, MHSA services. Early intervention and outpatient treatment services need to be in place at the same time in order to assure that persons identified receive the services they need in a timely fashion. Coordination of care needs to be in place to make sure individuals are receiving the full array of services they need from multiple systems of care.

Phase Two needs to occur shortly after Phase One in order to supplement the current MHSA system for those older persons with serious mental health and substance abuse problems, and to have available

the increased capacity for those individuals identified in Phase One who need more intensive services. Phase Two needs to address the special residential needs of older individuals with severe mental health and substance abuse need such as was part of the Geriatric Residential and Treatment System. These residential services included specialized group homes, therapeutic foster homes, supervised apartments, and special nursing home facilities.

Phase Three needs to address the long term needs of the older adult population with mental health and substance abuse problems, including those with dementia and other related problems assessed to be amenable to psychosocial interventions; and would build on those programs started in Phase Two.

Where and how should services be delivered, and by whom? Services should be delivered wherever the client can be best reached such as ALFs, nursing homes, independent housing, physicians' offices, meal sites, et cetera, assuming the required level of care is congruent with the setting. Mental health and substance abuse treatment services should be delivered by mental health or substance abuse professionals appropriately educated or trained in age-appropriate assessment and interventions, whether through a community-based service provider or individual. Similar age-appropriate protocols and outcomes should be required of every provider.

MHSA assessments and services for elders are to have research determined validity and effectiveness with older adults; or in compliance with national, consensus based "best practices" guidelines.
Gatekeepers, such as police, primary care physicians and nurses, DOEA case managers, senior resource centers and meals-on wheels staff, etc. should be trained to recognize mental health and substance abuse problems, document the incidence of MHSA problems identified, and make the necessary referrals for assessment. Training in available referral resources will also be necessary.

A multi-disciplinary team approach should be used including primary care physicians, psychiatrists, psychologists, social workers, occupational therapists, nurses, nutritionists, etc.

What are the funding mechanisms and who pays for what and when? State general revenue needs to be used to fill in the gaps where Medicare, Medicaid, insurance, and other federal resources are not available. Medicare, Medicaid, etc. need to be fully utilized through creative programming and incentives from the state and federal government so that providers use these funding sources first, to be complemented with other funds, secondarily.

Case rate funding (funding based on a specified mix of client characteristics) should be made available.

Other prospective payment or managed care financing mechanisms should be available in which medical and behavioral health care funding are inclusive, permitting the development of holistic services.

All funding mechanisms should exclude the costs of long term residential care, but provide/ fund "overlay" services to elders in such settings.

Federal changes to Medicare to support more mental health and substance abuse treatment should be pushed. See recommendations of the National Coalition on Mental Health and Aging to Secretary Shalala.

Fee-for-service funding for very specific, low volume types of services or where other funding mechanisms cannot work.

Grants for new projects or pilots, particularly innovative interagency projects.

Specific funding for specialized older adult services should not limit an elder's access to needed treatment should non-specialized services be the only ones available. Any designated funding implemented for elders, should be considered as a supplement to the current adult system, and not be used to supplant services currently available to older adults.

Frequent references throughout the Older Americans Act (OAA) (in the provisions of Title III-B services (Sec. 321), under Title III-D (In-Home Services), Title III-E (Special Needs), Title III-F (Health Promotion), and under Title IV which authorizes the funding of Training and Education) seem to make clear the intent of this legislation to authorize and promote the use of OAA funding to address mental health needs of older people. This needs to be actively explored with DOEA.

Also, under Title III-F (Health Promotion) of the OAA, the Department of Aging in Pennsylvania received funding to develop a comprehensive health promotion effort, which includes the promotion of mental health as a major strategy. Title III-F also allows the AAA's to undertake "screening for the prevention of depression, coordination of community mental health services, provision of educational activities, and referral to psychiatric and psychological services"; "gerontological counseling"; as well as "health promotion programs, including...alcohol and substance abuse reduction and stress management." Thus, the use of OAA funds needs to be further explored.

Who is involved in the planning? Two levels of planning need to occur, state level and local planning, with local planning providing input into state planning.

State planning should include all state agencies, local governments, consumer/family representatives and other stakeholders who have responsibility, either financially or clinically for older adults with a mental health or substance abuse problem. For example: Department of Health, Department of Children and Family Services, Department of Elder Affairs, Agency for Health Care Administration, a county, family member and provider representatives need to be part of the planning process.

At the more local level, families, service providers, and local governments need to organize and implement the larger state plan, as well as provide input into its development.

Also, experts in the field of aging, mental health and substance abuse need to be included.

Who covers LTC costs, ancillary services, etc.? Long term care is the responsibility of the state (as opposed to local responsibility). The state needs to investigate the best methods to extend its revenue either through purchasing long term care insurance for individuals or develop programs similar to the Kid-care plan, or Medicaid buy-in

.

Ancillary services not covered by a third party (Medicaid, Medicare, insurance) should be the responsibility of both the state and local government.

How should specialized elder behavioral health care services be contracted and reimbursed (i.e., fee for services, capitated, case rate, grants, etc.)? All of the above. Different sources of funding should be available to serve different consumer needs. Flexibility to mix different sources of funding and payment mechanisms should be implemented in such a manner as to promote use of federal funds along with state funds. The funding mechanisms should promote unique types of services by multiple providers.

What are appropriate performance outcomes for elders? Outcomes should demonstrate effectiveness of treatment specific to older adults often presenting with multiple needs. Standards should be set specific to age appropriate expectations of change, and based on methodology using age-appropriate instruments. Outcomes should address levels of functioning, residential stability, and social involvement.

Who determines and monitors the standards (protocols) for all providers? There needs to be one authority, with the associated funding for elders, responsible for assuring quality services appropriate to elders' needs, as well as continuity

across multiple systems. That authority could be a mental health, substance abuse or an elder affairs authority that, in turn, may create a consulting body of representatives from the other agencies not designated "lead." However, that authority should assure that there is minimal duplication of high cost services by using current programs or developing new programs within the most appropriate system (s). All agencies involved with elders should be involved in developing the appropriate protocols, program standards, etc., as well as screening individuals for mental health or substance abuse problems.

Ancillary services, such as early screening, support services etc. could be supported via different state agency budgets, but those resources should be identified for this population. The same contract standards and outcomes for the same services through different state agencies would apply.

7 Establish an integrated data collection and storage system.

To insure the adequate provision of services for older adults in need of mental health and substance abuse services, detailed information must be collected, maintained and analyzed. It is within the intent of the Legislature that an older adult MHSA treatment and support system develop performance measures. The lead agency should review annually, and adjust as needed, the specific performance measures and outcomes to assess the effectiveness of the intervention system and programs.

Analyses should be done of statewide healthcare service use by elders be undertaken by using Medicare, Medicaid, IDS (DCF) and CIRTS (DOEA) data in order to determine MHSA use rates, location and costs of services, as well as support policy development. In order to make better policy, planning and monitoring use of available data currently housed in separate organizations, it is recommended that an integrated data system be developed by DOEA and MHSA; to be housed in one agency or organization.

8 DOEA and the mental health and substance abuse programs of DCF should jointly commit to establishing a coordinated and comprehensive policy for addressing the mental health and substance abuse needs of older Floridians, and act on it.

In 1994, the parties signed an agreement, part of which reads,

"We collaboratively commit our energies and resources to increase the choice, and community inclusion of elder persons who have mental illness or substance abuse problems. In addition, we agree to develop a joint strategy to advocate for the comprehensive services for elder persons who have mental illness or substance abuse problems.

We affirm a mutual responsibility for the development and promotion of stronger linkages between mental health, substance abuse and elder agencies at the federal, state and local levels. It is our hope that the effort of these agencies will foster such partnerships throughout Florida."

In concert with the last sentence, it is recommended that local administrative agencies collaboratively generate local mental health and substance abuse plans appropriate to elders, and that those plans be expressed in annual local and state-level budget requests. Those plans should also include the development of innovative services in non-traditional settings.

Collaboration on joint LBRs regarding MHSA services may not only have system integration value, but indicate additional support for the budget initiative.

9 DOEA, MH, and SA should each appoint (full time) staff to be responsible for elder MH and SA issues.

This has worked quite well programmatically for children and younger adults with MH and SA conditions. It is almost like having advocates within the systems responsible for planning and allocating

resources. Thus, success of the other age groups represented internally to MH and SA program offices is one basis for recommending it. The other is that in the past staff in MH and SA were designated to promote elder initiatives, and the results were also positive. Regardless, the MH and SA needs of older Floridians are prevalent and important enough to warrant at least one FTE staff person in each department/agency. Similarly, MH and SA service issues for older adults should receive sufficient attention of staff at DOEA. Also, by having identifiable, designated staff responsible for elder MH and SA issues in each of the programs, the likelihood of cross-network collaboration markedly increases.

10 The legislature should provide funds for the development of new services within traditional and nontraditional settings.

In order to enhance innovation in elder MH and SA services, it is recommended that demonstration models be proposed and funded via an RFP process.

Demonstration Models within Traditional Settings The current community mental health and substance abuse systems should be enhanced to identify, attract and serve older adults. The system enhancement should address staffing, training and program development for older adults.

Implementation:

DCF's MH and SA program offices are to create a competitive selection process for funding proposals.

a. DCF should use an independent review panel to evaluate proposals.

b. All programs/initiatives funded through the System of Care Enhancement Program will be evaluated and continued based on successfully meeting the established goals.

Demonstration models within Nontraditional Settings Relative to establishing new programs within nontraditional settings, it is recommended that the Agency for Health Care Administration, the Department of Health, the Department of Children and Families, and the Department of Elder Affairs form a consortium by entering into an agreement to create and oversee Older Adult Care Demonstration Models. The partnership agreement should not divest any public or private agency of its responsibility for an older adult, but may allow participating agencies to better meet the needs of older adults through the sharing of resources.

The consortium should assure that funds appropriated in the General Appropriations Act for direct services to the target population (elders) are not expended for any other purpose. The departments shall collaborate to implement this demonstration model proposal.

The consortium should establish a local oversight body including representatives of the state agencies that comprise the consortium, representatives of local government, as well as other appropriate community entities, and older adults.

A demonstration model, unless otherwise authorized by the consortium, shall operate for three years utilizing existing funds. Pursuant to the direction of the consortium, each demonstration model shall maintain appropriate program and fiscal accountability.

Purpose:

The purpose of the Older Adult Interagency System of Care Demonstration Models is to test various designs and strategies for the planning, integration and/or coordination of the interagency delivery of services to older adults who have mental health or substance abuse problems, and their families or support systems. Each demonstration model shall seek to:

a. Enhance and expedite services to older adults with mental health or substance abuse problems;

b. Refine the process of case management using the strengths approach in assessment and service planning, and eliminate case

management duplication;

c. Employ natural supports in the family and the community to help meet the service needs of the older adult;

d. Improve interagency planning efforts through greater collaboration between public and private community-based agencies;

e. Test creative and flexible strategies for financing and purchasing mental health and substance abuse care for older adults; and

f. Establish information sharing mechanisms with state and community agencies.

The interagency consortium should establish a competitive selection process for soliciting and funding proposals for use of funds within nontraditional settings.

a. The consortium will use an independent review panel to evaluate the proposals.

b All programs/initiatives funded through the interagency consortium will be evaluated and continued based on successfully meeting the established goals.

Model Enhancements The legislature should fund demonstration models to provide the most appropriate care and treatment for older adults, including a range of traditional and nontraditional services in the least restrictive setting that is clinically appropriate to the needs of the older adult.

The consortium may use prospective payment mechanisms through which a demonstration model and its contracted service providers accept financial risk for producing outcomes for the target population.

The consortium should reinvest cost savings in the community-based older adult mental health and substance abuse system.

Rules for Implementation Each participating state agency is to adopt rules for implementing the demonstration models. These rules shall be developed in cooperation with other appropriate state agencies. The Medicaid program within the Agency for Health Care Administration may obtain any federal waivers necessary for implementing the demonstration models.

11 Require public sector agencies serving elders to conduct brief MH and SA screening.

These would include DOEA and its network, DCF and its providers, and the Department of Health

Elders are to be screened for depression and substance abuse with brief instruments such as the 15 item Geriatric Depression Scale and the four item CAGE (an alcohol screening instrument). Referrals are to be made as appropriate, and screening data are to be collected, stored, and reported at least quarterly.

12 Judges, general masters, assistant state attorneys, and assistant public defenders should be adequately trained and educated on general mental health and elder issues, including community resources.

They should also be educated on the issues identified in the Florida Supreme Court Commission on Fairness report on the Judicial Administration of the Baker Act and its Effect on Florida's Elders, prior to being assigned to Baker Act proceedings.

In addition, a) continuing educational programs on elder, mental health, and disability laws and issues should be made available to all Florida judges and lawyers on an on-going basis; b) the Florida Association of Prosecuting Attorneys and the Florida Bar should ensure that continuing legal education programs on elder, mental health, and disability laws and issues are made available on an on-going basis; and c) judges, general masters, state

attorneys, and public defenders should receive training on "dumping," and vigilantly guard against that or other abuses of the Baker Act in situations involving elder residents of nursing homes or assisted living facilities.

Relative to reported "dumping," the Florida Legislature should commission a study to determine whether nursing homes and other facilities are "dumping" residents because of a lack of funding to treat conditions not covered by governmental programs and private insurance, as well as for financial gain.

13 Mandate specific strategies to enhance service attractiveness, access and use.

- Create services that follow the older adult to sites often frequented.

  Provide outreach and treatment services in both traditional and alternative community-based settings.

- As a preventive measure, offer support and educational groups for elders at risk of developing behavioral problems, as well as elder caregivers.

- Have education and prevention efforts directed toward the general public, elders, loved ones, community gatekeepers, and professionals.

  The content would include awareness issues (of MH and SA problems) and available resources, as well as ways to counteract stigma and ageism.

- Have ongoing gatekeeper training, with monitoring, as well as criterion-based training for formal caregivers (based on age-appropriate curricula).

- Establish a standardized, statewide system of community-based intervention programs incorporating levels of care (e.g., intensive residential treatment, group homes, supervised apartments, day treatment, etc).

- Mandate increased cooperation among the organizations involved with the older person, or his/her family.

- Mandate that every provider in the adult system have elder-specific expertise in mental health/ substance abuse.

  Require this as part of any state contract.

- Be aware of the different cultures, languages, and preferences inherent to the elders being served.

- Have more senior staff (in terms of experience and knowledge) on the "front end" of the intake system.

  The capacity to fully answer questions, and anticipate needs, enhances both the confidence of elders and loved ones, and entrance to care; particularly in the early stages of seeking help. Skillful outreach and intake have to become recognized as just as critical to program and elder success as intervention skills

- Enhance staff longevity.

  Staff turnover is the bane of service delivery systems. An exemplary system has consistent, knowledgeable, competent staff members that are adequately compensated in order to discourage turnover.

- Screen elders for mental illness and substance abuse in traditional and nontraditional settings.

  The setting in which the elder is first identified as having a MH and/or SA problem will initiate an initial case management plan, refer the older person to appropriate care systems, with a formal follow-up plan to ensure that the elder reaches and obtains needed services.

- Aging, MH, SA and medical professionals should be concerned with the total individual.

  For example, aging network providers should consider MHSA needs, as well aging issues unique to their organization's mission and purpose; and MHSA providers should consider the web of problems often exacerbating/ sustaining (e.g., physical health status, housing,

etc.) MHSA problems. Thus, regardless of where the older adult enters the multi-system network, a comprehensive service plan should be developed, and case managed as needed. The goal is to serve and not allow the older adult to "fall through the cracks" inherent among agencies with different missions, management principles, and constituents.

- Place mental health providers in primary care settings (physician offices), using brief intervention approaches (e.g., 3-5 mental health visits).

  Refer for more intensive services if briefer therapies are inadequate. Cadres of trained mental health and substance abuse providers are being extensively and successfully used in primary care settings in England.

- Provide services that are affordable to older adults. Help seeking, initial and continued use of services, are related to out of pocket costs.

Assisted Living Facilities (ALFs) and Nursing Homes (NHs) For ALFs and nursing homes, the workgroup recommends additional "ideal" access system characteristics:

1. Implement a system of MHSA screening in the facilities.
2. Mental health is to be considered an important element of physical health. MH and SA needs must be addressed in addition to medical problems experienced by elders in NHs and ALFs.
3. Collaborative agreements between MH and SA providers and the facilities must be established, including stipulation of resources to support the enhanced services.
4. Ensure that there is a process to monitor against fraud and abuse of elders, as well as use of unqualified providers (in terms of knowledge of aging issues, and assessment and intervention techniques appropriate to elders in LTC).

CONCLUSIONS

Florida does not have a unified, integrated system of MHSA care for elders. There are many gaps in the system, meager support for existing programs, and little prospect for improvement.

Even though quality programs can be noted, they are too few. In fact, availability of MH and SA services for elders has drastically diminished in the last 10 years. This lack of recognition of elder needs continues as care for elders is not a priority for state and local governments, nor community facilities.

The need for specialized mental health and substance abuse services for elders has been established, and there are exemplary programs that demonstrate elders can be successfully treated. The problem is the lack of services resources, continuity and availability.

Florida has tried for years to adequately serve elders with MH and SA problems, using meager resources. Just as statewide policy has progressively served our younger citizens, newly established policy specific to elders would assist in countering the system problems noted above by:

- promoting adequate, accessible, quality care
- provided by appropriately educated/trained staff
- who could be relied upon on a continuing basis.

To paraphrase a few lines from a report created by the Florida Council for Community Mental Health Blue Ribbon Task Force on the Mental Health Needs of the Elderly (1990), older people with emotional and substance abuse problems are recognized as having the same basic needs and responsibilities as all other people. They have the need for acceptance, belonging, dignity, self-determination, and caring for others; to be a help rather than a burden. Any continuum of care must include elements that work in unison to provide environments of opportunity to continue one's personal development.

With a rapidly increasing older population, soaring health care costs and limited resources, it is imperative that more effective strategies be developed for addressing the mental health and substance abuse needs of our older population.

References

Adams, W. L., & Cox, N. S. (1997). Epidemiology of problem drinking among elderly people. In A. M. Gurnack (Ed.). *Older adults misuse of alcohol, medicines, and other drugs: Research and practice Issues.* New York: Springer, 1-23.

Alexopolous, G. S, (1996). Geriatric depression in primary care. *International Journal of Geriatric Psychiatry, 11*, 397-400.

Alexopoulos, G. S., Meyers, B. S., Young, R. C., et al. (1997). "Vascular depression" hypothesis. *Archives of General Psychiatry, 54*, 915-922.

Anthony, J. C., & Helzer, J. E. (1991). Syndromes of drug abuse and dependence. In L. N. Robins & D. A. Regier (Eds). *Psychiatric disorders in America: The epidemiologic Catchment Area study.* New York: Free Press, 116-154.

Beresford, T. P. (1995). Alcoholic elderly: Prevalence, screening, diagnosis, and prognosis. In T. Beresford and E. Gomberg (Eds.), *Alcohol and aging*. New York: Oxford Univ. Press, 3-18

Blazer, D. G. (1996). Epidemiology of psychiatric disorders in late life. In E. W. Busse & D.G. Blazer (Eds.). *The American Psychiatric Press textbook of geriatric psychiatry* (2nd ed.). Washington, DC: American Psychiatric Press, 155-171.

Butler, R. N. (1969). Age-ism: Another form of bigotry. *The Gerontologist, 9,* 243-246.

Callahan, C. M., Nienaber, N. A., Hendrie, H. C., & Tierney, W. M. (1992). Depression of elderly outpatients: Primary care physicians' attitudes and practice patterns. *Journal of General Internal Medicine*, 7, 26–31.

Callahan, C. M., Bertakis, & Azari, R. (1996). The influence of depression on physician-patient interaction in primary care. *Family Medicine*, 28, 346-351.

Chrischilles, E. A., Foley, D. J., Wallace, R. B., Lemke, J., Semla, T. P., Hanlon, J. T., Glynn, R. J., Ostfeld, A., & Guralnik, J. M. (1992). Use of medications by persons 65 and over: Data from the established populations for epidemiologic studies of the elderly. *Journals of Gerontology. Series A, Biological Sciences and Medical Sciences*, 47, M137–M144.

Cohen, G. D. (1990). Lessons from longitudinal studies of mentally ill and mentally healthy elderly: A 17-year perspective. In M. Bergener and S. I. Finkel (Eds.), *Clinical and scientific psychogeriatrics* (Vol. 1, pp. 135–148). New York: Springer.

Committee on Children and Families (1999). *Defining Publicly Funded Mental Health and Substance Abuse Services and Priority Population Groups* (Interim Project Report 2000-17). Tallahassee: The Florida Senate.

Demmler, J. (1998). *Utilization of Specialty Mental Health Services by Older Adults: National and State Profiles.* Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.

Devor, M., Wang, A., Renvall, M., Feigal, D., & Ramsdell, J. (1994). Compliance with social and safety recommendations in an outpatient comprehensive geriatric assessment program. *Journal of Gerontology, 49*, M168–M173.

Dupree, L.W. and Schonfeld, L. (1996) Substance abuse. In M. Hersen and V.B. Van Hasselt (Eds.) *Psychological treatment of older adults: An introductory text.* New York: Plenum Press (pp. 281-287).

Ellor, J. R., & Kurz, D. J. (1982). Misuse and abuse of prescription and nonprescription drugs by the elderly. *Nursing Clinics of North America, 17*, 319-330.

Finlayson, R. E., & Davis, L. J. (1994). Prescription drug dependence in the elderly population: Demographic and clinical features of 100 inpatients. *Mayo Clinic Proceedings, 69*, 1137-1145.

Flint, A. J. (1994). Epidemiology and comorbidity of anxiety disorders in the elderly. *American Journal of Psychiatry,151*, 640–649.

Florida Council for Community Mental Health (1990) *A model continuum of mental health treatment for older Floridians.* Report of the Blue Ribbon Task Force on the Mental Health Needs of the Elderly. Tallahassee, FL: Florida Council for Community Mental Health.

Florida Elder Mental Health Task Force (1997). *Mental Health and Older Floridians: Policy Report for the Department of Elder Affairs and Department of Children and Families.* Tampa, FL: Department of Aging and Mental Health, Louis de la Parte Florida Mental Health Institute, University of South Florida

Gatz, M., & Smyer, M. A. (1992). The mental health system and older adults in the 1990s. *American Psychologist, 47*, 741–751.

Gallo, J. J., & Lebowitz, B. D. (1999). The epidemiology of common late-life mental disorders in the community: Themes for the new century. *Psychiatric Services, 50,* 1158–1166.

German, P.S., Rovner, B.W., Burton, L.C., Brant, L.J., and Clark, R. (1992) The role of mental morbidity in the nursing home experience. *The Gerontologist, 32*, 152-158.

Gomberg, E.S., Drinking and problem drinking among the elderly. Institute of Gerontology, University of Michigan, Ann Arbor, (1980).

Gomberg, E.S.L.; Hegedus, A.M.; and Zucker, R.A.(Eds.,1998) *Alcohol Problems and Aging.* NIAAA Research Monograph No. 33. NIH Pub. No. 98-4163. Bethesda, MD: NIAAA.

Grant, B.F. and Harford, T. (1995). Co-morbidity between DSM-IV alcohol use disorders and major depressions: Results of a national survey. *Drug and Alcohol Dependence,* 39, 197-206.

Himmelfarb, S., & Murrell, S. A. (1984). The prevalence and correlates of anxiety symptoms in older adults. *Journal of Psychology*, 116, 159–167.

Hobbs, F.B. & Damon, B.L. (1996). *65+ in the United States.* U.S. Department of Commerce, Bureau of Census, Economics and Statistics Administration. Publication #P23-190.

Hoyert, D. L., Kochanke, K.D., & Murphy, S.L. (1999). *Deaths: Final data for 1997. National Vital Statistics Reports*, 47 (9). Hyattsville,MD: National Center for Health Statistics.

H.R. Report 102-852 (1992) *Alcohol abuse and misuse among the elderly.* Subcommittee on Health and Long-term Care, Select Committee on Aging.

Jeste, D. V., Alexopoulos, G. S., Bartels, S. J., et al. (1999). Consensus statement on the upcoming crisis in geriatric mental health: Research agenda for the next two decades. *Archives of General Psychiatry, 56*, 848-853.

Joseph, C. L. (1997). Misuse of alcohol and drugs in the nursing home. In A. M. Gurnack (Ed.). *Older Adults Misuse of Alcohol, Medicines, and Other Drugs: Research and Practice Issues.* New York: Springer, 228-254.

Katz, I. R., & Coyne, J. C. (2000). An editorial: The public health model for mental health care for the elderly. *Journal of the American Medical Association*, Vol. 283, No. 21.

King, C. J., Van Hasselt, V. B., Segal, D. L., & Hersen, M. (1994) Diagnosis and assessment of drug abuse in older adults: Current strategies and issues. *Addictive Behaviors, 19*, 41-55.

Kip, K. (2000) Florida Commission on Mental Health and Substance Abuse: Data work group report. Tallahassee: Florida Legislature.

Knight, B.G. & Kaskie, B. (1995). Models for mental health service delivery to older adults. In M. Gatz (Ed.). *Emerging issues in mental health and aging.* Washington, DC: American Psychological Association.

Koenig, H. G., George, L.K., & Schneider, R. (1994). Mental healthcare for older adults in the year 2020: A dangerous and avoided topic. *The Gerontologist*, 34, 674-679.

Lichtenberg, P.A. (1998). Mental Health Practice in Geriatric Health Care Settings. New York: Haworth Press

Light, E., & Lebowitz, B. D. (Eds.). (1991). The elderly with chronic mental illness. New York: Springer.

Liptzin, B., Grob, M. C., & Eisen, S. V. (1988). Family burden of demented and depressed elderly psychiatric inpatients. *The Gerontologist*, 28, 397-401.

Lombardo, N., Fogel, B., Robinson, G., & Weiss, H. (1995). Achieving mental health of nursing home residents: Overcoming barriers to mental health care. *Journal of Mental Health and Aging, 1(3)*, 165-203.

Meeks, S., Carstensen, L. L., Stafford, P. B., & Brenner, L. L. (1990). Mental health needs of the chronically ill elderly. *Psychology and Aging*, 5, 163-171.

Mellins, C. A., Blum, M. J., Boyd-Davis, S. L., & Gatz, M. (1993). Family network perspective on caregiving. *Generations*, 21-24.

Miller, N. S., Belkin, B. M., & Gold, M. S. (1991). Alcohol and drug dependence among the elderly: Epidemiology, diagnosis, and treatment. *Comprehensive Psychiatry*, 32, 153–165.

Moos, R. H., Mertens, J.R., Brennan, P. L. (1995). Program characteristics and readmission among older substance abuse patients: Comparisons with middle-age and younger patients. *Journal of Mental Health Administration*, 22, 332-345.

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.

Rabins, P. V., Black, B. S., Roca, R., et al. (2000). Effectiveness of a nurse-based outreach program for identifying and treating psychiatric illness in the elderly. *Journal of the American Medical Association, 283*, 2802-2809.

Regier, D. A., Boyd, J. H., Burke, J. D. Jr, Rae, D. S., Myers, J. K., Kramer, M., Robins, L. N., George, L. K., Karno, M., & Locke, B. Z. (1988). One-month prevalence of mental disorders in the United States. Based on five Epidemiologic Catchment Area sites. Archives of General Psychiatry, 45, 977–986.

Reid, M. C., & Anderson, P. A. (1997). Geriatric substance use disorders. Medical Clinics of North America, 81, 999–1016.

Ritchie, K., & Kildea, D. (1995). Is senile dementia "age-related" or "ageing-related"? Evidence from meta-analysis of dementia prevalence in the oldest old. Lancet, 346, 931–934.

Rubenstein, L.V., Jackson-Triche, M. and Unutzer, J. (1999) Evidence-based care for depression in managed primary care practices. *Health Affairs, 18*, 89-105.

Speer, D.C. (2000a) The mental health of older adults in primary care: Healthcare costs, psychosocial factors, and prevalence rates. I. Unpublished paper. Tampa: Department of Aging and Mental Health, Louis de la Parte Florida Mental Health Institute, USF.

Speer, D.C. (2000b) Primary care, the de facto mental health system for older adults: Diagnosis and treatment, physicians and patients, and interventions. II. Unpublished paper. Tampa: Department of Aging and Mental Health, Louis de la Parte Florida Mental Health Institute, USF.

Speer, D.C. and Demmler, J. (2000) Use of publicly supported mental health services by older Floridians in 1994. Unpublished paper. Tampa, FL: Department of Aging and Mental Health, Louis de la Parte Florida Mental Health Institute, USF.

Strahan, G.W. and Burns, B.J. (1991) Mental illness in nursing homes: United States 1985. In *Vital and health statistics,*13, 105. Hyattsville, MD: National Center for Health Statistics. DHHS Publication No. 91-1766.

Sturm, R., & Sherbourne, C. D. (1999). Are barriers to mental health and substance abuse care still rising? Manuscript submitted for publication. Substance Abuse and Mental Health Services Administration. (1998). State profiles on public sector managed behavioral health care and other reforms.

Tariot, P. N., Podgorski, C. A., Blazina, L., &Leibovici, L. (1993). Mental disorders in the nursing homes: Another perspective. *American Journal of Psychiatry, 150*, 1063-1069.

Treas, J.M.(1995) Older Americans in the 1990's and beyond. Population Reference Bureau: Population Bulletin Vol. 50, No.2.

Unutzer, J., Katon, W. J., Simon, G., Walker, E. A., Grembowski, D., & Patrick, D. (1996). Depression, quality of life, and use of health services in primary care patients over 65: A 4-year prospective study. *Psychosomatics, 37*, 35.

Unutzer, J., Patrick, D. L., Simon, G., Grembowski, D., Walker, E., Rutter, C., & Katon, W. (1997). Depressive symptoms and the cost of health services in HMO patients aged 65 years and older. A 4-year prospective study. *Journal of the American Medical Association, 277*, 1618–1623.

U.S. Census Bureau (1998). *Statistical abstract of the United States.*

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

Wetherell, J.L. (1998). Treatment of anxiety in older adults. *Psychotherapy, 35*, 4, 444-458.

Zisook, S., & Shuchter, S. R. (1993). Major depression associated with widowhood. *American Journal of Geriatric Psychiatry, 1*, 316–326.

Zisook, S., Shuchter, S. R., Irwin, M., Darko, D. F., Sledge, P., & Resovsky, K. (1994). Bereavement, depression, and immune function. *Psychiatry Research, 52,* 1–10.