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Mental Health and Older Adults

Staff Writer
Mental Health News

The past century has witnessed a remarkable lengthening of the average life span in the United States, from 47 years in 1900 to more than 75 years in the mid-1990s (National Center for Health Statistics [NCHS], 1993). Equally noteworthy has been the increase in the number of persons ages 85 and older. These trends will continue well into the next century and be magnified as the numbers of older Americans increase with the aging of the post–World War II baby boom generation.

Millions of older Americans—indeed, the majority—cope constructively with the physical limitations, cognitive changes, and various losses, such as bereavement, that frequently are associated with late life. Research has contributed immensely to our understanding of developmental processes that continue to unfold as we age. Drawing on new scientific information and acting on clinical common sense, mental health and

general health care providers are increasingly able to suggest mental health strategies and skills that older adults can hone to make this stage of the life span satisfying and rewarding.

The capacity for sound mental health among older adults notwithstanding, a substantial proportion of the population 55 and older—almost 20 percent of this age group—experience specific mental disorders that are not part of "normal" aging. Research that has helped differentiate mental disorders from "normal" aging has been one of the more important achievements of recent decades in the field of geriatric health.

For example, contrary to popular stereotypes, studies on aging reveal that most older people generally do not have a fear or dread of death in the absence of being depressed, encountering serious loss, or having been recently diagnosed with a terminal illness (Kastenbaum, 1985). Periodic thoughts of death—not in the form of dread or angst—do occur. But these are usually associated with the death of a friend or family member. When actual dread of death does occur, it should not be dismissed as accompanying aging, but rather as a signal of underlying distress (e.g., depression). This is particularly important in light of the high risk of suicide among depressed older adults, which is discussed later on in this report.

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Landmark Mental Health Bill Introduced To Address Senior Mental Health Needs in New York State

By Jane Linker

Legislation introduced in Albany this spring could put New York in the forefront of a growing national push to develop critically needed mental health services for the upcoming elder boom. The Comprehensive Geriatric Mental Health Act (S.4742/A.7672) would establish services demonstrations, public education, and workforce development programs and would also establish an interagency planning process.

"As our older adult population increases, my legislation will assure that there will be a well-trained geriatric mental health workforce in the future to deal with this potential problem. Existing services, workforce, governmental infrastructure, and state planning are inadequate to meet the special and unique needs of this key group. My bill begins to remedy these shortcomings," explained Senator Nicholas Spano who introduced the bill in the Senate, along with Senators Thomas Morahan, Martin Golden, Caesar Trunzo and James Wright.

"This is landmark legislation that will lay the groundwork for a multi-year effort

Senator Nicholas Spano

Assemblyman Peter Rivera

in New York State to prepare to meet the mental health needs of our aging population. The data is clear on this issue. New York needs to act now to prepare itself to be able to provide the mental health services our booming aging population will require," said Assemblyman Peter Rivera, chair of the Assembly Mental Health Committee, who introduced the bill in the Assembly along with Assemblypersons Steven Engelbright, Donna Lupardo, Audrey Pheffer, and Paul Tonko.

The need to plan for new service models is urgent, according to mental health advocates, who point to dramatically changing American demographics. The number of older adults in the United States is projected to double over the next 25 years from 35 million to 70 million. New York State will see the number of residents 65+ to go from 2.4 million to 3.7 million. 750,000 of these elderly are projected to have some form of mental illness.

The Act proposes integrating mental health, health and aging services in a more seamless continuum of care that will help people remain in the community while they access the services they need. Senior leadership in both the Office of Mental Health and the Office for the Aging will be designated to implement interagency planning and develop funding mechanisms that support home and community-based care.

Among the other provisions of the Act are a service demonstration initiative, administered by OMH, to fund innovative community-based pilot projects, a public education program to

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From The Publisher

Mental Health News Mission: Even More Vital With The Coming Elder Boom

By Ira H. Minot, CSW, Founder and Publisher, Mental Health News

We are now witnessing the dawn of a shift in age in our country's population as the baby boom generation moves from middle aged to elderly. The number of older adults in the United States is projected to double over the next 25 years from 35 million to 70 million—and here in New York State we expect to see the number of residents 65 and over to go from 2.4 million to 3.7 million. Three quarters of a million of these elderly are projected to have some form of mental illness.

This issue of *Mental Health News* couldn't be more relevant. The response to our theme of Mental Health and Older Adults was simply overwhelming. We had more articles and less time to process them than we would have needed, and apologize to those authors whose articles came in at the 11th hour which didn't make it into publication. The diverse and compelling nature of the topic of mental health and older adults speaks volumes to the practical and political nature of the vast population shift soon to take place.

I am a believer in the old saying that necessity is the mother of invention. In the case of the enormous mental health needs of our graying society, we learn in this issue of *Mental Health News* that there are forward thinking people and organizations who are laying the groundwork for tomorrow's solutions today.

For Example:

> We learn that key members of the New York State Assembly and Senate are championing a landmark bill entitled "The Comprehensive Geriatric Mental Health Act" to address the mental health needs of the elderly in our state. (see pages 1, 9 & 10)

> We learn that three years ago, New York State Governor George Pataki had the vision to begin an initiative called "Project 2015" which charged 36 cabinet-level state government agencies to review their major policies, programs, and structure in light of the State's increasingly older and more diverse population. The process resulted in a white paper, "Project 2015: State Agencies Prepare for the Impact of an Aging New York," which has gained national attention as a model for service planning for the Baby Boom generation. (see page 9)

> We learn that the New York State Office of Mental Health (OMH) is developing plans to address what many mental health advocates feel is an upcoming crisis in care for the growing elder population. OMH's "Five Year Plan," released last January, targets geriatric mental health as one of its priority areas and commits to the development of a comprehensive plan for serving older adults. A series of roundtable discussions is planned in 2005 to bring together experts, stakeholders, and providers to help formulate future programs and policies. (see page 9)

Through twenty other articles and columns of interest in this issue of *Mental Health News*, we learn about vital programs, services and research that target older adults around our region. (see our table of contents)

And finally, through a special four page centerfold supplement sponsored by The Geriatric Mental Health Alliance of New York, we learn about this vital group's advocacy efforts throughout New York State. Under the leadership of Michael B. Friedman, The Center for Policy and Advocacy of The Mental Health Associations of New York City and of Westchester County, established The Geriatric Mental Health Alliance of New York at the end of 2003 because "the current mental health system does not serve older adults with mental health conditions adequately and because there has been so little preparation to respond to the growth of mental health needs that will emerge during the elder boom." The Alliance's 10 Point Agenda helps focus attention to the need for us all to support a federal and state Comprehensive Geriatric Mental Health Act, including the need to:

1. Enable older adults to remain in, or return to, the community.
2. Improve access to services
3. Improve quality of services
4. Integrate mental health, health and aging
5. Increase the capacity of the system to serve cultural minorities
6. Provide support for family caregivers
7. Provide public education
8. Organize a workforce development initiative
9. Design new finance models
10. Promote governmental readiness (see pages 23 - 26 for the full story)

As a graying member of the baby boom generation myself, I am proud of our mental health community and its response and monitoring of the pending crisis in mental health care and services for the coming elder boom. I am also proud of the role *Mental Health News* is playing in bringing the issues of the mental health community to the forefront.

Ira H. Minot, CSW

Mental health education is a vital component of our mental health system. By uniting people with mental illness and their families with the news, events and services within the mental health community, we create a bridge to the recovery community. In addition, by creating a forum for ideas that providers of mental health services can participate in -- we see the development of a forward thinking agenda that serves to ultimately benefit the consumer.

Mental Health News was created to unite people with mental illness to the many aspects of the mental health world around them. Our philosophy is centered on the idea that recovery from mental illness is possible but that it requires a community of support. Our aim is to empower people with mental illness with the information and education to better access that community of support.

Your participation in our efforts is vital to our success. Thanks to your continued support and encouragement we look forward to entering our eighth year of service to the community this fall.

We wish to thank our funders, advertisers, subscribers and the community of writers and advisors who make each issue of Mental Health News a tremendous success. Please continue to send us your thoughts and suggestions by E-mail to mhnmail@aol.com.

Have A Great Summer !!

Mental Health News Upcoming Themes & Deadlines
your participation is welcomed

Fall 2005 Issue
"Understanding and Treating Schizophrenia"
Deadline: August 1, 2005

Winter 2006 Issue
"The Many Faces of Anxiety Disorders"
Deadline: November 1, 2006

Spring 2006 Issue
"Managing Mental Health Crises"
Deadline: February 1, 2006

Summer 2006 Issue
"Understanding Autism Spectrum Disorders"
Deadline: May 1, 2006

Letters To The Publisher

Priorities For The Whitehouse Conference On Aging

By Gary J. Kennedy, MD

Mental illness is the leading threat to the health and independence of older Americans. This is despite the observation that rates of mental illness excluding dementia are lower among the present cohort of seniors than among any other segment of the adult population. However, because the baby boomers already exhibit a higher rate of depression and anxiety disorders than their parents, the total burden of mental illness in late life will likely increase. For example, despite the increasing acceptance of the newer, safer antidepressants medications by older adults, the number of suicides in late life now exceeds that seen prior to the introduction of Prozac. The need to care for an aged parent is now more often cited than childcare for days absent from work by middle aged Americans.

Compounding the problem is the lack of access to, and acceptability of mental health services for seniors. Roughly 10% of older adults with a serious mental disorder receive care from a psychiatric social worker, psychologist, psychiatric nurse practitioner or psychiatrist. And the number seeing a mental health specialist specifically trained to work with older adults and their families is even smaller. It should come as no surprise that 1% or less of total Medicare expenditures are for mental health care. This is tragic given the extensive evidence that treatment, whether it be psychotherapy, medication, or caregiver counseling works for the older as well as the younger patient. Yet primary care providers who are overwhelmingly responsible for the diagnosis and treatment of senior patients with mental illness were never trained in the use of "safe-for-seniors" psychotherapeutic medications much less the proven psychotherapies. The misfortune of unnecessary disability due to untreated mental illness is especially acute for older émigrés, disadvantaged minority groups, and rural elders. For them the stigma associated with mental health care, the lack of shared language between patient and provider, and the distance from specialized services almost insures care will be inadequate if not absent.

But however pessimistic this assessment may sound, there is ample reason for optimism if consumers and providers capitalize on emerging trends. To offer but one example, dementia, not heart disease, cancer or arthritis is the major cause of lost independence in late life. Not surprisingly the intensity of research into agents that might arrest the progression of dementia or prevent its development is immense—receiving substantial support from both the public and private sectors. Present medications approved for the treatment of Alzheimer's disease are only modestly effective but like medications for depression they are generally safe and well tolerated. They provide symptomatic, temporary relief like Tylenol for arthritis. When the next generation of medications for dementia arrive they will likely be more effective but more toxic. And it is unlikely that the first wave will be curative. Thus the symptomatic relief and family support that are state of the art in dementia care will be as important as ever. The point being that the non-pharmacologic approaches and service systems must continue to be refined and expanded. If our policy makers and the public wait for the medication breakthrough or the genomic solution, we will have a generation of seniors in nursing homes that need not be there. In short, scientific advances are critical but will fall short of the mark if not translated into comprehensive services. And we have the services research in hand to know how mental health interventions should be delivered for seniors and the family members who care for them.

We also have legislation before congress to train more health care professionals in geriatrics and more scientists in gerontology, to integrate mental health services into primary care sites, home care agencies, and retirement communities, to put insurance payments for mental illness on par with physical disorders, and to recognize, inadequate though it may be, that the cost of medications prevent some seniors from paying for other essential services. We doubled the budget for the National Institutes of Health in less than a decade with the result that we have more effective medications, more efficient psychotherapies, better diagnostic and functional assessment techniques, services that are agreeable and accessible for seniors and their families, even data on illness prevention and health promotion.

Given this remarkable potential to protect seniors' interdependence in the face of clearly recognized threats, what accounts for the slow advance of mental health policy? I suggest there are two problems which the White House Conference on Aging is uniquely positioned to address. First is the problem of stigma, by which I mean the fear, prejudice, and nihilism associated with all aspects of mental illness. Counted among the stigmatized are not only those with a psychiatric disorder, but their families, their providers, the interventions they receive and related research. Those of us who advocate on behalf of mentally ill seniors are so accustomed to ignoring the barrier of stigma, just in order to do our jobs that we forget stigma's pervasive, insidious impact. Here are some phrases to refresh our memories. For mentally ill seniors we hear "dangerous, crazy old lady,

see Whitehouse on page 46

Protecting The Disabled Is Protecting Ourselves

By Joseph A. Deltito, MD

There are those who might divide our population into the Disabled and the Non-Disabled. I believe it is much more accurate, given the fact of an ever increasing life expectancy, to divide the population into the Disabled and the yet to become Disabled. At least 80 % of our population will find themselves either temporarily or terminally disabled in some significant manner at some point of their lifetime. Those who are already partially or more fully disabled due to Psychiatric or Developmental Disabilities (mental retardation) with advancing age can unfortunately expect to become more and not less dependent on families, the society and the "kindness of strangers". I believe our society is actually becoming less tolerant rather than more tolerant of those who might be "different" from someone with a prototypical "Ideal" life. Disabled individuals should not be viewed as "other" than the rest, but as merely "us" with special needs and vulnerabilities.

These issues are particularly ripe in my mind; at the point that I am writing this editorial it is a few days after the death of Terri Schiavo and John Paul II. The "Schiavo" case is one that I will not try to present in depth in this editorial. My position on this case (a neurologically disabled woman without a terminal illness who died from dehydration secondarily to food and fluids being denied to her) might be familiar to those readers who may have seen me as a medical commentator with CNN; a position which allowed me to have access to extensive research material on all aspects of the case. What I found most disturbing was the large number of "experts" and commentators who basically felt that her life was not worth living even if she did have conscious awareness of her surroundings. One commentator who claimed to have some credentials in the field of neurology and neuroscience actually stated that keeping her alive was a waste of medical resources. There were many individuals involved in this case who were advancing their own agendas on issues of life and death. Many were invested in not seeing Terri Schiavo as somehow fully human for fear that the general public might become sensitized to see other vulnerable individuals (the elderly, those with medical, psychiatric and developmental difficulties, or in utero fetuses) as deserving care, protection and life. I sustain that we are a better society when we protect those who can not easily protect themselves and to speak out when we see injustices committed against those who others see as less than worthy of life. We, who may have severe psychiatric illnesses, or love those who are severely psychiatrically ill, or who treat the psychiatrically ill need to be ever vigilant of those who would find it much more cost effective or convenient to not choose life or care for those with severe psychiatric illnesses.

Martin Niemoeller who died in 1984 was a prominent Protestant Clergyman during the Nazis rise to power in Germany. He eventually was imprisoned in a concentration camp as a guest of the Nazis and after the war was a popular and powerful lecturer and author. He wrote:

"In Germany they came first for the Communists, and I didn't speak up because I wasn't a Communist. Then they came for the Jews, and I didn't speak up because I wasn't a Jew. Then they came for the trade unionists, and I didn't speak up because I wasn't a trade unionist. They came for the Catholics; I didn't speak up because I was a Protestant. Then they came for me, by that time no one was left to speak up."

If he would have related this poignant quote more precisely to the initial rise of the Nazis he would have pointed out that before they came for the Communists and the Jews in the early 1930s they came for and eliminated hundred of thousands of their own citizens who were considered physically or mentally defective or disabled. Their existence did not fit into their vision of the perfect Arian life. To me the horror of the atrocities of the Nazis is not that they were a bloodthirsty group of sociopathic sadists, but that most of those who actively or passively contributed to the extermination of Jews, Gypsies, the Disabled and others were essentially psychologically normal people who under a certain Authority were convinced that these people were somehow less than human. Their extermination was of no moral concern.

I do believe I am witnessing a disturbing trend in out popular culture where those who do not manifest some prototypical ideal self or lifestyle are not to be tolerated and indeed need to be "altered" in order to be considered somehow "worthy". These attitudes can be readily seen by an eruption of TV shows emphasizing "remaking" individuals so they can be more readily considered proper members of society. The most profound of these actually provide radical cosmetic surgery to alter people so they will be rendered acceptable to their friends and families. The "Contestants", according to the formula, when their transformation is complete have a "coming out" party with all their friends and family congratulating them on how wonderful their transformation have been. A slightly more benign, but perhaps more insidious version of these shows is "The Queer Eye For the Straight Guy" and its spin-offs that have a group of Homosexual "Style-Gurus" transform a non-Homosexual

see Protecting on page 46

An Innovative Intervention for Depression in the Elderly

By Kerry Newell, MS, Research Coordinator and Jo Anne Sirey, PhD, Associate Professor of Psychology in Psychiatry, Weill Cornell Institute of Geriatric Psychiatry, NewYork-Presbyterian Hospital/Westchester Division

Kerry Newell, MS and Jo Anne Sirey, PhD

With age comes an increase in chronic physical problems, life changes and potentially increasing disabilities that are strong risk factors for depression. Many older adults become overwhelmed and have difficulty adjusting to these changes. According to statistics, 1 in 5 older adults suffer from a mental disorder with approximately 15% of community residents, age 65 and older, experiencing symptoms of depression and 2-3% of the population suffering from major depression. If left untreated, depression worsens the course of medical illness, leads to suicide, and increases disability and mortality. The profound impact of depression is compounded by the reluctance of seniors to seek mental health services or accept mental health referrals.

Older adults face a multitude of barriers to using mental health services ranging from logistical barriers, such as cost and transportation to attitudinal barriers, such as social stigma and denial of need. Late-life depressive symptoms are often attributed to the aging process or seen as a by-product of deteriorating physical health. Consequently, these symptoms are often overlooked, underreported by seniors or misdiagnosed by healthcare professionals. When left untreated, depression can exacerbate existing medical conditions and lead to the development of new health problems. These adverse health outcomes and a lower quality of life make it increasingly important to identify, assess and link depressed seniors to care.

Weill Cornell Institute for Geriatric Psychiatry at New York Presbyterian Hospital's Westchester Division, directed by George S. Alexopoulos, M.D., recently partnered with the Westchester County Department of Senior Programs and Services (WCDSPS) to develop innovative methods to assess the mental health needs of seniors in Westchester County and bridge the gap to care. The collaboration is supported by a four-year $1.5 million dollar grant awarded by the National Institute of Mental Health to form a Research Network Development Core (RNDC).

The Weill Cornell Institute for Geriatric Psychiatry conducts research and training in geriatric psychiatric disorders and provides specialized psychiatric care to older adults. The function of the RNDC is to create a community research partnership that would support ongoing innovative projects to improve access and referrals to mental health services. In addition, it offers a venue to extend Evidence-Based Treatments for major depression in late life to community settings. Projects are developed and implemented through the collaborative efforts of the Weill Cornell Institute and WCDSPS partnership. Activities include: needs assessments to identify the prevalence of depression and the need for care among seniors in social service settings; training in depression screening for WCDSPS agencies and staff members; and pilot studies to develop and extend effective interventions to community elderly.

Combining the sensitivity and resources allocated to seniors by WCDSPS and the scientific skills of researchers at Cornell will undoubtedly advance the access to quality care for depressed seniors in Westchester County. Led by Commissioner Mae Carpenter, WCDSPS oversees numerous social service agencies that provide a diverse selection of programs designed to meet the varied needs of Westchester's elderly residents. WCDSPS seeks to identify and prioritize the physical, mental and social needs of Westchester County seniors and create comprehensive care plans for those identified as being in need. They currently provide services to more than 170,000 county residents age 60 and over and are committed to the welfare of older adults in the community.

WCDSPS is an ideal partner for this type of research because of their pre-existing relationship with the elderly population in Westchester County. Social service agencies have day-to-day contact with a population that may lack the knowledge or opportunity to obtain mental health treatment on their own. For residents with limited mobility or financial constraints, WCDSPS may be the main, and for some, the only point of contact for services. They are in a unique position to integrate mental health screenings and referrals into their existing services.

Since its inception in November 2004, the RNDC has begun three pilot studies. The first project, entitled "Heads Up and Don't Fall", lead by Jo Anne Sirey, Ph.D., Associate Professor of Psychology at Cornell and Diane Booker, M.S.W, Deputy Commissioner of WCDSPS, seeks to identify the concerns and needs of seniors, particularly those at risk for depression, and help make connections to much needed services. Seniors are screened for depression as well as alcoholism, history of pain, memory deficits, and psychological impairment. Researchers also seek to identify barriers to care and perceptions of stigma associated with depression among home-delivered meal recipients.

Home delivered meals are provided to seniors age 60 and over who are frail, unable to prepare meals for themselves and lack strong social supports. The home delivered meals population is at greater risk for developing depression than the average older adult because of their increased exposure to depressive risk factors such as limited mobility, social isolation, disabilities, and medical illness. These factors also contribute to limited access and utilization of mental health services. We have found a prevalence of 12% of significant depressive symptoms in this group.

The second project focuses on developing preventive and treatment strategies for older adults with chronic pain headed by Cary Reid, M.D., Associate Professor of Medicine at Cornell. The study utilizes Problem Solving Therapy (PST) as an alternative to physical or drug therapies for treatment of chronic back pain and depression. Many seniors have difficulties engaging in physical therapies and substantial side effects and increasing costs of prescription medications may deter older adults from adhering to drug treatment guidelines. Through PST, seniors in Westchester learn how to solve everyday functional problems generally associated with pain and depression.

The third project addresses the problem of self-neglect among elders, which is becoming an increasingly common occurrence among older adults. Self-neglectors are characterized by their inability or unwillingness to attend to personal health and hygiene needs taking a tremendous toll on the individual, family, and the medical system. This type of behavior usually stems from underlying psychological or medical diagnoses. This project led by Mark Lachs, M.D, Co-Chief of the Division of Geriatrics and Gerontology at Weill Cornell Medical College, focuses on screening and identifying older adults in Westchester County suffering from self-neglect.

Collectively, the Weill Cornell Institute of Geriatric Psychiatry and the Westchester Department of Senior Programs possess the skills and expertise necessary to sustain a successful partnership. The results of this collaboration will, in the short-term, provide insight into the mental health needs of seniors, help make connections to mental heath services, and in the long-term help improve and maintain positive mental health outcomes for older adults in Westchester County.

Weill Cornell Institute of Geriatric Psychiatry, located at New York Presbyterian Hospital's Westchester Division, provides specialized mental health treatment and referrals. If you or someone you know is experiencing symptoms of depression and is interested in treatment, call (914) 997-4331 for a free screening. □

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MENTAL HEALTH NEWSDESK

New York State Mental Health Commissioner Named Chair of National Suicide Prevention Steering Committee

Staff Writer
Mental Health News

Sharon E. Carpinello, R.N., Ph.D., Commissioner of the New York State Office of Mental Health (OMH), has been named Chairperson of the National Suicide Prevention Lifeline Steering Committee. The national hotline – 1-800-273-TALK – was launched earlier this year by the Mental Health Association of New York City (MHA of NYC) and its partners, the National Association of State Mental Health Program Directors (NASMHPD), Columbia University and Rutgers University.

The only national suicide prevention and intervention telephone resource funded by the Federal government, the Lifeline is a network of local crisis centers located in communities across the nation that are committed to suicide prevention. It is part of the National Suicide Prevention Initiative, a collaborative effort led by the Federal Substance Abuse and Mental Health Services Administration, that incorporates the best practices and research findings in suicide prevention and intervention with the goal of reducing the incidence of suicide nationwide. Each year over 30,000 Americans take their own lives.

Sharon E. Carpinello

Implementing Governor Pataki's vision for an improved public understanding of mental health and wellness issues, Commissioner Carpinello has become an innovator in suicide prevention. She personally oversaw the development and implementation of SPEAK, OMH's first education and awareness campaign that uses a public mental health model to help people become familiar with the risks for and warning signs of suicide. Launched in May 2004, SPEAK has received wide attention in both the public and private sectors, and has been featured in regional and national publications including *Governing Magazine, Mental Health Weekly* and *Behavioral Healthcare Tomorrow*.

"I am truly honored to have been chosen to chair the National Suicide Prevention Lifeline Steering Committee," said Commissioner Carpinello. "Under Governor Pataki's leadership, OMH is working hard to raise awareness within New York State about the risks and warning signs for suicide, and I now look forward to expanding that effort and promoting suicide prevention on the national level."

"When we sought a leader for the National Suicide Prevention Lifeline Steering Committee, we immediately turned to Dr. Carpinello," explains Giselle Stolper, Executive Director of the MHA of NYC. "During her tenure in the State Office of Mental Health, Dr. Carpinello has worked tirelessly both to improve New York's behavioral health services and increase New Yorker's access to these services. Dr. Carpinello understands that if we can encourage those in distress to seek treatment before they reach the crisis point, we can ultimately reduce the suicide rate in New York."

"Dr. Carpinello was a natural selection to represent our association and lead the steering committee of this national network effort," said Robert Glover, Ph.D., Executive Director of NASMHPD. "She has demonstrated her commitment to suicide prevention through her leadership in suicide prevention in New York State, and with the entire membership of NASMHPD."

"SPEAK is a model public education to promote suicide prevention," says Dr. John Draper, National Director of the National Suicide Prevention Lifeline. "SPEAK imparts straight facts about suicide and techniques for prevention, conveys empathy for those who are in pain, and offers resources so people feeling emotional pain have a place to turn. Dr. Carpinello's leadership role on the Lifeline Steering Committee will ensure that we can broadly disseminate the knowledge, insight and expertise that went into the creation of SPEAK for New York State so others nationwide can benefit."

The mission of the National Suicide Prevention Lifeline Steering Committee is to provide recommendations and advice that support the Lifeline's overall mission and to enhance its capacity to reach and serve persons throughout the United States who are in crisis and potentially could be suicidal. □

Exercise Slows Development of Alzheimer's in Mice

National Institute on Aging (NIA)
www.nia.nih.gov

Physical activity appears to inhibit Alzheimer's-like brain changes in mice, slowing the development of a key feature of the disease, according to a new study. The research demonstrated that long-term physical activity enhanced the learning ability of mice and decreased the level of plaque-forming beta-amyloid protein fragments -- a hallmark characteristic of Alzheimer's disease (AD) -- in their brains.

A number of population-based studies suggest that lifestyle interventions may help to slow the onset and progression of AD. Because of these studies, scientists are seeking to find out if and how physically or cognitively stimulating activity might delay the onset and progression of Alzheimer's disease. In this study, scientists have now shown in an animal model system that one simple behavioral intervention -- exercise -- could delay, or even prevent, development of AD-like pathology by decreasing beta-amyloid levels.

Results of this study, conducted by Paul A. Adlard, Ph.D., Carl W. Cotman, Ph.D., and colleagues at the University of California, Irvine, are published in the April 27, 2005, issue of "The Journal of Neuroscience". The research was funded in part by the National Institute on Aging (NIA), a component of the NIH, U.S. Department of Health and Human Services. Additional funding was provided by the Christopher Reeve Paralysis Foundation.

To directly test the possibility that exercise (in the form of voluntary running) may reduce the cognitive decline and brain pathology that characterizes AD, the study utilized a transgenic mouse model of AD rather than normal mice. The transgenic mice begin to develop AD-like amyloid plaques at around 3 months of age. Initially, young mice (6 weeks or 1 month of age) were placed in cages with or without running wheels for periods of either 1 month or 5 months, respectively. Mice with access to running wheels had the opportunity to exercise any time, while those without the wheels were classified as "sedentary."

On 6 consecutive days after the exercise phase, the researchers placed each mouse in a Morris water maze to examine how fast it could learn the location of a hidden platform and how long it retained this information. (This water maze task involves a small pool of water with a submerged platform that the mouse must learn how to find.) The animals that exercised learned the task faster. Thus the mice that used the running wheels for 5 months took less time than the sedentary animals to find the escape platform. The exercised mice acquired maximal performance after only 2 days on the task, while it took more than 4 days for the sedentary mice to reach that same level of performance. This suggests that exercise may help to offset learning/cognitive deficits present in AD patients.

Next, the investigators examined tissues from the brains of mice that had exercised for 5 months. They compared the levels of plaques, beta-amyloid fragments, and amyloid precursor protein, a protein found throughout the body and from which the beta-amyloid peptide is derived. In AD, beta-amyloid fragments clump together to form plaques in the hippocampus and cerebral cortex, the brain regions used in memory, thinking, and decision making.

Compared to the sedentary animals, mice that had exercised for 5 months on the running wheels had significantly fewer plaques and fewer beta-amyloid fragments (peptides) in the cerebral cortex and hippocampus, approximately by 50 percent. Additional studies, of exercised animals at 10 weeks old, showed that the mechanism underlying this difference began within the first month of exercise.

"These results suggest that exercise -- a simple behavioral strategy -- in these mice may bring about a change in the way that amyloid precursor protein is metabolized," says D. Stephen Snyder, Ph.D., director of the etiology of Alzheimer's program in the NIA's Neuroscience and Neuropsychology of Aging Program. "From other research, it is known that in the aging human brain, deposits of beta-amyloid normally increase. This study tells us that development of those deposits can be reduced and possibly eliminated through exercise, at least in this mouse model."

These findings follow another recent report of a link between an enriched environment and Alzheimer's-like brain changes. That study, published Orly Lazarov, Ph.D., and colleagues in the March 11, 2005, issue of the journal "Cell", found that beta-amyloid levels decreased in the brains of another kind of transgenic mice when they were housed in groups and in environments that were enriched with running wheels, colored tunnels, and toys.

"Both of these studies are exciting because they offer insight into one of the pathways through which exercise and environment might promote resistance to development of cognitive changes that come with aging and AD," Snyder notes. "It is as though exercise or environmental enrichment forces the metabolism of amyloid precursor protein through a pathway that is less harmful and might even be beneficial. Further research will help us to understand those mechanisms, to learn how much and what kind of exercise is best, and to see if these same effects occur in humans." □

MENTAL HEALTH NEWSDESK

Growing Geriatric Mental Health Need in New York State: Where Do NYS Officials Stand?

By Jane Linker

Concerned about the skyrocketing numbers of seniors who will need a growing array of services, including mental health programs, as they age, New York State's political leadership is focusing increased attention on preparing for the elder boom.

In 2002, Governor Pataki initiated Project 2015, which charged 36 cabinet-level state government agencies to review their major policies, programs, and structure in light of the State's increasingly older and more diverse population. The process resulted in a white paper, "Project 2015: State Agencies Prepare for the Impact of an Aging New York," which has gained national attention as a model for service planning for the Baby Boom generation.

The Office of Mental Health (OMH) has been an important player in this effort, leading an initiative to develop plans to address what many mental health advocates feel is an upcoming crisis in care. Population projections clearly highlight the need for more services. Advocates like the Geriatric Mental Health Alliance, which numbers more than 600 individual and organizational members from the fields of mental health, health, and aging, point to research that shows one in five elderly have some form of mental disorder. In 25 years, New York State is expected to have 3.7 million seniors, and 750,000 will have some form of mental illness. Without a significant increase in programs and services, their needs will be largely unmet, advocates feel.

In its Five Year Plan, released last January, OMH targets geriatric mental health as one of its priority areas and commits to the development of a comprehensive plan for serving older adults. A series of roundtable discussions is planned in 2005 to bring together experts, stakeholders, and providers to help formulate future programs and policies.

"OMH has been collaborating with various stakeholder groups concerning the issues associated with an aging population. These collaborations have resulted in the identification of two subpopulations for consideration: individuals with mental illness who are getting older and developing co-morbid health conditions related to aging; and older New Yorkers who are at risk for developing mental illness," points out Sharon E. Carpinello, Commissioner of the New York State Office of Mental Health. "In recent years, OMH has focused on fundamentally changing the way mental health treatment is provided to all New Yorkers, including our seniors, by focusing on new evidence-based community treatment models and extensive community outreach. We've seen the positive impact of these programs and remain committed to working to build on this success."

Senator Thomas Morahan

Assemblyman Steven Engelbright

Planning for a Culturally Diverse Population

New York State's unique demographics play a role in planning efforts, according to Neal E. Lane, Acting Director of the NYS Office for the Aging, which was designated by Governor Pataki as the leadership agency for Project 2015. Lane points to New York's increasing diversity as a critical factor in service planning.

"The percentage of immigrants making up New York's population grew to 20 percent by the 2000 Census, and this trend is expected to continue. The number of minority elderly in New York will increase over 50 percent between the year 2000 and 2015 reaching a total of 1.1 million. Increased diversity will require that services be provided in culturally and language sensitive ways," he advocates.

Legislative Response

New York State legislators have responded to the growing concern over inadequate mental health services for the elderly by proposing the Comprehensive Geriatric Mental Health Act (S.4742/A.7672). Introduced in April, the bill would establish a strong interagency planning process, and create service demonstration projects, public education programs, and a workforce development initiative. It is believed to be the first such legislation introduced in the United States.

"Existing services, workforce, governmental infrastructure, and state planning are inadequate to meet the special and unique needs of this key group. My bill begins to remedy these shortcomings," said State Senator Nicholas Spano, who introduced the Comprehensive Geriatric Mental Health Act in the Senate.

Assemblyman Peter Rivera, Chair of the Assembly Mental Health Committee, introduced the Bill in the Assembly, calling it landmark legislation that would lay the groundwork for a multi-year state effort to meet the mental health needs of an aging population.

"The data is clear on this issue. New York needs to act now to prepare itself to be able to provide the mental health services our booming aging population will require and need," said Assemblyman Rivera.

Of special concern to many mental health practitioners who work with the elderly is the lack of expertise and awareness in the overall health care community. The Act seeks to address this issue, calling for increased training and education.

"Often the mental health professionals serving adults do not have special expertise in geriatric mental health, and even though the co-occurrence of mental and physical illness is common, usually mental health services are not coordinated with physical health services. This legislation will go a long way in raising public awareness, planning and ultimately serving the senior population more effectively," said Assemblyman Steven Engelbright, who co-sponsored the bill with Assemblyman Peter Rivera.

The proposed legislation addresses the importance of providing community-based mental health services for the elderly that are not only readily available but work closely with primary health care providers. Overcoming the stigma of mental illness is also a priority.

"Reluctance on the part of many senior citizens to utilize traditional mental health services will require State and local governments and mental health providers to consider mechanisms that increase accessibility of mental health services to locations where the elderly reside and spend their time, especially at home and congregation living situations. Integration of mental health services with the public health system will also be important, as primary care providers can be extremely helpful in prevention and early intervention strategies," said Senator Thomas P. Morahan, Chairman of the Senate Committee on Mental Health and Developmental Disabilities with co-sponsored the Act in the Senate with Senator Nicholas Spano.

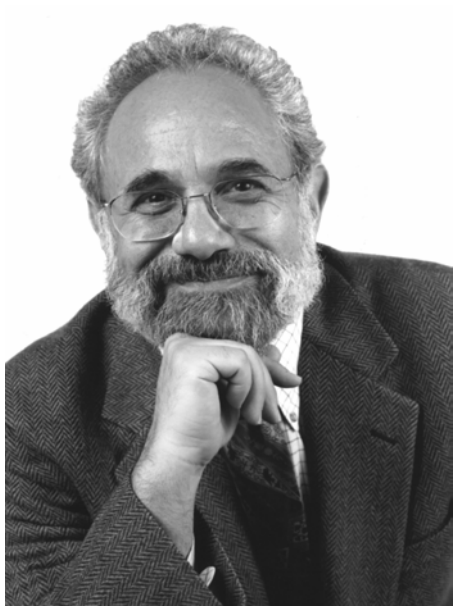
A key concern for planners is providing the supports families need to be able to continue to care for their elderly relatives at home, including those affected by mental and behavioral disorders.

"We have been developing programs that emphasize and strengthen family caregiving, specialty programs for special ailments, nutrition and exercise, housing, and other that provide treatment and support in the community for those who have mental illnesses. Appropriate treatment and management of some of these ailments require professionally trained caregivers; others require stronger families and removing the barriers to what we might call "love equity," that is, the willingness of family to provide care and support for senior family members," said Senator Marty Golden, Chairman of the Senate Aging Committee. □

POINT OF VIEW

Support the Comprehensive Geriatric Mental Health Act

By Michael B. Friedman, LMSW



Michael B. Friedman

Thanks to the vision and leadership of State Senators Nicholas Spano and Thomas Morahan and Martin Golden as well as Assemblymen Peter Rivera and Steven Englebright and others, a Comprehensive Geriatric Mental Health Act (S.4742/ A.7672) has been introduced in the New York State Legislature. If passed and signed into law, the Act will lay the groundwork for a long-term effort to confront and meet the mental health needs of older adults in New York State. It will also establish a national model.

The Act arises from recognition that services to older adults with mental disorders are currently inadequate and that neither our state nor our nation is prepared for the mental health challenges that will emerge during the elder boom.

Nationally, the number of older adults will increase from 35 million to 70 million over the next quarter century. Consequently, the number of older adults with mental disorders will increase from 7 million to 14 million.

The Act draws from The President's New Freedom Commission's report on mental health, the NYS Office for the Aging's 2015 plan, the Office of Mental Health's most recent five-year plan, and other governmental and academic studies, all of which point to critical shortfalls in geriatric mental health practice and policy including:

- The need to increase community supports so as to help older adults with both longstanding and late onset mental disorders to remain in, or return to, the community
- The need to improve access to mental health services
- The need to improve quality of mental health care both in the community and in institutional settings
- The need for more mental health services provided in the home and in community settings such as senior centers, NORCS, and houses of worship where older adults go for help
- The need for integration of mental health, health, and aging services
- The need to increase the capacity of the system to serve cultural minorities
- The need to support family caregivers
- The need for public education targeted to older adults, their families, and service providers focused on issues of stigma, ageism, and ignorance about the effectiveness of treatment
- The need to build a workforce that is clinically and culturally competent and large enough to respond to the mental health needs of the growing elderly population
- The need for more research
- The need to develop financing models which support the use of best practices and innovation
- The need for enhanced governmental preparation for the mental health challenges of the elder boom.

The Comprehensive Geriatric Mental Health Act touches on all of these critical needs. It would not solve all the problems with the wave of a legislative wand, but it would accelerate efforts that have begun in New York State to address geriatric mental health needs over the next decade.

The essential elements of the Act are:

- A call for innovation through the establishment of a wide-ranging services demonstration grants program that would be administered by the Office of Mental Health
- A new effort to address problems of stigma, ageism, and ignorance about mental illness, the effectiveness of treatment, and where to go for help through the establishment of a public education program targeted specifically to older adults, their families, and their service providers
- A workforce development initiative that would focus on building a geriatric mental health workforce for the future by (1) providing incentives to become a geriatric professional—especially for bilingual and bicultural staff, (2) improving education regarding geriatrics in professional schools, (3) providing increased training in best practices, and (4) crafting new roles designed to draw on the strengths of elders themselves, many of whom have the energy and skill to be part of the solution rather than part of the problem.
- An initiative to improve quality of care through development of relevant standards of care, the dissemination of information about best practices, and enhanced research
- Structural changes in government to facilitate readiness to meet the mental health challenges of the elder boom, including designated senior leadership in the Office of Mental Health and the Office for the Aging, the establishment of an interagency planning group, and requirements regarding comprehensive planning.

Implementation of the Act will not be expensive, which is why I refer to it as "The Comprehensive (But Inexpensive) Geriatric Mental Health Act." Those who have worked on the bill believe that $5 million will enable New York State to take this major leap forward.

In its current form the bill does not include an appropriation. We hope that the Governor will request the needed funds next year.

Let's join together to set the stage for meeting the mental health needs of older adults and to create a model for our nation. Support The Comprehensive Geriatric Mental Health Act.

Michael B. Friedman is the Director of the Center for Policy and Advocacy of The Mental Health Associations of New York City and Westchester. He can be reached at center@mhaofnyc.org. The opinions in this article are his own and do not necessarily reflect the positions of The Mental Health Associations. □

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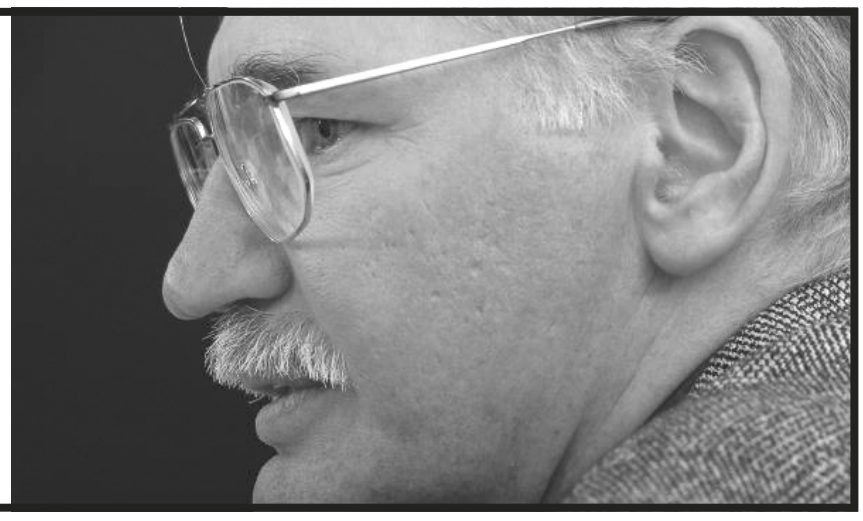

The NYSPA Report

Reconsidering a Preferred Drug List for Psychotropics

By Barry Perlman, MD, President
New York State Psychiatric Association

Once again the NYS Executive Budget proposal for 2005 incorporated legislation to create a Preferred Drug List (PDL) for participants in the state's Medicaid program as a means to achieve $80 million in savings. Once again the proposal exempted certain classes of medications from prior authorization (PA) requirements. The exempted classes of medications include atypical anti-psychotics and antidepressants among others. In noting the exceptions my initial reaction is a positive one. I'm impressed that NYSPA along with other groups which advocate on behalf of persons with mental illness have made their case well and been heard. In past years my thinking would not have gone further and I would not have entertained doubt about the correctness of our position.

This year I find myself wondering about the correctness of our position and considering alternative stances we might take with regard to the possibility of including psychotropic medications within the proposed PDL. What has changed is a clear recognition of the alarming rate of growth of pharmacy costs for state Medicaid programs and my observation that drug companies never seem to compete on price. A NYS budget document states, "Pharmacy spending in New York's Medicaid program continues to be the fastest growing component of health care costs, with annual increases of nearly 20 percent between 1994-95 and 2004-05. Left unabated, this rapid growth jeopardizes the State's ability to provide quality health care services to those who need it most."

To me, these words are neither hollow nor hyped. In our field, the expenditure for atypical antipsychotic drugs has skyrocketed from $255,200,006 in 2000 to $582,208,881 in 2004 (DOH/)MM AFFP Datamart). These numbers reflect a 228% increase in just 5 years. No responsible psychiatrist or citizen can look at these increases without wondering what contribution we might make towards the goal of taming these unaffordable increases without causing clinical harm.

As many of us who are besieged by drug "detail" persons have learned, the drug companies: 1) present information pushing the newest and most costly preparations. 2) present data highlighting often trivial differences among drugs within a class, may withhold other data of interest, and rarely present data derived from well controlled head to head trials. 3) never suggest that their product should be considered because of a significant reduction in price.

Barry Perlman, MD

Recognizing these facts, the question becomes whether or not NYSPA and other advocacy groups should continue to insist on open access to all medications within a class of psychotropic medications such as atypical antipsychotics where no clear differences been demonstrated in relation to therapeutic benefit nor safety. I believe that the time may have come for NYSPA and other advocacy groups to consider supporting a selective PDL constructed in such a way that it would be neither harmful to patients nor overly burdensome for prescribing psychiatrists. Nuance is required where extreme positions have previously been endorsed. In seeking guidance in this area I believe that the American Psychiatric Association's Position Statement on Pharmacy Benefit Management/ Pharmacy Benefit Managers (APA Document Reference No. 200204) prepared by the APA Committee on Managed Care may provide some principles for consideration as we think about accepting such limitations in the public sector.

Let me provide an example of how such a plan might work. In considering the possibility of endorsing a PDL for certain psychotropic medications we must be aware that if such limitations were incorporated into the Medicaid program persons of limited financial resources would be involved who would be unable to go outside their plan to purchase costly non included medicines. Furthermore, many persons with serious and persistent mental illness would be impacted for whom psychotropic medications are critical to stabilizing lives and work towards recovery. Currently there are 5 atypical antipsychotic medications being marketed aside from clozapine. No substantial data clearly separates the clinical indications among these medications, yet, we know, that different patients respond differently to different preparations. States, based on the Medicaid statute and court decisions, have a number of tools available by which they may try to control drug costs. Some of these, I believe, can be adopted in modified form with the goal of reducing the cost of atypical antipsychotic medications. Certainly, in keeping with the sound clinical principles enumerated in the APA's position statement, we would reject blanket "switching" and "Fail-first" policies for persons already stabilized on a particular atypical medication. However, we might well entertain a policy which would insist that when an individual not yet stabilized on an atypical was being started on one it be drawn from 2 or 3 selected from among the 5 presently marketed. While not the most radical position and thus unlikely to save the most money, such a stance would provide the state with significant economic leverage as the companies which manufacture the medications would be forced to compete on efficacy, safety and price for inclusion in the state's Medicaid PDL. By sidestepping "switching" policies persons stabilized on a particular medication are unlikely to experience unnecessary adverse effects. By acknowledging the current clinical primacy of the atypicals, enrollees would not confront wrong headed "fail-first" situations under which a trial with older, typical antipsychotics might be required. A similar approach could easily be considered for antidepressants of the several classes which exist. In that case none should contest the state's insistence on first turning to generics if they exist in the class.

I write this column not to insist that advocacy organizations including NYSPA immediately change their public position, but with the hope that it will encourage our association and others to reconsider their position about how psychotropics should be treated within the proposed NYS Medicaid PDL. I would like to think that as citizens and psychiatrists with an interest in protecting persons with serious mental illness served in the public sector we would consider what contribution we can make to the commonweal by advocating for public policies which insist that adequate representation from critical classes of medications be included in the PDL and that scarce funds be properly expended. □

The NARSAD Report

The National Alliance for Research on Schizophrenia and Depression

Mental Illness in Seniors: New Hope Through Research

By Constance E. Lieber, President NARSAD

Constance E. Lieber

The past century has witnessed a remarkable lengthening of life expectancy at birth, from about 50 years in 1900 to roughly 77 years today. Moreover, many more people than ever before can expect to live into their mid-eighties and beyond. Our increasing longevity is a gift in many ways – those of us who have children can hope to see and enjoy our grandchildren for many years. Lengthy retirements can provide opportunities for travel, pursuing hobbies, and even exploring secondary careers. Nevertheless, advancing can be a mixed blessing. Eventually, many older people must cope with physical limitations, health problems, cognitive changes, bereavements – and often find themselves struggling under the burden of depression. Physical changes that occur in the aging brain have been linked to depression in the elderly as well. There are also people who enter their senior years already living with a psychiatric disorder, and treatment for these pre-existing mental illnesses may be complicated by the effects of aging. Contrary to common misperceptions, however, depression and mental disorders are not an inevitable consequence of aging, and treatments exist for this population just as they do for other age groups. Disturbingly, studies have shown that even among those older adults who are diagnosed as being impaired, the proportion that receives adequate treatment is markedly lower than in younger groups.

Over the past twenty years, research science has generated a vastly expanded understanding of mental illness from what was previously known. At the forefront of these efforts is the National Alliance for Research on Schizophrenia and Depression (NARSAD), funding researchers studying a wide range of psychiatric disorders. Many NARSAD scientists are actively conducting research to shed light on the particular issues of geriatric mental illness. From studies that observe patients' symptoms and treatments (clinical studies) to research that utilizes the latest technologies to look at brain function (imaging studies) NARSAD researchers are engaged in important investigations that may eventually help to improve the quality of life for senior adults.

Until recently, neuroscience researchers could only make educated guesses about what went on in the human brain. However, dramatic advances in neuroimaging technologies have made it possible for scientists to observe brain processes in operation. NARSAD investigators are utilizing these imaging techniques to study geriatric mental illness. Howard Aizenstein, M.D., Ph.D., University of Pittsburgh (NARSAD 2004 Young Investigator) is conducting an fMRI imaging study of cognitive impairment in geriatric depression. Depression, common in the elderly, is often caused by cognitive impairments, but researchers differ as to whether they have more in common with Alzheimer's disease or vascular disease of the brain. Dr. Aizenstein hopes that by better understanding the neurobiology of these impairments we can find better treatments for them – especially as new treatments become available for Alzheimer's and vascular disease. John L. Beyer, M.D., Duke University Medical Center (NARSAD 2003 Young Investigator) is using Diffusion Tensor Imaging to study the changes that occur in the prefrontal cortex of the brain in late-life bipolar disorder. His study aims to provide more information on the impact that bipolar disorder has on individuals late in life, and how these changes might affect their response to treatment.

Investigating the relationship between depression and cognitive decline is Kevin Duff, Ph.D., University of Iowa (NARSAD 2005 Young Investigator). Dr. Duff is analyzing data compiled on people who have been the subjects of a long-term health studies. Looking at their mental health over the span of years – particularly as it relates to episodes of depression – has the potential to answer many important questions about the affect of depression on medical conditions, behavior, and cognition. Kristine Yaffe, M.D., University of California, San Francisco, a three-time NARSAD grant recipient (2004 Independent Investigator, 2001 Young Investigator, 1997 Young Investigator), continues her research on mental illness in older people, studying the role of inflammation and cerebrovascular disease in depression and cognitive impairment among older people. Studying mental health in older women is Laura D. Baker, Ph.D, University of Washington (NARSAD 2002 Young Investigator). With menopause come many hormonal changes for women which impact on systems throughout the body. Dr. Baker is researching the effects of estrogen on older women's response to stress, which may yield information that leads to better treatment approaches for them.

Schizophrenia is a psychiatric disorder that often begins in young adulthood and is usually a life-long condition. With the graying of America, the number of senior citizens with schizophrenia is expected to more than double over the next three decades, yet relatively little research has focused on this rapidly growing group. The aging of schizophrenia patients is another area being studied by NARSAD researchers. Sarah Pratt, Ph.D., Dartmouth College (NARSAD 2003 Young Investigator), has embarked on an investigation of medication adherence and the use of memory strategies in older adults with schizophrenia. Individuals with schizophrenia frequently have difficulty adhering to medication regimens. At the same time, older schizophrenia patients face the substantial risk posed by other medical conditions. Not adhering to medication schedules places this vulnerable group at risk not only psychiatrically, but also for serious medical complications. Dr. Pratt is evaluating whether using certain memory strategies will have an impact on their ability to keep up with their medications. Findings from her project will be used to design an intervention program tailored to older people with schizophrenia, using memory strategies that seem most effective for this group. Laura B. Dunn, M.D., University of California, San Diego (NARSAD 2002 Young Investigator), is focusing on the ethics of research on older schizophrenia patients. A fundamental principle of research is the requirement to obtain informed consent from the subjects being studied. When those needed for a study may not fully understand what they are agreeing to – as can be the case with cognitively impaired or severely mentally ill individuals – the research community endeavors to establish appropriate standards to best inform them. Dr. Dunn is examining an enhanced method of informing older schizophrenia patients, with the hope of laying the groundwork for better procedures in this area in the future.

Finally, NARSAD researchers are working toward improving the independence and quality of life for mentally ill seniors. Dilip V. Jeste, M.D., University of California, San Diego (NARSAD 2002 Distinguished Investigator), has concluded a study that looked at the possibility of work rehabilitation in older people with schizophrenia. Dr. Jeste studied a group of 400 middle-aged and elderly patients who had grappled with schizophrenia most of their adult lives. Finding that many were not functioning up to their potential, he believed that work rehabilitation programs – such as supported employment – could benefit them vocationally while at the same time improving their overall quality of life. In describing his work, Dr. Jeste's pointed out that society has a fundamental bias against aging – a bias which reinforces in this population a self-fulfilling prophecy that older people with schizophrenia are incapable of benefiting from work rehabilitation programs. The data which resulted from the study provided supporting evidence that older schizophrenia patients can, indeed, benefit from such programs. Moreover, the results of the NARSAD project enabled members of the team to obtain more funding to continue this line of research.

As in other areas of neuroscience, progress in the battle against mental illness in the elderly comes slowly – but research provides hope. With the continuing support of all of us, scientists will continue to generate the building-blocks of knowledge that lead us toward better treatments and eventually cures.

The National Alliance for Research on Schizophrenia and Depression (NARSAD) is the largest donor-supported organization in the world devoted exclusively to supporting scientific research on brain and behavior disorders. Since 1987, NARSAD has awarded $175.7 million in research grants to 2,067 scientists at 329 leading universities, institutions and teaching hospitals in the United States and in 23 other countries. By raising and distributing funds for research on psychiatric brain disorders, the pace has accelerated resulting in greater knowledge of brain functioning, neurochemistry, new/improved treatments and genetic origins. Constance E. Lieber has served as President of NARSAD since 1989. □

Westchester County Department of Community Mental Health Reaches Out to Seniors

Staff Writer
Mental Health News

The Department of Community Mental Health has established a confidential phone line in both English and Spanish to help seniors who may be depressed get help. If you call the information and referral line you will be able to speak to a mental health professional as well as get a referral for treatment if you are interested.

Seniors have on of the highest risks for depression. 22,000 seniors over age 60 will be affected in our county alone this year. Are you one of them? As in younger adults, clinical depression may be precipitated by adverse life events, including poor health, loss of friends, or loved ones, loss of physical functioning or loss of self-esteem related to aging. Depression is not a normal part of aging; however, the process of aging can be lonely and increase one's vulnerability. In addition medications for other health-related problems can also trigger depression.

Because men are not diagnosed as easily and are less likely to reach out for help, they have a higher incidence of suicide. Men also tend to have less social supports in their life and are therefore at greater risk for isolation and loneliness.

Improved recognition of depression in the later years can help an individual enjoy that time of life and feel more fulfilled. Depression should not be tolerated as apart of the experience of aging. With the proper treatment an individual will have more energy to pursue areas of interest ands more desire to have social connections.

If you would like to speak to someone please call the Depression Support Network at (914) 995-5236 or Spanish Speaking (914) 231-2925 or look on our website www.westchestergov.com/mentalhealth. □

Suicide Help - Please Call

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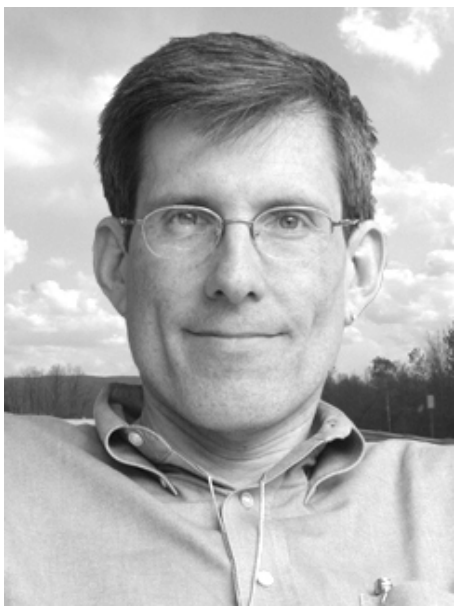
A Voice of Sanity: A Consumer Advocacy Column

A Tale of Two Cities

By Joshua Koerner
Executive Director, CHOICE



Joshua Koerner

In my experience, addiction is not as different from other mental illnesses as addiction treatment is different from other treatments. Granted, I haven't had every mental illness -- just three or four. But among the entire staff of CHOICE we have all the major mental illnesses covered. Mental illnesses all have the same basic components: you do crazy stuff, you think crazy stuff, and you have a lifetime's worth of wreckage as a result.

Addiction is a mental illness. It's right there in the Diagnostic and Statistical Manual of Mental Disorders, the book on how to describe and diagnose a mental illness: one hundred pages on dependence, withdrawal, and the abuse of everything from alcohol and amphetamines to cocaine, hallucinogens, opiates and sedatives. But really, do we need a book to tell us this? Dr. Harris Stratyner, Associate Professor of Psychiatry and Director of the Addiction Recovery Division at Mount Sinai School of Medicine, tells the story of a well known musician who had been invited by a wealthy fan to attend a jazz festival, all expenses paid. About two months after the festival took place, the musician and the fan ran into each other. The fan, perplexed by the musician's absence, asked "I sent you a first class ticket to come to the festival -- where were you?" The musician promptly replied, "I was there," blitzed on drugs to the point that he really believed he'd flown to Colorado. The moral, as Harris put it, is that "If that isn't mental illness, I don't know what is."

Yet addiction treatment is, in many fundamental respects, quite different from other forms of treatment for mental illness. Viva le difference! I was at a dead end after a decade of mental health treatment; only after experiencing addiction treatment was I finally able to achieve a measure of recovery from mental illness. It is vitally important for the mental health field to acknowledge why.

Managed care companies and big hospitals, in their marketing drive to sound cutting edge, often refer to their services as "behavioral health," "behavioral science." Ironically, the biggest difference between addiction treatment and all other forms of mental health treatment is that addiction services care about behavior first -- considerations of thoughts and feelings come second. All other forms of mental health treatment care about thoughts and feelings first; actions come second. Neither system has it completely right, and each has much to learn from the other. But after years of inpatient, outpatient, day treatment and individual therapy, I still wasn't recovering from mental illness, and I wasn't feeling better. After less than a year in an addiction milieu my life was turned around, because finally I was behaving differently, and with new behaviors came new results, followed by new feelings. It's a well known recovery slogan: insanity is doing the same thing over and over and expecting different results. That's a behavioral analysis of mental illness.

There's no denying the mental health system cares about behavior if they think you're going to hurt yourself or someone else. That's the justification for the most expensive and damaging abuses of the system, and I spent my share of time in restraints and seclusion. The rest of the time, the thing they were trying to change was how I felt. That's what had to be medicated, that's what had to be changed. They monitored my affect closely. Being calm was defined as success, and soon I learned that as long as I was calm I was doing well. I was pretty calm all those years I was unemployed, doing busy work at the day hospital, collecting disability checks and going nowhere.

One of the reasons I was so calm was that I was smoking dope and severely depressed. When my therapists finally figured out they'd reached a dead end, that there was no working with me in that state, they handed me over to the addictionologists. As soon as I entered rehab, I was given a brand new definition of success: not using drugs. As long as my drug use had ceased, I was a success. Thinking about my thinking used to make me crazy: how happy was too happy? How sad was too sad? Was I having a crazy thought? How about now? But in recovery they teach you "feelings aren't facts". Behaviors, on the other hand, are. You can see them, measure them, know for a fact whether you did something or you didn't.

Addiction medicine gave me an achievable measurement for success: just don't use. It got measured every time they made me piss in a cup. It represented my first chance to be a winner. If I wasn't using, the staff was happy, and giving me tons of positive feedback. We know you feel like crap, they'd say, but feelings aren't facts. Look at what you're doing: you're clean. Staying clean is an awesome achievement, and every day you maintain your sobriety is another victory. They were even able to recast previous actions in a positive new light. Before I was in treatment for addiction, everything I'd done to get and use drugs had been condemned by the mental health system. In treatment I learned that addicts are incredibly inventive in pursuit of drugs. There was no denying that. When I was living at home, with no car, I'd talk my neighbor, a friend of my mother's, into driving me into the Bronx to cop, in exchange for a taste. I learned that addicts are tough, resourceful and resilient. We just had to redirect our actions in a positive direction.

The mental health system isn't good about giving positive feedback. They don't celebrate achievement; they're much more about avoiding failure. They don't give out symbols of achievement, like the key chains and coins so common to twelve step programs. I've never been given so much as a simple round of applause in an inpatient community meeting. Addiction treatment always holds out a brass ring.

Another profound difference between the addiction and mental health systems is the use of peers. Most of the people who treated me for addiction were addicts themselves and made no secret of it. It is an accepted, recognized aspect of addiction medicine that people in recovery have something vital, irreplaceable and irreproducible to offer, and because addiction medicine is focused on measurable results, they embrace it. Contrast that with the rest of mental health treatment. There is an entire movement dedicated to convincing mental health practitioners that peer services are valuable, but many refuse to listen. We've marshaled research, advocacy, protests, and still, the use of peers is controversial. The underlying reason is sad and disturbing: there is more prejudice within the field of mental health treatment against people with mental illness than there is in the substance abuse field against addicts. The mental health establishment field is already loaded with peers, but many are afraid to come out. As but a single, stunning example, noted author and researcher Kaye Redfield Jameson's career in medicine was ruined when she revealed her own diagnosis of bipolar disorder. Recently, a researcher told me a story about an ACT team that was struggling with the problem of hiring a peer (and only because they were mandated to). Where, they wanted to know, was this peer worker to have lunch? It was like asking, can they drink from the whites only water fountain? It happens all the time: the peers aren't like us treatment professionals, but they aren't the patients, either. Where do they have lunch? In the mental health field, the patients are still in the untouchable class.

In addiction medicine, having been through it oneself is a positive, because recovery is a positive. I was treated by men and women who sincerely valued what I could accomplish because they had accomplished it themselves, and I in turn sincerely valued what they had to say, because they'd walked the walk they were talking. I have never, ever, been prescribed a medication for the treatment of mental illness by anyone who admitted to having taken it themselves, or suffered its side effects. My peer counselors in addiction knew what I was going through, and they also offered a vision of a hopeful future. That future was achievable through action: just take the next right action, even if you don't feel good about it, even if you think it isn't going to work. Fake it, they say, until you make it.

Addiction also offers a clear definition of failure: if you use drugs, you've failed. We don't hate you for it, but it's not ignored. But the mental health system's view of failure is bizarre and tainted by prejudice. On the one hand, clients aren't responsible for their failures, and need to be protected from them, because we've screwed up our lives so badly. Failure is an important tool of growth often denied to those in treatment. The mental health system is so frightened by the possibility that our decisions will have disastrous consequences that decision-making is preempted, thus denying us the critical life lessons that only failure can teach. Those who are never allowed to make bad decisions never learn to make good decisions, either.

And yet, when treatment fails it is the failure of the client, never the clinician. It is we in treatment who, when faced with inappropriate treatment alternatives, "fail" by virtue of our noncompliance. It is never the clinician who fails to deliver appropriate services. Clinicians are often blind to their own lack of progress, and project it back on to the patient, so whatever it was that wasn't working before – drugs, confrontation, coercion – they just try again, and again. That's one reason people remain in treatment for years without getting better.

Treatment for addiction isn't just about actions. There is a substantial focus on thoughts and beliefs. But here as well, the contrast with the mental health system is profound. In a future column, I'll address the use of spirituality as a tool of recovery.

CHOICE of New Rochelle, New York, is a nonprofit consumer advocacy organization dedicated to helping people with mental illness. You may reach Mr. Koerner at (914) 576-0173. □

THE MENTAL HEALTH LAWYER

New York's Guardianship Law: The Broad Issues

By Carolyn Reinach Wolf, Esq.

Carolyn Reinach Wolf, Esq.

Often acute hospitalizations are successful in treating and stabilizing the immediate and most severe symptoms of a mental illness. However, the enduring medical, social and financial issues that remain are left to the individual, family and other community based healthcare providers to contend with. Without a legal determination of incapacity, an individual with a serious mental illness is responsible for her financial and personal decisions. She is well within her legal rights to refuse outpatient care, choose where and how she will live and to whom she gives her money. However, when decision-making ability begins to deteriorate and poses harm to her health or financial well-being, family members may choose to seek a Guardianship Order. This article will address the broad issues of New York's Guardianship law and its relation to families that care for individuals with mental illness who reside in the community.

New York Mental Hygiene Law, Article 81, is the legal mechanism through which a family member can be given decision-making authority (Guardianship) over an "Incapacitated Person."

Incapacity is defined in three parts; 1) The Alleged Incapacitated Person (the "AIP"), has certain functional limitations; 2) The AIP lacks an understanding and appreciation of the nature and consequences of his/her functional limitations; and, 3) There is a likelihood that the person will suffer harm because of the person's functional limitations and inability to adequately understand and appreciate the nature and consequences of such functional limitations.

It should be highlighted that the incapacity must be enduring. The incapacity cannot be a brief psychiatric decompensation that will be remedied in an acute psychiatric hospital or by a community intervention. Rather, as a result of chronic illness, the AIP, even at his or her baseline, remains incapacitated to do certain things.

It is also important to note that incapacity in this regard need not be total. In fact, the law encourages the greatest amount of participation in decision-making by the Incapacitated Person consistent with their functional limitations. Moreover, the Judge hearing the case is obligated to narrowly tailor the powers granted to the Guardian after considering the Incapacitated Person's functional limitations. After a judicial determination of incapacity, a Guardian may be given powers relating to the Incapacitated Person's personal needs, property management or both. For example, while the Incapacitated Person may be able to pay her monthly bills, you may need powers to arrange for home-care, general outpatient medical care and even supervise the distribution of her inheritance.

When considering Guardianship, it is advisable to assess your loved one's needs. Speak with family, treatment providers, landlords, bank officials or whoever may have an interest in your relative's life. Compile a list of specific personal and property management needs to be presented to the Court. At the hearing, the Judge may inquire as to their necessity and expected duration. A Guardian's authority may be for a specified period of time or it may be indefinite. Personal Needs powers that are frequently granted by the Court include but are not limited to: the authority to choose where the incapacitated person will live; authority to make routine and major medical and dental decisions; make decisions regarding social environment and other social aspects of the life of the incapacitated person; authorize access to or release of confidential records. Property management powers that are frequently granted by the Court include but are not limited to: marshal and collect assets; pay all bills; invest assets (with certain limitations); apply for government and private benefits, including Medicaid planning; enter into contracts; make gifts; purchase real estate; and sell real estate (usually with prior judicial approval). Furthermore, specific requests can be made for authority to hire experts such as a lawyer, accountant or financial advisor to administer an inheritance, make general investments and advise on other issues, as deemed necessary by the Court.

There are certain aspects of an Incapacitated Person's care that may never be delegated to a Guardian. A Guardian may not consent to the involuntary administration of psychiatric medications at any time, and/or consent to an involuntary medical procedure when the Incapacitated Person is in a psychiatric facility. In addition, previously executed advanced directives, such as a healthcare proxy, living-will or power-of-attorney may only be terminated by the Incapacitated Person or a Judge's order in the Guardianship proceeding. Otherwise these advance directives will "survive" the Guardianship and remain in effect.

There is a great deal to consider in determining if someone will benefit from having a Guardian. However, once the decision is made, you may find that having the authority to arrange for consistent out-patient treatment appointments, provide home healthcare and protect her assets will help to avoid future psychiatric hospitalizations and have a financially secure future. Whether an older relative residing in the community or a family member needing placement in a long-term care facility, Guardianship will serve as a valuable connection between your loved one and the appropriate care he or she deserves.

The Law Firm of Carolyn Reinach Wolf, P.C. specializes in legal representation and consultation, in the fields of Mental Health and Elder Law, to families, individuals, hospitals, skilled nursing facilities, out-patient centers, mental health professionals and other attorneys.

Our attorneys have extensive experience with the Mental Hygiene Law, Article 81 Guardianship; civil and criminal litigation and negotiation specific to Mental Health issues. □

The NAMI-NYS Corner

Providing support to families and friends of individuals with mental illness and working to improve the quality of life for individuals with mental illness.
Helpline: 800-950-3228 (NY Only) • www.naminys.org • Families Helping Families

The Many Facets of Aging and Mental Illness

By J. David Seay, JD
Executive Director, NAMI-NYS

J. David Seay, JD

Mental health and older adults, the theme of this issue, is a topic of great concern to NAMI members nationwide. As the baby-boom generation ages and as medical care gives people longer lives, many of us will experience the luxury of old age as well as the other things that can come with it. And that includes mental illness.

There are many facets to the issue of aging and mental illness. There is the older adult with a mental illness. There is that person's caregiver or caregivers. There are the other members of her or his family, friends and neighbors. There are the aging parents of now adult mentally ill children who are terrified about what will happen to their sick children when they can no longer take care of them. Aging and mental illness affects all of these individuals and more. For example, a study done some years ago by the New York State Office of Mental Health found that housing is disrupted for up to 1,500 adults with serious mental illness each year due to the death or disability of their parents or other family caregivers. Of course this just adds to the already serious crisis in housing for persons with serious mental illness. And yet housing is but one of a host of related issues.

Our colleagues at NAMI New Hampshire published an excellent handbook in 2001 on these topics titled *Mental Health, Mental Illness, Healthy Aging: A NH Guide for Older Adults and Caregivers*. Although some of the book is New Hampshire-oriented (such as the listing of local and state resources), most of the book provides very important and useful information for aging adults and the people who help provide their care. There are great chapters on needs of the caregiver (you are not alone), wellness and healthy living, mental illness myths and facts, mental health disorders, types of treatment available, medical concerns, coping with challenging behaviors, domestic violence and adult abuse, diversity issues, legal issues, on death and dying and on resources available.

Unfortunately, I do not have the space here to devote to all of these issues, but I do commend the book and excerpt from the *Forward* by Stephen J. Bartels, MD, MS, who was at the time of publication the Medical Director of the New Hampshire Division of Behavioral Health and President of the American Association for Geriatric Psychiatry:

"One in five older persons suffers from a diagnosable psychiatric illness and the number of persons age 65 and older with a psychiatric disorder will more than double over the coming decades. These disorders can substantially impair functioning and can result in unnecessary hospitalizations and nursing home placement, poorer health outcomes, and increased rates of mortality. For example, older persons who suffer from depression have worse outcomes after medical events such as hip fractures, heart attacks, or cancer, and individuals who are age 75 and older have the highest suicide rate of any age group."

"Fortunately, there have been dramatic advances in our understanding of these disorders over the last decade and major gains in developing new treatments. Effective treatments are now available for most of these disorders, resulting in increased functioning and greater quality of life. Yet all too often older persons with psychiatric illnesses fail to receive treatments and services that they need. Family members are often left with the task of sorting out a confusing array of providers, treatments, and systems of care, without access to basic information…. Being informed is a first step toward achieving better health."

The handbook provides that basic information. Copies of the book can be obtained by contacting NAMI New Hampshire at: NAMI NH, 15 Green Street, Concord, NH, 03301. The phone number is (603) 225-5359. There is a $15 charge but copies can be downloaded for free from their website which is www.naminh.org. Our NAMI-NYS hats are off to our friends at NAMI-NH for doing us all such a great service with this handbook.

Our hats are also off to Michael Friedman of the Mental Health Associations of New York City and Westchester for launching the New York State Geriatric Mental Health Alliance. NAMI-NYS has been supportive of this effort and will continue to work with Michael and the Alliance to further an agenda of advocacy and policy change for aging New Yorkers living with mental illnesses. The group has already been successful in getting a number of their issues on the legislative radar screen in Albany, and that is no small feat given the myriad distractions in Albany.

As you know by now, the New York State budget has been put to rest, more or less, and the mental health world was spared some of the more Draconian cuts that had been proposed. Mental health benefits were kept in the Family Health Plus program, $4.1 million of the $7.7 million in last year's cuts in aid to localities was restored and half of the cuts to the OMH research budget -- $400,000 – were put back in. There is also some substantial new funding – over $6 million -- for housing stipends. There is money to build some housing units that were promised in prior years, but nothing new proposed this year. Mental health advocates, including NAMI-NYS, lost our battle opposing a preferred drug list (PDL) under Medicaid, but at least got some protections within it. They include a carve-out of certain psychiatric medications, consumer/advocate representation of the pharmacy and therapeutics committee within the Department of health and the prescribing physician's "override" or final say about any medication prescribed for a Medicaid patient. Also under Medicaid, the "optional services" for psychologists, podiatrists and dentists, were retained. Overall, the budget could have been a lot worse.

As far as legislation is concerned, NAMI-NYS is leading the fight to improve and make Kendra's Law for assisted outpatient treatment (AOT) permanent. We are also fighting hard with the Timothy's Law Campaign to get mental health parity in health insurance enacted this year. With the able assistance of NAMI-NYS Associate Director for Criminal Justice Bob Corliss, we are working with a statewide coalition to get legislation that would ban the use of the "special housing units" (SHUs) in prisons for persons with mental illness. These are the punitive, 23-hour solitary confinement cells, also known as "the box" and "the hole." Great strides have been made with identical bills introduced in both houses of the Legislature. And we are also pressing for a bill that would require the state to maintain waiting lists for community mental health housing. We applaud Senator Thomas Morahan for introducing this legislation in the Senate this year and we urge him to take it all the way to passage.

Mark you calendar now for NAMI-NYS's 23rd Annual Meeting and Educational Conference. It will be held October 28-30, 2005, at the Desmond Hotel and Conference Center in Albany. Friday, October 28th will be an all-day session on mental illness and the criminal justice system. Saturday morning will feature the annual meeting and election of NAMI-NYS Directors. NYSOMH Commissioner Sharon Carpinello will speak at 11:00 that morning followed by a prominent luncheon speaker, twelve afternoon workshops and a reception and banquet that will include a very prominent Keynote Speaker as well as presentation of the 2005 NAMI-NYS Awards. Sunday, October 30th will feature an all medical plenary session as well as the ever-popular "Ask the Doctor" session with Dr. Lewis Opler. Look for the brochure this summer or call us to get one, at (800) 952-FACT or (518) 462-2000.

Have a great summer ! □

A Mental Health News Personal Message: You May Sometimes Feel Like Giving Up Because You Are Feeling Hopeless. This Is Common During A Mental Illness. It Is Not Your Fault It Is Your "Illness Talking." Call Your Treatment Professionals Today, And Tell Them You Need Extra Help. Don't Ever Give Up - This Crisis Will Pass. You Are Needed In This World !

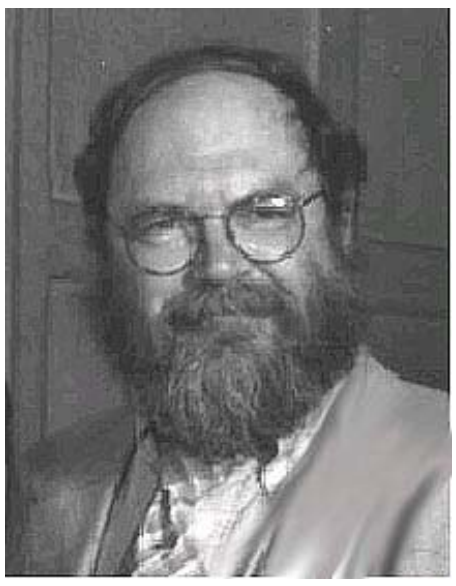
WORKING WITH MEDICATIONS

Mania And Lithium

By Richard H. McCarthy, MD, CM, PhD

Mania is an interesting illness. If we had to pick a mental illness to have, it would probably be mania. It is characterized by a series of symptoms that, on first blush, most of us would see as positive. So, people with mania have elevated mood, increased self esteem, need very little sleep, have an increase in goal directed behavior, and are overly involved in pleasurable activities. So, what is the down side? People with mania can be amazingly irritable, extremely distractible, and, since they feel so good and have such an inflated sense of themselves and their abilities, they can get in to incredible difficulty. Like many of the mental illnesses they can also become psychotic, which invariable makes things worse. Moreover, mania often, but not always alternates with depression, a process called cycling. As good as one may feel, the corresponding depression of Bipolar Disorder is devastating. An observation that the number of people have had over the years is that the rate of cycling seems to increase the more often a person has episodes. Not only do the cycles increase in frequency, they also seem to increase in intensity and become harder to treat. There is a growing sense among physicians that a major goal in the treatment of bipolar disorder is to prevent the illness from getting worse. Unfortunately, there were very few good treatments of mania.

Enter John Cade. Doctor Cade was an Australian physician who believed that mania might be caused by intoxication caused by normal body products. The particular substance that he was investigating was urate, a byproduct of purine metabolism. His study methods required that he give lab animals, guinea pigs, very high doses of urate. Unfortunately, using high doses of uric acid caused kidney damage. However, the salt, lithium urate, was very water soluble and could



Dr. Richard H. McCarthy

be given to the guinea pigs in high doses with significantly less harm to the kidney. Cade noticed that the guinea pigs became quite calm. Shortly thereafter, he used lithium urate to treat ten manic patients. These men had been in hospital, and nearly continuously manic for years. Within four days, the patients were dramatically better. The year was 1949. If you thought that everyone would be using lithium, you thought wrong.

In the late 40's an early 50's lithium salts, specifically, lithium chloride, were commonly used as table salt substitutes for patients on sodium restricted diets for heart or kidney problems. A number of these patients used very large amounts of lithium chloride on their food and died. Thus, there developed a sense that lithium was a dangerous substance; too dangerous to use with mentally ill people. This sense that lithium was dangerous is certainly one of the reasons why lithium was not developed as an anti-manic agent. Others [(1)] have suggested that the slow development of lithium was due to the lack of commercial interest in an inexpensive mineral that could not be patented. Cade himself thought that a discovery "made by a [then] unknown psychiatrist with no research training, working in a small chronic hospital with primitive techniques and negligible equipment, was not likely to command attention." [(2)] Fortunately, a number of researchers and clinicians continued to study lithium anyway. There was pretty good evidence that lithium was effective. Over the years, the studies also continued to demonstrate this. What needed to be shown was that it was safe to use.

You can not prove that something is safe. After all, nothing really is safe apart from how it is used. Water is safe, as long as you do not hold your head under it for very long. If you do it is deadly. I know, dumb example. How about this one? Vitamin D is necessary to help us deposit calcium in our bones. Without it, we have bones that are to soft and flexible and we can not move. However, very high doses of vitamin D are not only unhelpful, they are potentially lethal. Fortunately, unless you are eating polar bear liver, which has extreme amounts of Vitamin D, it is hard to ingest enough Vitamin D to harm yourself. In the parlance of pharmacology, we would say that there is a wide "therapeutic index" for vitamin D. The therapeutic index is the difference between the amount of something that helps you and the amount of that same that will hurt you. Things with a wide therapeutic index are very safe and very easy to use. Something with a very narrow therapeutic index is much less safe and much more difficult to use. Most medications in psychiatry have a wide therapeutic index. This is a good thing, because it is best to be able to use very safe agents with patients who may use them improperly. The fact that a medication has as narrow therapeutic index does not mean that it can not be used at all, only that its use must be more carefully. Over the years, physicians have determined that lithium can be used, quite safely even with very ill patients, as long as the amount of lithium in the blood is monitored. Used within a narrow range, lithium is both safe and effective.

If you are taking lithium you should be aware of the signs and symptoms of lithium toxicity. Most of these are exaggerations of the normal side effects of lithium. These normal adverse effects include drinking a lot of water and urinating a lot, occasional stomach upset and a mild tremor. As the amount of lithium in the blood increases, these normal adverse effect move from being merely unpleasant to seriously disruptive to potentially lethal. These include symptoms such as nausea and vomiting, diarrhea, weakness and fatigue, lethargy and confusion and tremor. In mild to moderate toxicity one sees generalized weakness, the development or worsening of a fine tremor, usually in the hands at rest and mild confusion. As toxicity worsens, and moves to moderate-to-severe toxicity the tremor becomes sever, muscles begin to twitch and seizures can occur. In light of this you may want to not take lithium. I would advise against it. If you are taking lithium, you should know what the potential problems with it are so that you can do something about it if any problem develops. After all it is your life. However, I will repeat what I said before: used within a narrow range, lithium is both safe and effective. In fact, lithium is one of the most effective agents we have in psychiatry, if not all of medicine.

Dr. McCarthy is an Associate Professor of Psychiatry at the Albert Einstein College of Medicine. □

(1) Baldessarini, RJ: Chemotherapy in psychiatry, Harvard University Press, Cambridge, 1985Massachusetts.

(2) Cade JF: The story of lithium, in Discoveries in Biological Psychiatry. Edited by Ayd FJ, Blackwell B. Baltimore, Ayd Medical Communications, 1970

New 50 Bed Residential Facility Opens in Suffolk

Staff Writer
Mental Health News

Federation of Organizations is proud to announce the opening of its new 50 bed CR/SRO (community residence single room occupancy) residential facility located on the grounds of Pilgrim Psychiatric Center in Brentwood, Long Island in early Spring 2005. This residence is named in honor of Irving Berkowitz, President of the Board of Directors of Federation of Organizations. The Project is funded by the New York State Office of Mental Health, the New York State Office of Temporary and Disability Assistance, and Suffolk County Department of Community Mental Hygiene Services.

The facility is designated as a transitional housing project to assist Suffolk County Residents who may have had extreme difficulty obtaining housing from more traditional models. It is Federation's philosophy that with additional supports and encouragement people can live independently in the community. The CR/SRO will provide training to enrich the residents' ability to live in a supportive environment that meets their individual needs. Focus will be on identifying rehabilitative goals and developing plans with each resident for those goals to be achieved.

The CR/SRO will also be accepting referrals for individuals who are ready to be discharged from local hospitals and do not yet have their housing in place. The step down service will provide rapid access to supportive services and relocate individuals within a three-week period. Referrals can be made through the Suffolk County SPA (single point of access) housing process at 631-231-3562. For further information about the residential facility, call Camille Reidy, Associate Director of Programs, at 631-447-6460, ext. 124. □

Doris Wagner, Deputy Executive Director, Federation of Organizations; Richard Scalia, The Baldassano Architectural Group; Beau Gardon, Facilities Manager, Federation of Organizations; Sheldon Dorsey, Project Manager, New York State Office of Mental Health; Terry McGowan, Project Manager, DASNY; Michael Borruto, Contractor

Landmark from page 1

address issues of ageism, stigma, and ignorance about mental health which prevent people from utilizing needed care, and the development and implementation of a plan to increase the workforce in geriatric mental health, expected to fall far short of the anticipated need.

"The Comprehensive Mental Health Act will set a national model, putting New York in the forefront of geriatric mental health policy development," said Michael Friedman, Chairman of the Geriatric Mental Health Alliance of New York, the advocacy group which proposed the Act. "We are very grateful to the vision of Senators Spano and Morahan and Assemblymen Rivera and Engelbright and others on the New York State Legislature who have championed this measure. Implementation of the Act will not be expensive: we believe that $5 million will enable New York State to take a major leap forward."

While there is no appropriation in the current bill, proponents are hopeful that Governor Pataki will request funding in his budget request next year. □

Editor's Note: At the time this article was written the New York State administration had not yet seen the bill and therefore was not asked to comment. Mental Health News will provide the administration's point of view in our next issue.

Jane Linker writes frequently on mental health, child welfare, and social services.

Outreach to Elders: Helps Seniors in Rockland County New York

Dr. Gail K. Golden, Clinical Director
Volunteer Counseling Service

Volunteer Counseling Service (VCS) in New City, NY has a long history of using professionally trained and supervised volunteers to provide counseling services to Rockland County residents who have difficulty accessing more traditional mental health services. These are typically uninsured, underinsured, immigrant and working families making minimum wage. Client groups for whom we have developed particular expertise are: acting-out teens, battered women, separating couples, abusive or neglectful parents, relatives raising other family members children. In addition we see a wide variety of clients who do not have serious diagnoses, but who encounter problems of living such as partner relationships, issues with aging parents, parent child-problems etc. We also counsel people with mild to moderate depression and/or anxiety.

Several years ago, the Rockland County Office for the Aging (OFA) contacted VCS and asked that we consider expanding our services to a new population group, using a slightly different counseling model. OFA was concerned about the growing number of frail and infirm elderly people who had difficulty leaving the home for services and were in need of counseling support.

In response, we developed our 'Outreach to Elders' program providing short term (8-12 sessions) in-home counseling, using the skills of professionally trained and supervised volunteers. The service is underwritten by OFA, and is therefore free to all who qualify.

Rockland Seniors have issues that are growing all too familiar across the country. Many live far from other family members. Family members who live close by are often working full time and somewhat unavailable. Rockland County is fairly unmanageable without a car. Public transportation in Rockland is a serious problem and the county sponsored TRIPS bus cannot accommodate individual schedules. Seniors who need to stop driving are often at a loss. Affordable housing is quite limited. The cost of living is high. Anxiety about how to accomplish regular tasks can be continuous. Depression and loneliness are epidemic. Disorientation may ensue as a corollary of depression or may be a symptom of developing organic problems.

Clients are referred by other agencies or family members that have concerns about the senior. All referred seniors have a 90-minute assessment, in their own home, by a member of the VCS staff who has many years of experience working with the elderly. She determines a plan for the senior. VCS volunteers are trained to accomplish a variety of task depending on the need of the client. Some clients want to talk about their relationships with children, grandchildren or friends and neighbors. Many need help coming to terms with the limits of what they can and can not control within these relationships. Others have withdrawn from social opportunities because of infirmity or depression. Volunteers can act as a link back into the community by offering support, encouragement or suggesting concrete resources that may support the senior's efforts.

Some clients need to express their anger at losing their independence. Others want a chance to tell their life story to an interested listener or want help reconnecting to a faith community. Because certain clients have serious concrete needs, we make referrals to Meals on Wheels, Adult Protective Services, health clinics and psychiatrists. We assist people in getting walkers, Life Alert systems, hearing aids and free computers. Some seniors need support exploring alternative housing options when they can no longer maintain their own home. Some need emotional support adjusting to new living arrangements.

Outreach to Elders is not a substitute for traditional mental health services. People who need full psychiatric assessments, treatments and medications should of course be referred accordingly. (In fact, many of our clients are already seeing a Psychiatrist for medications. Nonetheless, they appreciate having more time to talk than most doctors can manage.) What Outreach to Elders can do effectively is provide an important service to the many clients who really need and want to talk, who can not easily get out of their homes on a weekly basis, and who exist on very limited incomes.

Our experience is that that are always a cadre of people in the community who value and enjoy older people. They have good feelings about being able to be there for an elder who is struggling. They find that participating in this program is a rich learning experience. Some of the counselors have upgraded their relationships with their own parents as a result of working with other seniors.

All of the counselors go through the VCS counselor training program. If they complete the program successfully they are assigned 1-2 cases and then participate in group supervision conducted by the program director and the Clinical Director of the Agency. The group meets every other week for 90 minutes. Counselors are free to call in between meetings for individual supervision if necessary.

Many of the struggles encountered by seniors fall below the level of serious psychiatric problems. Years ago when extended families lived in closer proximity to each other, it is likely that family members might have provided some of the services which our volunteers offer. Unfortunately many seniors are isolated from family and fall back on community services. The Outreach to Elder program makes good use of community resources and could no doubt be replicated in other communities, both rural and suburban, where getting to support services is a significant problem.

As we look toward a coming 'elder boom'. We also know that there is a vast shortage of clinically competent mental health professionals, especially in outlying communities. Using several skilled clinicians to train a cadre of volunteers to work with selected seniors is one creative way to maximize community resources. □

Baby Boomers Are Coming

By Catherine Cavanaugh, LCSW Program Coordinator, Senior Services Putnam Family and Community Services

Catherine Cavanaugh, LCSW

The baby boomers are coming. As this population spike enters the ranks of official senior citizen-dom, all services for older persons will need to expand to meet the greater demand, but there will be a special need for additional mental health services.

Traditionally underserved in mental health,, older adults face severe risks. The New York State Office of Mental Health estimates that nearly 2 million Americans over 65 have a depressive illness and another 5 million, while not meeting the full criteria for a major depression, have symptoms that are associated with an increase risk of suicide. While the elderly make up 13% of the population, they are 18% of suicides. White men over 85 have more than five times the national suicide rate.

Research is demonstrating that health and disability are the most salient factors predicting the onset of mood disorders in the elderly. (Kennedy, 2000) Other issues, such as loneliness or reduced income, may play a part in the process, but functional disability is the most important. Many illnesses associated with aging, including multiple sclerosis, Parkinson's disease, diabetes, arthritis, and heart disease, all entail disabilities that have a high risk for depression, which is often under-diagnosed and under-treated. For those seniors who have four or more disabling illnesses, which is not uncommon, the chances rise to 25% for the development of major depression. (Kennedy, 2000)

Complicating the mental health picture for seniors are the losses experienced. There is the high probability of the loss of loved ones, of life style, of former comfortable and successful roles. Most devastating is often the loss of independence. Trying to cope with unresolved grief and bereavement issues is difficult at any time of life, but especially difficult at a time when physical health and resiliency may be compromised. Grief exacerbates physical illness and interferes with the course of recovery. Losses in later life also tend to increase isolation, to decrease the availability of needed supports, and to increase a fear of dependency. As the disabilities increase, the depression increases, the physical condition worsens and the vicious cycle continues.

However, the cycle can be broken. One recent study shows that 80% of older adults recovered from depression when treated with a combination of psychotherapy and anti-depressant medication. (Older Women's' League, 2005)

When we began Senior Services here at Putnam Family and Community Services as part of the mental health clinic eighteen months ago, we soon realized that we only had begun to scratch the surface in meeting the mental health needs of seniors. Referrals have increased exponentially each month. The most common presenting problem, as expected, has been depression. Adjustment disorders have been a close second.

Service mobility and coordination among professional disciplines are design elements of Putnam Family and Community Services, Inc.'s Senior Services that have proved most effective in reaching out to this population. The core service has been individual interpersonal therapy that addresses the elder's response to dependency, loss, and the realities of aging. The services are mobile and about 70% of our visits are delivered in the home. Home visits have been very helpful in resolving access issues for infirm seniors. They have also addressed the "stigma" often attached to mental health care by the elderly.

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The demographics of older adults show that this population is only going to grow. We know that increased demands are going to be placed on the mental health delivery system in the very near future. Now is the time for the mental health community to begin prudent planning for service expansion.. They are coming; we had better build it.

For further information call (845) 225-2700 ext. 232 □

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the mental health association of new york city, inc.

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We Are Hundreds of Individuals and Organizations Including:

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- Researchers
- Academic leaders
- Consumers
- Older adults
- Advocates
- Public Officials

Our Activities Include:

- Policy Analysis and Development
- Advocacy for Systems Change
- Qualitative Research via Focus Groups
- Promotion of Best Practices
- Fostering Innovations
- Information Updates
- Opportunities for Networking

Presentations on Best Practices include:

- Late-life depression
- Dementia
- Schizophrenia in late-life
- Anxiety disorders
- Substance abuse
- Suicide prevention
- Evidence-based treatment
- Integrating mental health in primary care
- Home health and mental health
- Nursing and adult homes
- Anxiety disorders
- Elder abuse
- And More

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Michael B. Friedman, Chairman
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Meeting The Mental Health Challenges of The Elder Boom

By Michael B. Friedman, Chairperson
The Geriatric Mental Health Alliance of New York

Alliance Formed In Response To Urgent Need

The Center for Policy and Advocacy of the Mental Health Associations of New York City and Westchester formed the Geriatric Mental Health Alliance of New York in December 2003 after a series of discussion groups with over 100 providers from the fields of mental health, health, and aging services as well as researchers, academic leaders, advocates, consumers, and public officials. These meetings revealed vast inadequacies in current geriatric mental health practice and policy and a widespread sense of alarm about lack of readiness to meet the mental health challenges of the coming elder boom.

Will Quality Services Be Available As The Number Of Older Adults with Mental Disorders Grows From 7 Million to 14 Million?

The massive growth of the population of older adults that will take place over the next quarter century has fueled great concern about the future solvency of the Social Security system and of Medicare. Less noticed is the fact that approximately 20% of older adults have diagnosable mental disorders in any given year and that, accordingly, as the population of adults 65 and older grows from 35 million to 70 million, the number of older adults with mental disorders will grow from 7 million to 14 million. Will services be available to meet their mental health needs?

Reasons for Concern

There are reasons for concern. The current system does not do enough to help older adults with mental disorders to remain in the community. It does not provide adequate access to services. Generally services are not designed to respond to the unique needs of older adults. Mental health, health, and aging services are excessively fragmented. There is limited capacity to serve cultural minorities, who will grow from roughly 15% of the elderly population to over 25%.

> The current mental health system does not provide adequate access. Services are often not designed to respond to the unique needs of older adults. Mental health, health, and aging services are excessively fragmented. And there is limited capacity to serve cultural minorities, who will grow from roughly 15 % of the elderly population to over 25 %.

In addition, fewer than 25% of older adults with mental disorders get treatment from mental health professionals. An additional 25% get treatment from primary care physicians, many of whom do not provide adequate care. The rest may get help from family, friends, clergy, and community organizations, but they do not get treatment. What will happen as the population doubles?

Were the size of the helping professions increasing at the same pace, things might not get worse. But in fact, as older adults increase, from 13% to 20% of the American population, the proportion of working age adults will decrease by 5%, creating a shortage of those who could help those older adults who need help.

Of course, the majority of older adults are between the ages of 65 and 75. Most are healthy and have abilities that they can use to help other people. With creative planning, they can become part of the solution rather than part of the problem.

> Fewer than 25% of older adults with mental disorders get treatment from a mental health professional.

Older Adults With Mental Disorders Are A Heterogeneous Population

When most people think about mental disorders among the elderly they think of either depression or dementia. While these are common disorders of old age, the sorts of mental disorders that affect older adults are much more diverse. It is particularly important to distinguish among (1) people with long-term psychiatric disabilities that began when they were young, and who are now aging, (2) people with mental disorders that began in old age, and (3) people who have difficulty meeting the developmental challenges of old age, such as retirement and losses of family and friends.

People with Long-Term Psychiatric Disabilities Who Are Aging

People with long-term psychiatric disabilities have been the primary responsibility of the public mental health system for the past two centuries. Until about 50 years ago, our nation met this responsibility by putting people into institutions. Towards the middle of the 20th century, the United States adopted a policy of serving people with severe psychiatric disabilities in the community and using institutions only as a last resort.

During the first phase of the community mental health movement—"deinstitutionalization"—a few people who would have been in institutions, did well. But most were dumped in the community without adequate services or were taken in by their families, who were not provided with supports to help them manage.

In the late 1970s our nation shifted to a policy of community support and began to make housing, rehabilitation, and case management available while also expanding outpatient treatment services and shifting towards the use of psychiatry units in general hospitals instead of state psychiatric hospitals.

Although still incomplete, the community support program has made a decent quality of life possible for hundreds of thousands of people with long-term psychiatric disabilities. However, the vast majority of its services are designed for working age adults, and they will need to be redesigned as this population becomes old.

Actually, the first concern needs to be assuring that people with serious mental illnesses live long enough to become old. The life expectancy of people with serious mental illnesses is 10 years less than the general population. The reasons for this appear to be their increased risks of (1) poor health –especially obesity, high blood pressure, diabetes, and cardiac and respiratory diseases, (2) accidents, and (3) suicide. It is therefore critical to improve medical care for people with serious mental illness and to develop approaches to prevent accidents and suicide.

> People with serious mental illnesses live ten years less than the general population.

Even without an increase in life expectancy, the population of older adults with long-term psychiatric disabilities will probably grow from about 350,000 people nationwide to 700,000 (150,000 more than the total population in state hospitals in the United States at their peak use in the mid-1950s.)

To avoid unnecessary institutionalization of older adults with long-term psychiatric disabilities, the current community support system will need to be adapted to take into account changes due to aging. For example, people with long-term psychiatric illnesses are also prone to the physical illnesses common in old age. Therefore, linking health and mental health services will be increasingly important as this population ages. In addition housing programs may need to provide more assistance with medication management and with activities of daily living than they do for younger adults. And rehabilitation programs, which are now heavily oriented towards work, may need to be more oriented towards "retirement" in order to respond to the developmental needs of older people.

> To avoid unnecessary institutionalization of older adults with long-term psychiatric disabilities, the current community support system will need to be adapted to take into account changes due to aging.

People with Mental Disorders That Develop in Later Life

Mental disorders that develop in later life range from those that are as disabling as long-term, severe mental disorders to those that are distressing but not disabling.

At the more severe end of the spectrum are the dementias—which affect 6-7% of people over the age of 65, but which increase dramatically as people age. (The prevalence of dementias doubles every five years beginning at age 60.) Many people with dementia also develop anxiety and/or depressive disorders; sometimes treating these disorders reduces cognitive impairment.

In addition there are psychotic conditions that develop in late life, including late-onset schizophrenia and paranoid conditions. Many of the behavioral problems which can make older adults difficult to serve such as distrust, refusal to adhere to treatment, belligerence, and social isolation may reflect undiagnosed and untreated paranoid conditions. Such behavioral problems are major contributing factors to placement in nursing homes. Mental health services will, therefore, be key to current efforts to reduce the use of nursing homes and to provide home and community-based care instead.

> Since behavioral problems frequently cause older adults to be placed in nursing homes, enhanced mental health services are key to reducing their use and to provide home and community-based services instead.

The most common mental disorders of old age are anxiety and depression. Approximately 15% of older adults have anxiety and/or depressive disorders, which often contribute to severe social isolation and

see Challenges on page 25

Challenges from page 24

inactivity. These symptoms in turn often cause deepening anxiety and depression—a vicious cycle that is difficult to break.

Depressive disorders contribute to the high rate of suicide among older adults. Overall adults 65 and older are 50% more likely to commit suicide; this rises to 600% in white men 85 and older.

Many people with anxiety and depressive disorders do not go to mental health professionals for help because of a sense of shame and embarrassment, because of ignorance about mental illness and effective treatment, and because they often cannot, or will not, leave their homes. For this population it is critical (1) that the mental health system be more mobile—that mental health professionals go to people in their homes and community settings where they are comfortable rather than waiting for them to come into the office and (2) that there be better linkages between mental health and both primary health care and home health care providers.

People Who Have Difficulty Adapting To Developmental Changes in Late Life

Becoming old involves many changes in social roles, abilities, and relationships including retirement, loss of status and respect, caregiving responsibilities for very old parents or for grandchildren, decline of physical or mental abilities, and increasingly frequent deaths of family and friends, and preparing for one's death.

Although the developmental challenges of old age do not necessarily result in a diagnosable mental disorder, they do often stir up considerable emotional distress for which people can get help. In addition, prevention of developmental distress may be possible through such activities as retirement planning, family life education, and changes in lifestyle.

Older Adults with Mental Disorders Usually Also Have Chronic Physical Conditions

Older adults with mental disorders almost always also have chronic physical conditions—for three reasons. (1) Most older adults develop chronic physical conditions such as hypertension, arthritis, diabetes, etc. People with mental disorders are at least equally susceptible to the frailties of old age. (2) Some mental illnesses create greater risks of developing physical conditions. For example obesity, high blood pressure, diabetes, and heart conditions are associated with serious mental illness. (3) Many physical illnesses have psychological correlates. People with cardiac disease, dementia, Parkinson's Disease, and other serious illnesses are also at greater risk of anxiety and/or depressive disorders and of cognitive impairment, sometimes of psychotic proportions.

For this reason integrated treatment of health and mental health conditions becomes increasingly important as people age. This can be done in several ways: (1) incorporate mental health professionals into primary care practices, (2) enhance the ability of primary care providers to identify and treat mental disorders, (3) incorporate mental health expertise into home health services, (4) improve linkages between mental health and specialty services such as cardiology and neurology, (5) incorporate health and mental health services in community settings such as senior centers and social service programs in naturally occurring retirement communities (NORCs), and (6) especially for people with long-term psychiatric disabilities, incorporate physical health care into mental health settings where they are already being served.

> Older adults need mental health services that are more mobile and better integrated with primary and home health care and with aging services.

Family Caregivers Are The Major Source of Support

Family caregivers are the major source of care and support for people with mental or physical disabilities, whether old or young. A study of family caregiving in 1997 estimated that the economic value of their services was nearly $200 billion (the equivalent of about 18% of health expenditures in the United States that year.)

But the economic value of the caregiving does not begin to measure how much family caregiving adds to quality of life.

In the context of the needs of older adults, we tend to think, of course, about the care provided by younger family members for older family members. And this is indeed critical.

But we need also to be aware that older family members provide considerable care for younger family members. Older adults with grown children with long-term psychiatric or developmental disabilities frequently provide care until they become too disabled to do so or die. In addition, grandparents raising their grandchildren have become increasingly common in the United States.

Caregiving takes its toll on the family members who provide it, increasing their risk of anxiety and/or depression and of physical illnesses. Therefore, support for family caregivers needs to be included as a core component of any service system designed to meet the mental health needs of older adults.

Problems of Access Are Widespread

Many older adults with mental disorders or their families encounter difficulties getting service because (1) services are in short supply, (2) they cannot afford them, (3) they cannot travel to places where services are provided, and (4) service providers cannot speak their language or otherwise understand their culture.

> Shortages of competent providers, high cost of care, difficulty traveling to appointments, and lack of cultural competence impede access to care.

Ignorance, Stigma, and Ageism

In addition older adults, their families, and their primary care physicians frequently choose not to seek mental health services. In part this reflects ignorance about what mental illness is, that it can be treated effectively, or where to go for treatment. In part this reflects a denial of mental illness rooted in a sense of shame and embarrassment. And in part their choice reflects ageist assumptions common to our society—beliefs that, for example, depression or severe cognitive decline is a normal part of aging, which they are not.

Workforce Shortage

There is a substantial shortage of mental health professionals who are trained to serve older adults. To address this shortage there will need to be incentives to become geriatric mental health professionals, better education in professional schools, and on-the-job training initiatives.

However, it is extremely unlikely that there will ever be enough geriatric mental health professionals. It will be necessary, therefore, to make innovative use of paraprofessionals and volunteers, especially of people who are themselves old, but who can become an important part of the workforce serving older adults with mental health problems.

Clergy, who can help to respond to the spiritual concerns of older adults, could also help with mental health issues, if properly trained.

> The majority of older adults are between 65 and 75. Most are healthy and able. With creative planning, they can become part of the solution.

Research

The greatest hope for being able to meet the mental health needs of the elder boom population is a major research breakthrough. Unfortunately there has not been a substantial investment in research regarding geriatric mental illness nor has there been an adequate effort to translate what is known from research into practice. To address these shortfalls, the federal government should develop a long-term plan for research and technology transfer regarding geriatric mental health, and NYS should encourage its research institutes to focus more efforts on this area.

Financing Problems

Financing problems are a major cause of underservice of older adults with mental disorders. These problems relate not only to the amount of funding that is available but also to a number of structural problems.

In general, current funding models do not support the use of best practices and innovative services and do not promote integrated service delivery.

Specific issues include:

- The use of only a fee-for-service, medical model for reimbursement by Medicare and private insurers
- Lack of equal coverage of health and mental health conditions ("parity") by Medicare and private insurers
- Lack of reasonable funding for home and community-based services among all payers
- Restrictions on the expansion of mental health programs that use Medicaid as a source of support
- Inadequate prescription drug coverage.

> Current funding models do not support the use of best practices and innovative services and do not promote integrated service delivery.

Lack of Governmental Readiness

Some progress has been made in gaining recognition of the importance of geriatric mental health issues. For example, the Federal Administration on Aging issued a major report on geriatric mental health a few years ago, and the Substance Abuse and Mental Health Administration (SAMHSA) has established a section on geriatric mental health and has begun to give grants. In New York State, The Office of Mental Health has committed to develop a long-term plan regarding geriatric mental health and to organize a "roundtable" on how to promote integration of health and mental health services.

But much remains to be done to improve the quality of services currently provided and to prepare to meet the mental health challenges of the elder boom. The Geriatric Mental Health Alliance's Ten-Point Agenda for Change is on the next page. □

Meeting The Mental Health Challenges Of The Elder Boom
A Ten-Point Agenda For Change

In addition to challenges related to the future viability of Social Security and Medicare, the elder boom will create challenges related to meeting the mental health needs of older adults. The Geriatric Mental Health Alliance of New York has developed the following ten-point agenda for change in response to these challenges.

1. **Enable older adults to remain in, or return to, the community.**

- Adapt the mental health system's community support program to the needs of older adults with long-term psychiatric disabilities including:
  - Efforts to increase life expectancy through improved medical care, suicide prevention, and accident prevention
  - Increased and enhanced housing programs
  - Modifications of rehabilitation programs consistent with the developmental needs of older adults.
- Enhance the capacity of home and community-based mental health, health, and aging services to respond to the psychological and behavioral problems that frequently result in avoidable placements of disabled older adults in nursing homes.

2. **Improve access to services** through

- Service expansion
- Increased mobile and community and home-based services
- Enhanced cultural competence
- Increased affordability.

3. **Improve quality of services** through

- New models of community based services,
- Improved and expanded mental health services in adult and nursing homes
- Standards and guidelines related to the specific needs of older adults
- Enhanced suicide prevention efforts
- Increased competence of mental health, health, and aging services personnel through:
  - Training
  - Dissemination of best practices
- Increased research on geriatric mental health and improved translation of research findings into practice including:
  - A Ten-Year Geriatric Mental Health Research Plan for NIMH and other federal research agencies
  - Increased geriatric mental health research at NYS research centers

4. **Integrate mental health, health and aging** services using a variety of approaches including:

- Incorporation of mental health professionals in primary and specialty care settings
- Incorporation of primary health care in mental health settings
- Linkages of home health and mental health services
- Incorporation of mental health and/or health personnel in service centers for the aging
- Disease and case management models

5. **Increase the capacity of the system to serve cultural minorities** through increased outreach, home and community-based services, and enhanced cultural competence, especially bilingual bicultural personnel.

6. **Provide support for family caregivers** including:

- Caregivers of older adults with mental and physical disabilities
- Older family members caring for adult children with mental disabilities
- Grandparents raising grandchildren

7. **Provide public education** to address issues of
- Stigma,
- Ageism
- Ignorance about mental illness, the effectiveness of treatment, and where to get treatment.

8. **Organize a workforce development initiative** to increase the supply and quality of geriatric mental health, health, and aging service providers including:

- Incentives to become geriatric mental health professionals, especially for people who are bilingual and bicultural
- Work with professional schools to prepare their students to serve older adults
- Training for mental health, health, and aging services providers as well as clergy and others to whom older adults turn for help regarding geriatric mental health.
- Make innovative use of paraprofessionals and volunteers, especially older adults.

9. **Design new finance models** that will

- Support best practices and innovative services that are responsive to the unique mental health needs of older adults
- Promote integrated service delivery
- Provide parity, and
- Create incentives to enhance the workforce.

10. **Promote governmental readiness** to meet the mental health challenges of the elder boom including:

- Designated leadership in appropriate federal, state and local agencies;
- Interdepartmental structures; and
- Long-term planning.

Support A Federal And A State Comprehensive Geriatric Mental Health Act

A Unique Haven For Seniors With Persistent Mental Illness

By Daphne Balick and Susan Jacobs, LMSW, The Guidance Center

Did you ever wonder what resource options are available for seniors with severe and persistent mental illness? Where can seniors who have lost their family, caretakers or support network reach out for help? Where can seniors with chronic schizophrenia or depression (who spent decades in psychiatric hospitals that have since been closed down) go and what support is out there to teach them to cope with living alone?

In Westchester, The Guidance Center offers a unique day program called STEP (Supported Treatment of Elderly Persons) for these seniors. In a cheerful, home-like atmosphere 25 seniors from Central and Southern Westchester can forget about their emotional stresses, often accompanied by physical illness and disabilities. The center is open 5 days a week and offers a rich assortment of programs and free home-cooked lunches prepared at the site.

"The STEP program offers services based on the idea that anyone, regardless of age or functional level, is capable of sustaining growth, and organizing his/her own life while prioritizing his own goals," explains Michael Kamen, LCSW, the Program Director. "Patience, respect, therapeutic support and the importance of human connection are the cornerstones of the STEP philosophy. We stress the belief that people can and do recover from mental illness," adds Susan Jacobs, LMSW, the beloved coordinator of the activities at the center. There is something for everyone offered each day to meet a variety of interests and abilities; no one is left out. Group discussion on the range of options regarding housing, education, work, social opportunities, the effects of medications, and stress reduction allow clients to make informed choices about their lives. The program offers much more than traditional therapeutic services. Activities include weekly music, art, creative dance, and yoga classes. Trips to malls, cultural performances, libraries and frequent BBQ outings every summer add a holistic dimension to the STEP experience.

"Transforming things happen here," says art therapist Janet Getler, who has led the art therapy workshops at the center for the past nine years. M., a quiet man of 70, has difficulty with his speech, but through his colorful watercolors and oil paintings he reveals the beauty and textures of the everyday objects he encounters: bottles of Coca-Cola, a bag of peanuts, a wooden cross. "I always write a message on the picture," he says. He makes cards for everyone for every occasion.

When she first came to STEP, P. was withdrawn, socially isolated and she never smiled. She could not read or write and has trouble enunciating words. When first introduced to a sewing machine, P. did not know the concept of straight and her stitches zigzagged in every direction. Once she was coached in sewing her first dress, P.'s world transformed. As P. creates her own vivid expressions, the glowing smile never leaves her face. P. keeps a rag doll she made at STEP by her pillow to remind her of her favorite class and the new friends she has made through working together.

"The weekly yoga classes I started here two years ago have changed my life and helped me live pain-free. There were many movements I could not do, but with the direction of the instructors I can now do them properly," shares L. who has suffered from continual back pain, arthritis and poor circulation. L. also participates in the Creative Dance class. Contact exercises and creative role play in movement allow her to have fun while learning more about herself and the ways she relates to others. Last year she started tutoring P., who lives in the same group home, to learn how to read children's books, thanks to the Literacy Volunteers of Westchester certification classes offered here. P. is most responsive and is busy creating colorful illustrations for some of the stories they read together.

"At first I felt like I did not belong here, I could not fit in," shares R., the most recent newcomer who came to STEP after losing his long-time job and his home. "But with the encouragement of peers and staff to give it a chance, the daily activities at STEP have become an important part of my life and give purpose to each day," he explains. At STEP the isolation and fears of mentally ill seniors have been replaced by ongoing supportive programs and a sense of community which has prevented deterioration and relapse in many of the individuals. □

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The Mental Health News

New York City Section

Mental Health Care for Older Adults in the 21st Century

By Zvi D. Gellis, PhD, Director
Center for Mental Health and Aging
State University of NY at Albany

As the population continues to grow older in the United States, the need for assistance with chronic illness, financial, caregiving, and psychological concerns also increases. According to the U.S. Census, this is particularly significant between the years 2010 and 2030, when older adults (65 years+) will account for 20 percent of the total population, up from 13 percent. Added to this trend is the increasing proportion of minority older adults including African-American, Hispanic, and Asian-Americans. Due to this rapid growth, strategic planning to meet the call for geriatric mental health services is crucial since older adults consume a disproportionately large share of health care and social services.

Mental health problems in later life will also increase as the population ages and will demand more attention to minimize their effects on disability and the quality of life. Older adults with mental health problems are likely to have relatively longer life spans in the future due to expected advances in treatments, and healthier aging lifestyles. Given the problems of cognitive decline, and physical illness on daily functioning,

Zvi Gellis, PhD

understanding the factors associated with positive mental health in later life assumes great importance as an issue for public health.

The majority of older adults are healthy, however nearly 20 percent of those 60 years and older experience mental disorders that are not part of aging. Common disorders in this group are anxiety disorders, severe cognitive disabilities, and mood disorders such as depression. The development of schizophrenia during late life is rare but a significant number of persons diagnosed with this disorder as young adults do grow old.

Psychiatric disorders in older adults are quite prevalent. Inadequate recognition and treatment of these problems have important effects on social service and mental health service use, and on the allocation of health care resources. The provision of mental health care to older adults with severe mental disorders poses a unique set of challenges to human service providers. Barriers to the provision of care exist at both the individual and system levels. Many older adults are reluctant to seek mental health services due to stigma, denial of problems, service access barriers, language barriers, or a lack of culturally- sensitive programs. Sometimes older adults do not receive appropriate care when they do seek help due to fragmented mental health services, a lack of training or knowledge about geriatric mental health issues in primary care, or gaps in services. Likewise, there is a critical shortage of professional staff trained in the geriatric mental health field to meet this looming national public health crisis.

Older adults are seriously underserved by mental health service systems across all care settings. Current estimates of the incidence of mental illness among older persons range from 15 to 25 percent yet only about 2.5% receive assistance from traditional mental health services and another 2% receive help for mental health problems from their primary care physician. Research suggests that the rate of emotional disorders among baby boomers exceeds the rate among the current cohort of older persons. The large anticipated growth in the number of older persons makes the provision of mental health services to older adults increasingly important. Combining this growth with an increased rate of emotional disorders magnifies the problem.

Major Depression is a common and disabling disorder in older adults. Researchers estimate that 7% of older medical patients meet criteria for Major Depression. Alcohol abuse is a less common disorder in older patients, yet it is becoming an increasingly detrimental disorder in older patients, with rates varying between 3 and 10 percent for abuse, 17% for problem drinking and between 10-22% for daily drinking. In addition, alcohol abuse in older adults is often comorbid with other psychiatric disorders such as depression. While the literature is still preliminary, as many as 12% of older adults with Alcohol Abuse also have a comorbid Mood Disorder. Depression and alcohol abuse are also costly illnesses. Direct medical costs of depressed patients are approximately 50% higher than those on-depressed controls matched for age, gender and severity of medical problems.

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Court Denies NYC's Attempt to Cut Care to Mentally Ill Inmates Previously Guaranteed By Brad H. Settlement

Urban Justice Center & NY Lawyers For The Public Interest

Over two years ago, the City settled Brad H. v. City of New York and agreed to stop discharging inmates with mental illness at Queens Plaza in the middle of the night with no medication and nothing but $1.50 and a Metro Card. Under the settlement, the 25,000 people who receive treatment for mental illness in City jails each year are entitled to services upon release, such as continued mental health care, medications and prescriptions, substance abuse treatment, case management, public benefits including Medicaid and Public Assistance, housing, and transportation.

Since signing the settlement, the City has refused to provide any discharge planning services in the psychiatric detention wards at Bellevue, Kings County, and Elmhurst Hospitals. People with psychiatric disabilities who are so severely ill as to need treatment in a hospital are taken to these psychiatric detention wards operated by the Department of Correction and New York City Health and Hospitals Corporation.

The Court rejected the City's argument that these inmates are not covered by the settlement stating, "Those units contain inmates treated for psychological problems who are probably most in need of discharge planning due to their serious functional impairments. To interpret the agreement otherwise would prevent these most needy individuals from securing discharge planning that they particularly require, and is inconsistent with the overall purpose of the stipulation of settlement which is to give those inmates the discharge planning which they are entitled to receive and as a consequence reduce crime."

"I am frustrated that the City has focused its energy on finding ways to avoid providing services to people who are most in need of assistance connecting with treatment, medication, benefits, and housing," states Jennifer Parish, Director of Criminal Justice Advocacy at the Urban Justice Center, one of the organizations that filed the lawsuit. "If the City would put its energy into ensuring that inmates with mental illness have the treatment and services they need instead of litigation, everyone would be better served."

"It is long past time for the City to turn over a new leaf. For everybody's sake, it needs to stop fighting its obligation to provide discharge planning so that inmates who are mentally ill can continue their treatment after they are released from jail. Nobody wins when the City resists or fails," says John A. Gresham, Senior Litigation Counsel at New York Lawyers for the Public Interest, which is also part of the team representing the inmates. "We all need our officials to take to heart a mission of decency and common sense. This will benefit everyone, reduce illness and suffering, and save money by avoiding re-arrests and re-hospitalizations."

Contact: Jennifer J. Parish, Director of Criminal Justice Advocacy, Urban Justice Center Office, jparish@urbanjustice.org : John A. Gresham, Senior Litigation Counsel, New York Lawyers for the Public Interest lgresham@nylpi.org □

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Depressive disorders can be persistent, intermittent and/or recurrent and result in significant physical and psychological comorbidity and functional impairment that negatively influences the course of depression. Older individuals often develop depression in the face of one or more general medical conditions. Depression with physical illness increases levels of functional disability, use of health services, and health care costs particularly among older adults and also delays or inhibits physical recovery.

The literature on the efficacy of treatment for Major Depression is more prevalent than it is for older Alcohol Abuse. Several psychosocial interventions have been demonstrated to be effective among older adults, particularly those persons who reject medication or who are coping with low social support or stressful situations. Evidence-based approaches including structured cognitive behavioral therapy (CBT), interpersonal (IPT), and problem-solving treatment (PST) are effective alternatives or adjuncts to medication treatment. Therapeutic effect sizes from efficacy trials for treating depression with antidepressants are 18% when compared to placebo control, and 26% for psychotherapy when compared to no treatment control indicating that these are beneficial treatments for late-life depression. In short, there is considerable evidence showing that Major Depression can be treated in older people.

Even though there are efficacious methods for treating Major Depression for older adults, only 5% of older adults in need of mental health services are ever seen in the mental health sector. Instead, older adults prefer to seek help from the primary care sector and are therefore more likely to be identified and treated for their physical problems in their doctor's office than they are in the mental health setting.

Anxiety disorders also appear to be a common class of psychiatric disorders among older people, more prevalent than depression or severe cognitive impairment. Prevalence rates range from 0.7% to 18.6% for all anxiety disorders of individuals at least 65 years and older, with Generalized Anxiety Disorder (GAD) and phobias being the most common. Other researchers summarized the prevalence of various anxiety disorders in older community-based epidemiological samples as follows: phobias, including agoraphobia and social phobia, 0.7 - 12.0%; GAD, 1.1 - 7.1%; obsessive-compulsive disorder, 0.1 - 1.5%; and panic disorder, 0.0 - 0.3%.

Anxiety disorders are frequently comorbid with depressive disorders in older adults. Researchers have estimated the prevalence rate of anxiety disorders at 47.5% among community-residing older adults with depressive disorders. Older persons with anxiety and depression present with greater somatic symptoms, high levels of disability, and higher suicidal ideation. Findings of a relationship between anxiety and cognitive disorders such as Alzheimer's disease or vascular dementia are mixed. Older adults with dementia are found to have symptoms of both anxiety and depression but rarely anxiety alone. Changes in memory function and increased confusion may also produce anxiety symptoms. Medical conditions may also present in older adults with GAD such as hyperthyroidism, congestive heart failure, and chronic diseases and symptoms of a medical condition may be misinterpreted as anxiety.

Anxiety symptoms and disorders are associated with increased disability, lower levels of well-being, and inappropriate use of medical services among older adults. Primary care patients with untreated anxiety report functioning and well-being levels within ranges characteristic of patients with chronic physical diseases. Comorbid medical conditions such as hypoglycemia, hypertension, and coronary heart disease can be worsened through chronic stress and anxiety. Compared with men reporting no symptoms of anxiety, men in the Normative Aging Study reporting two or more anxiety symptoms, had elevated risk of fatal coronary heart disease. Higher levels of anxiety have been associated with greater use of pain-relieving medications and more postoperative disability days for surgical patients.

Anxiolytic medications, including benzodiazepines, are the most common treatment for late life anxiety. Epidemiological data suggest that benzodiazepine use among the elderly is approximately 14%, higher than the rates for younger adults.

Antidepressant medications such as selective serotonin reuptake inhibitors (SSRIs) are often used to treat anxiety in later life since they have a lower side effect profile. However, SSRIs have not completely replaced benzodiazepines as a treatment for anxiety in older people. Benzodiazepine use among older adults decreased somewhat over a 10-year period in one recent investigation, although approximately 10% of those over the age of 65 were still taking benzodiazepines in 1996.

Available empirical data on the psychosocial treatment of late life anxiety is currently limited and therefore firm conclusions cannot be drawn. Many studies have used community or senior center volunteers. For example, some researchers found significant effects on subjective anxiety for relaxation and relaxation with meditation over cognitive restructuring and pseudo-relaxation conditions. These gains were maintained at one-year follow-up. Another group of investigators compared the efficacy of four sessions of individual progressive relaxation (involving tensing and releasing muscle groups) or imaginal relaxation (no tensing required) to a wait list control condition among a group of older adult volunteers who reported subjective tension or anxiety. Both active conditions significantly reduced state, but not trait, anxiety and miscellaneous psychological symptomatology relative to the control condition; neither active condition was superior to the other.

Another research group compared cognitive therapy with non-directive supportive therapy for late life generalized anxiety disorder. Participants reported benefit in both conditions though no significant differences between groups on measures of anxiety and worry were found. The current scientific research provide some beginning evidence for the utility of cognitive behavior therapy for anxiety disorders though more confirmation and study is required.

It is clear that there is a need for coherent public policy that integrates the needs of older adults within their families and social support systems. Unless society finds better ways to ease the burden and cost of psychiatric diseases for those who are afflicted and their families, there will be an exponential growth of a large population who are not only at risk for mental illness but also less able to care for themselves. Thus, caring for a growing aging population is creating a public health crisis. □

The MHA of Nassau County Initiates Geriatric Mental Health Project

By Steve Greenfield, Executive Director
MHA of Nassau County

Steve Greenfield

Like many of New York's counties, Nassau County is in the beginning stages of an "elder boom." Older adults are the fastest growing segment of our population. In fact, Nassau has a larger percentage of people over age 65 (15%) than does New York State (12.9%).

This same trend is true for seniors with mental health disorders. While other segments of Nassau's population with mental health disorders will decline over the next thirty years, there will be an enormous increase among the elderly. It is anticipated that while the number of children (10-19) will decrease by 17.1% and the number of adults (20-54) will decline by 13%, the number of adults over age 55 will increase by 60% over the same time span. These numbers indicate an urgent need to prepare our local mental health system to meet the ever-growing needs of the elderly including a growing proportion of seniors from minority cultures.

To meet these needs on Long Island, the Mental Health Association of Nassau County is embarking on a special project with the assistance of a challenge grant from the Long Island Community Foundation, a division of the New York Community Trust.

Our goal is to raise awareness of the mental health needs of the elderly and to promote planning here in Nassau County with outreach to partners in Suffolk County. We have begun to assess these needs by interviewing agencies, organizations, advocates and seniors themselves. The MHA is also seeking assistance from County departments many of which have already expressed interest in this important issue. Marcia Feuer, MHA's Director of Public Policy, stated "In meeting with others, we are finding a growing recognition of the unmet mental health needs of older adults and the willingness of providers to work together to address these needs."

Our MHA is collaborating with Adelphi University's School of Social Work on this project. Adelphi will undertake necessary research and analyze information gathered from focus groups. In the near future, we hope to set up training events, public education programs and discussions with our legislators to address the public policy implications of the growing need for mental health services for seniors.

We plan to form the Nassau Geriatric Mental Health Alliance this Spring. The objectives of the Alliance will include:

- Building a network of people from varied backgrounds who have an interest in meeting the needs of seniors with mental health needs,
- Promoting integration of training and services between mental health and physical health providers,
- Seeking ways to reduce and prevent the incidence of mental illness in the senior population,
- Reducing the ignorance, stigma and discrimination related to mental illness and educating the public about the effectiveness of treatment,
- Advocating with local and state governments to include elder services in their planning,
- Identifying and reaching out to partners in Suffolk County to form a broader Long Island-based alliance,
- Presenting a series of trainings based on best practices for mental health professionals and other professionals from areas such as aging and health,
- Planning a downstate conference on the issue of geriatric mental health in collaboration with the Geriatric Mental Health Alliance of New York.

We are joining similar efforts underway in other areas of the State most notably by the Mental Health Geriatric Alliance of New York State led by Michael Friedman. Michael and his staff have done a terrific job over the past year of bringing this important issue to the forefront of the mental health system. We are excited to expand the effort on Long Island. The combined efforts of the Geriatric Mental Health Alliances of Westchester, New York City, Nassau and elsewhere aim to promote proper consideration of the neglected and growing needs of elder New Yorkers.

For too long, the mental health system has been one to react to crises instead of taking steps to prevent them. Today we have an opportunity to be proactive. It is a fact that our Country is aging and there will be more mental health needs than ever before. By planning now, we hope to be ready to meet the challenges that face our seniors now and in the coming decades. □

Help For Daughters and Sons Of a Parent With a Mental Illness

By Stasia Pasela
Daughter and Sons Group Facilitator
NAMI NYC Metro

Do you have a parent with a mental illness? Perhaps you have a loving family, friends, a great therapist but, you feel they just don't fully understand your burden, frustration, hope, exhaustion, or fear. "Daughters and Sons" is a NAMI support group where you can share, in confidence, any issue related to having a parent with mental illness.

"Daughters and Sons" is a NAMI sponsored group of men and women, age 20 to about 75, who meet monthly to learn information and gain support. Our situations are all different -- some live with parents, some do not speak with their parents; other parents have died or have no insight that they are ill -- yet our experiences are similar. Members give one another thoughtful feedback revealing creativity and courage. After all, how many people can say they saved a life? How many people can say their love, advocacy, and partnership with their parents changed lives?

Members discuss a wide range of issues -- our frustrations to keep our parents safe, how to help them advocate health care, and our feelings about what we lost when our Mother or Father became ill. We celebrate resilience and acknowledge skillful advocacy. Our group encourages self-care; time to rest and feel relief when a danger is removed. Daughters and sons are often driven to search for cures, forgetting that the best medical practitioners don't even have our answers. The reality is many people with mental illness die and too many people fall between the 'cracks'. We know what happens; we live it along side our parents, our lives changing with each episode, relapse, and recovery.

We are astounded to hear among our group the years of suffering without medical care. We have feared symptoms and lived under stress of impending danger and relapse. We "tough it out" and get through life, hyper-vigilant, strong with a little extra adrenaline. Even with our best efforts, the collective strain may compromise our own health, welfare, and erode of our relationships. People who write books about families say that many seek treatment for stress, depression, and anxiety. Less discussed is that love, education, and advocacy on behalf of a parent can also greatly heal the daughter or son. We love and protect our parents. Love is most important! No social service program, doctor, or drug, can replicate the love and pride a child brings to a parent. There is a strong bond, parent-to-child, as co-survivors of mental illness. The resilience of our parents can be learned or perhaps inherited – and some of our lives have depended on it.

In the group we find freedom to share family memories both sad and happy. We often laugh discovering similarities in our coping strategies—how clever we talk about our family, skillfully erasing the 'mentally ill' part of the story. We protect our parent's privacy, dance around the stigma, and smile courageously.

To participate the Daughters and Sons support group call the NAMI Helpline at (212) 684-3264. The facilitator will phone you back. The support group meets monthly on a Monday evening at the NAMI-metro Office, 505 Eighth Avenue, (35th and 36th Streets.) There is no charge to participate.

Not able to attend on a Monday? Call the Helpline for other resources. NAMI NYC Metro offers 20 support groups a month. (212-684-3264) All are free of charge. Also, NAMI's on –line community discussion offers support www.nami.org under "find support" or type "daughters and sons" in the search box. □

Social Work Challenges With Elderly Clients With Mental Illness

By Susan Winston, LCSW
Manager F.E.G.S.
Rego Park Counseling Center

The fastest growing population in the United States is seniors over the age of 85. In the United States, our elderly face many challenges that are even greater for those suffering from mental illness. According to The Merck Manual of Geriatrics, "The over-85 group currently accounts for about 12% of all elderly and is projected to account for 18% by the year 2040. Centenarians are increasing from 50,0000 persons in 1996 to an estimation of 447,000 by 2040." The average number of years a person can be expected to live fairly free of physical or cognitive disability is now 77 for men and 81 for women. This has many implications for the needs of or increasing elderly.

Innovations in medicine, pharmacology and other healthcare services have reduced mortality and morbidity rates As a result, hospital stays have been sharply reduced, prompting an expansion of needed community-based services. This includes home care medical and home-attendant services, social work and psychiatric supports, senior centers for socialization and recreation, medical day programs, medical care, hospice care, and more. More seniors are staying at home rather than relying on institutional care. Social work challenges include addressing clients' problems, such as: increased social isolation, restricted mobility, elder abuse, chronic pain, substance abuse (alcohol and tranquilizers are most prevalent substance abuse in the elderly), physical impairment, and symptoms of mental illness that can impact on coping skills, judgment, and the ability to manage life independently. An increasing number of senior adults are living alone.

Due to increased longevity, seniors are often faced with inadequate savings and income, plus increasing cost of living expenses. This can pose a significant psychosocial stressor as well as a serious threat to day-to-day existence. High medical co-payments, spend-downs, and prescription costs can be obstacles to needed medical care.

At the F.E.G.S. Rego Park Counseling Center, we provide a variety of psychosocial and psychiatric services for families, children, adolescents, and adults. We service a large elderly population, many of whom are monolingual Russian speaking and who have significant psychiatric, medical and psychosocial impairment. To meet the changing needs of our elderly population, we have developed special services that include: a resource program for refugees requiring assistance with translations, concrete services), entitlements, and linkages to other needed services. We have a large bi-lingual staff of social workers, psychiatrists, and other support staff who are linguistically and culturally competent to meet the needs of the community we serve. Behavioral health home visiting is provided for the frail elderly who are unable to travel to the clinic.

An illustration of the special needs of the elderly served at F.E.G.S.

Mrs. M. is a divorced immigrant from the former Soviet Union, with a history of psychiatric hospitalizations due to severe depressive episodes. The stress of immigration exacerbated her symptoms and prompted her to seek services. She reported an inability to leave her bed, attend to her usual daily activities such as bathing, eating, and getting proper sleep. She was provided with individual psychotherapy and medication management to help her depression and increase her coping skills. Although she became psychiatrically stable with improved daily functioning, her medical health deteriorated. She was diagnosed with hepatitis C, high blood pressure, and asthma. Her depression worsened during chemotherapy treatment prescribed for her hepatitis condition. This is a common problem in the elderly where medications can have adverse psychiatric and physical symptoms, complicating the treatment plan. In this case, the client stopped taking her psychotropic medication, her severe depression returned, and a prolonged psychiatric hospitalization followed.

Challenges for the social worker included: collaborating with the patient's various medical and psychiatric providers, monitoring medication, and medical treatment compliance and linking her to a Medical Day Program that could provide daily medical and social and support as well as attend to her activities of daily living. Collaboration and coordination were key to the success of this individual.

Mr. B. is a 73-year-old married man from Uzbekistan who suffers from dementia with depressed and psychotic symptoms. Due to significant symptoms of high blood pressure, diabetes and dementia, travel to the clinic was an obstacle. His wife also suffers from medical and psychiatric problems and both have difficulty attending to daily living skills. In collaboration with the client's medical doctor, a home attendant was arranged to assist with housekeeping, shopping and meal preparation, as well as monitoring medication compliance. A home-visiting psychiatrist was able to prescribe medication to address depressive and psychotic symptoms. The social worker provided therapeutic support, psychiatric and psychosocial monitoring, and coordination with providers as well as intervention to address depression, and coping skills. Cognitive remediation was provided to help client organize and adapt to declining cognitive functioning.

see Social Work on page 45

Specialized Mental Health Services At Senior Centers

By Nancy Harvey, Executive Director
New York Service Program for Older People

Older adults face a myriad of mental health issues – depression, anxiety, social isolation, and the emotional losses associated with aging. They must also confront their physical decline and cope with a range of stresses that can have serious consequences on their mental health. Seniors often survive on small fixed incomes, must deal with complex health care organizations, and the burden of taking care of their own aging parents or spouses.

While there are effective treatments for most psychological illnesses in older adults, only 22.5% of seniors with mental illness receive treatment from mental health professionals. (U.S. Dept. of Health and Human Services, Older Adults and Mental Health: Issues and Opportunities, Rockville, MD: 2001.) Even fewer seniors receive services at home or at community-based centers.

Unfortunately, the cost of not treating mental illness in the elderly is high. Older adults with mental illness are less able to care for themselves or seek care. In addition, untreated mental illness can directly contribute to the development of physical illness. (HHS, 1999.)

Several obstacles prevent older adults

Nancy Harvey

from receiving mental health services. First, seniors are more reluctant to seek out mental health services than younger adults. This is partly due to a generational perception that attaches a stigma to mental health services. Seniors view these services as necessary only for the most extreme cases of mental illness. Second, seniors with low incomes or education levels, such as those who most commonly visit senior centers, tend to shy away from traditional mental health service providers, such as clinics and hospitals, because they may be intimidated by the complex bureaucracy of these providers and because they may previously have had frustrating experiences with other large bureaucracies, such as income maintenance programs, insurance providers, and large hospitals.

In addition, health professionals and social service providers are often unaware of the mental health needs of older people. Signs of mental health problems may be mistakenly attributed to the use of certain medications or seen as a natural part of the aging process. These obstacles point to the crucial need for mental health professionals specifically trained to treat older people's mental health problems.

Providing mental health services where seniors congregate – senior centers, NORC's (naturally occurring retirement communities) – is crucial to ensuring the older adult's access to services. The New York Service Program for Older People, Inc. (SPOP) has developed a model program – Senior Outreach Program (SOP) – for serving the hard-to-reach, and under served mentally-ill elderly. This award-winning program situates social workers at designated senior sites, removing both the geographical obstacles and the stigma that older people attach to receiving help at traditional mental health facilities. If a senior needs counseling and is unable to travel due to physical or psychological illness, the SOP social workers provide counseling at the senior's home. As a result, the SOP provides mental health services to older adults who otherwise would not receive treatment.

The SOP fills a crucial gap in the continuum of mental health services for older adults. Although many senior centers provide case management and health screening, these services do not address the mental health needs of the senior center population. Case managers and health workers are rarely specifically trained in geriatric mental health. In addition, senior center staffs are often overwhelmed with the day-to-day concrete needs of their populations, such as providing meals, running activities, and assisting with emergency needs and entitlements. Often, it is only when a senior center client stops attending activities, that the need for intervention is recognized. Consequently, the mental health needs of the senior center population often fall between the cracks.

By providing mental health services on-site and establishing a regular presence at the senior site, the SOP Social Worker is integrated into the daily activities of the senior site. As a result of the regular presence of the Social Worker, senior center participants transfer their trust from senior center/site staff

see Specialized on page 46

The Graying of Schizophrenia

By Carl I. Cohen, MD
Professor & Director
Division of Geriatric Psychiatry
SUNY Downstate Medical Center

There is a crisis emerging in mental health care: 2% of persons aged 55 and over (1 million people) have severe mental illness (SMI)-- schizophrenia, bipolar illness, chronic depression-- and this will double over the next 25 years. Their numbers have already begun to increase as the "baby boomers" reach late middle age. Within this group, those with schizophrenia represent more than half, and they are among the most impaired. Schizophrenia usually begins in early life, with 85% developing the disorder before age 45. Until the last third of the 20th century, most schizophrenic persons spent their lives in institutions, but advances in therapy and alterations in treatment ideology shifted the site of care: 85% of older schizophrenic persons now live in the community, 13% are in nursing homes, and 2% are in hospitals.

Deinstitutionalization spawned a service system for young and middle-aged SMI that has now become ill equipped to deal with the growth of aging schizophrenic persons. Thus, 35% and 45% of older schizophrenic persons in the community and nursing homes, respectively, receive no mental health services. A survey of psychiatry leaders rated no current geriatric mental health services in their communities as more than borderline adequate. The research community has also neglected this population, e.g., only 1% of the literature on schizophrenia has been devoted to aging.

There are compelling reasons to believe that age-appropriate treatment for older schizophrenic persons could have a major impact on their quality of life. Many of the features of schizophrenia often relent in later life. About half of older schizophrenic persons show improvement or recovery from symptoms such as hallucinations and delusions as well as improvement in social functioning. However, it is a heterogeneous condition, and one-third remain unchanged, and 20% do poorly in later life. Moreover, 40% of older schizophrenic persons manifest clinical depression, and three-fourths have cognitive deficits such as impaired memory or executive functioning. In most cases the cognitive impairment is mild. However, there is an age-related worsening and deficits are more severe than their non schizophrenic age peers. Like other aging individuals, they may develop Alzheimer's disease and other dementias. Importantly, cognitive dysfunction is the most potent predictor of adaptive community functioning. Finally, regarding health care, while the number of physical disorders and the percentage having seen a physician in the past year are similar to non-schizophrenic persons (85%), schizophrenic persons' medical conditions are less likely to be treated. Older schizophrenic persons also have higher mortality rates.

Thus, schizophrenia and aging is a mixed picture, with improvements in many areas and declines in others. Although additional research is needed, there is much that we do know. Even where some elements have worsened over time, nearly all are at least partially remediable. Thus, cognitive deficits may be helped by social skills training and cognitive behavioral treatment. Depression may be addressed by targeting its risk factors such as psychotic symptoms, smaller social support networks, and lower income. There are a variety of methods to augment social supports using indigenous networks, creating new networks through peer groups, or strengthening existing networks by working with families or non-kin linkages. Medications, particularly the newer anti-psychotics and anti-depressives, may help psychoses, diminish negative symptoms (e.g., avolition, anhedonia, paucity of thought), relieve depression, and improve cognitive deficits. Unfortunately, treatment and health financing policies have not evolved to meet the needs of this population.

There are severe restrictions in Medicare coverage. These include a lack of mental health parity under Medicare (e.g., 50% psychiatric co-payment vs. 20% for medical services), limited prescription drug coverage, limits on inpatient psychiatric days, and no coverage for psychiatric services such as adult day care, respite care, residential care, and home health care.

Less than 1.5% of Medicare funding is for geriatric mental health services. Medicaid provides coverage for low-income persons with disabilities. However, many states have restrictions on coverage for prescription drugs, impose limitations on number of mental health visits, and typically reimburse service providers at rates that are 25% below standard market rates.

Conventional HMOs have failed to address the needs of older schizophrenic persons. They make insufficient use of specialty providers and are unwilling to offer the spectrum of services that older schizophrenic persons require.

Also, many insurers have withdrawn from the Medicare HMO market because reimbursement is too low. On the positive side, federal waiver programs have promoted innovative, state-initiated, managed long-term care demonstration

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the mental health association of new york city, inc.

Helping Older Adults 'Take Care' for Improved Mental Health

By Giselle Stolper, Executive Director
The Mental Health Association
Of New York City

In April I had the pleasure of attending the first-year anniversary of *Take Care New York*, a public health initiative launched by the New York City Department of Health and Mental Hygiene. *Take Care New York* features 10 steps that reminds our community of the importance of preventive care to ward off illness, disability and premature death. The Mental Health Association of New York City (MHA of NYC) is serving as a partner of *Take Care New York* through an initiative to reach out to senior citizens in a community in the South Bronx.

The 10 Points of *Take Care New York* are:

Have a Regular Doctor or Other Health Care Provider

Be Tobacco Free

Keep Your Heart Healthy

Know Your HIV Status

Get Help for Depression

Live Free of Dependence on Alcohol and Drugs

Get Checked for Cancer

Get the Immunizations You Need

Make Your Home Safe and Healthy

Have a Healthy Baby

The MHA of NYC is delighted that *Take Care New York* includes two points directly related to behavioral health issues – screening for depression and curbing substance abuse. These points underscore the importance of maintain emotional health as well as staying physically fit.

Giselle Stolper

We know the enormous toll that depression and substance abuse, if left untreated, can take on our community. In the United States, of the 30,000 suicides each year, over 90 percent are committed by people with a mental illness, and over 60 percent of individuals who commit suicide suffer from depression. Alcohol abuse is a factor in over 30 percent of all suicides.

The MHA of NYC is a longtime partner of DOHMH through 1-800-LIFENET, the 24/7 crisis, information and referral services hotline that serves as an entry point to New York City's mental health services for over 72,000 callers each year. The MHA of NYC uses LifeNet caller trends to monitor emerging mental health needs in New York. In the past year, nearly 2,000 adults over 65 called the LifeNet hotline, reporting depression and anxiety as their top two concerns.

Mental health is closely tied to physical health and longevity, so it is important to help New York City's seniors to maintain their emotional well-being. The older adult population is at least as much at risk for depression and anxiety-related disorders as people in other age groups. Yet these disorders are not a natural part of the aging process - there is no need to feel depressed simply because we are growing older. Treatment for depression and anxiety works for seniors with a 60 to 80 percent rate.

When these disorders are left untreated, senior citizens are at great risk for suicidal thinking and behavior. In the U.S., seniors over the age of 65 make up 13 percent of the population, but they comprise 18 percent of the nation's total suicides. The majority of these suicides are among older men, whose risk for suicide increases every year past the age of 50. The other age group sharing this high level of risk for suicide is young males, age 15 to 24.

The MHA of NYC can help prevent suicide if we can heighten awareness of depression and anxiety disorders and their accompanying symptoms, in this case, within the elderly population. If seniors receive education about the warning signs of emotional distress and screen for early signs, they are in a better position to find the help they need at the onset, when treatment has the greatest chance for success.

Identifying the symptoms of depression in older adults, and referring people to treatment is at the heart of the initial stages of the MHA of NYC's partnership with DOHMH. Using the *2004 New York City Elderly Services Need Analysis,* we sought an appropriate population segment, which led us to a community in the Bronx, cited as one of the top five in New York City "most in need of public health and social service intervention for elderly residents."

The MHA of NYC is collaboratively developing and implementing a multi-pronged model which will bring together constituencies in a coordinated program of outreach, education, screening, triage, and linkage to services when the need arises. Participating agencies and other stakeholders include facilities from the Health and Hospital Corporation, voluntary hospitals, primary care and mental health outpatient clinics, community-based organizations, faith-based groups, naturally occurring retirement communities, and other city agencies such as the Department for the Aging, who share our interest in promoting better health and mental health outcomes among our city's elderly.

This model will apply two tiers of training and education to impart knowledge to both providers and consumers. On one level, home health aides, senior center staff and social workers will be trained to help them identify symptoms of depression and other disorders among the older adults they care for every day. And through a "train the trainer" program, participating licensed social workers will learn how to conduct mental health screenings. All programs will be conducted in English and Spanish to ensure cultural competence.

This initiative will incorporate educational activities and mental health screenings to help seniors identify the symptoms and the warning signs of depression within themselves and others in their community. These programs will be conducted on-site where seniors spend most of their time: senior centers, faith-based organizations, even support groups for grandparents raising grandchildren. Where possible these sessions will be combined with other health events, such as holding a Mental Health Day at a site where seniors are receiving flu shots.

A great deal of the advance work is going into planning and preparation for our triage approach. We want to be sure, before we launch our educational programs, that if a participant is in need of treatment or other services, they can be linked quickly to those services quickly and conduct efficient follow up and make sure they are linked to appropriate treatment.

By working in partnership, by going neighborhood to neighborhood, community to community, age group to age group, using tested tools and best clinical practices available we can make a difference in improving the quality of life and health and mental health status of all New Yorkers. The *Take Care New York* initiative offers a great start.

Dr. Gerald McCleery, Director of the LifeNet Multicultural Network and Public Education for the MHA of NYC contributed to this article. For more information about our programs for older adults please call us at 1-800-LIFENET (1-800-543-3638). To learn more about Take Care New York visit their website at www.takecarenewyork.org. □

Adult Day Health Centers: The Best Kept Secret in Geriatric Mental Health

Sheila Merolla, LCSW, Director
Village Adult Day Health Center

Adult day health centers (ADHCs) are an essential, but frequently overlooked, component of a comprehensive treatment modality for older adults with mental illness. By their very nature, these programs facilitate adherence to treatment, while at the same time provide a nurturing well-rounded environment on a day-to-day basis in a non mental health setting.

The single largest obstacle in the treatment of mental illness for people of all ages is non compliance. This problem is magnified for the geriatric population. Why do so many elderly patients do well in the hospital, but decompensate afterwards when discharged back to the community? While hospitalized, the patient's needs are being met in a regimented way. They are in a safe, contained environment receiving three meals a day, medication, structure, and support. Services are coordinated and easy to access.

Contrast this to what happens when the patient is discharged? All at once, the burden for adherence to their treatment regime becomes primarily their responsibility. They are given prescriptions and follow-up appointments and there is an assumption, often faulty, that somehow they will remember to take these medications and to keep the appointments. Yet many hurdles prevent these assumptions from becoming realities. Older mental health patients, left on their own, may forget or choose not to take their medications. Shopping and cooking may present a challenge. Problems with a Medicaid card will make the renewal of prescriptions impossible. Using public transportation to visit the doctor may be problematic for someone with physical disabilities.

Thus, the downward spiral begins, and we frequently see the results. The patient no longer takes his medications. If he is not getting proper nutrition and hydration, other chronic medical conditions may worsen, resulting in confusion or disorientation. Inevitably, rehospitalization becomes necessary and the cycle begins anew.

ADHCs are programs for those who suffer from chronic physical or mental health problems. The goal of these programs is to maximize the physical and mental health of all its participants and to allow them to remain within the community with the greatest amount of independence, safety, and dignity. At the time of admission, the interdisciplinary team assesses the participant's strengths and weaknesses and then decides on treatment plans and goals. In the case of older adults with psychiatric histories, the following questions are always asked: Can, or will, the participant take his own medications? How good is his long and short term memory? Is there anyone at home to ensure compliance? Does he have chronic medical needs that also must be addressed? How can he best be socially engaged?

As soon as the interdisciplinary team's assessment is completed, the nurse begins her role of case manager. She may give medication daily, pre-pour medications for the weekend, and arrange for all medical and psychiatric appointments. Passenger vans that bring participants to the program also drive them to appointments, ensuring greater compliance. Following the visit, the doctor will write a Physician's Order to be picked up by program nurses. ADHCs are inherently structured to monitor physical or behavioral changes, which are quickly noted and communicated to the participant's community physician.

Untreated chronic age-related disabilities, e.g., diabetes, arthritis, and cardio vascular illness, if left untreated, may aggravate an individual's mental health outlook. At the ADHC's, a holistic approach is employed. Many people with mental health histories have compromised their health by not getting proper medical treatment and by pursuing an unhealthy life style. Conversely, others may see too many doctors and are

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Meeting the Needs of Older Adults: An Integrated Service Model

By Amy Chalfy, Bronx District Director
JASA

Aging well involves taking pleasure in family, friends, and meaningful activity. It can be a time of genuine renewal and fulfillment. It can also be a time of daunting challenges, requiring greater resiliency of spirit and energy than at any other period of life. A societal ageism that questions an older person's capacity for change, as well as a generational self-consciousness about seeking treatment, are additional burdens. Even those individuals who have coped well during previous life crises may find that they struggle. Those who have suffered from persistent mental illness are significantly vulnerable when losses related to physical health, social supports, and financial security occur.

Older adults rarely present with a mental health issue only. Ill-health (whether chronic or sudden onset), isolation from family and friends, and financial needs are usually prominent in the presenting situation. Stabilizing a client's mental health functioning may require extensive case management and, in cases where individuals are difficult to engage, resolving a social service need often facilitates mental health service delivery. The JASA Geriatric Mental Health Outreach Service clinics in the Bronx and Manhattan were developed to provide an integrated and cohesive response to meeting mental health and multiple case management needs.

Under the supervision of the Clinic medical director, the primary therapist, a social worker psychotherapist, leads the treatment team and also directly addresses case management issues, whether it is to access entitlements or arrange for homecare. All clinical and case management services are available in-home.

An enriched and inter-disciplinary team approach includes mental health workers who provide chore and personal care duties.

JASA, the Jewish Association for Services for the Aged, was established in 1968 to meet the needs of aging NYC residents and its mission is to sustain and promote successful community living for elders for as long as possible. JASA staff operate on the understanding that being elderly and emotionally frail are not obstacles to successful treatment and improved daily living. □

Mental Health Issues for Grandparents Raising Grandchildren

By Deborah Langosch, PhD, LCSW
Program Director, JBFCS

Deborah Langosch, PhD, LCSW

According to the 2000 US Census, 5.8 million grandparents are living in households with one or more of their grandchildren under the age of 18. More than 2.4 million of these grandparents have the primary responsibility of raising their grandchildren. Although the majority of caregivers are between 55 and 64, almost one-quarter are over the age of 65.This expanding phenomenon of relative caregiving is largely due to parental substance abuse, incarceration, HIV/AIDS, death, poverty, abuse and neglect, family violence, teen pregnancy and poverty. Grandparents have assumed care of their grandchildren in order to provide support and continuity to help the children maintain a sense of family identity, conditions severely undermined by separation from biological parents.

Although grandparents care deeply about the welfare of their grandchildren, they are often faced with overwhelming challenges and emotional stressors once they assume care of their grandchildren. These stressors have been shown to cause significantly higher rates of depression and anxiety (Cox, 2000, Burnette, 1999) and increased social isolation. Burnette's study of Latino caregivers revealed that 47% of these women were clinically depressed compared to 7% of non-caregiving adults of the same age. Depression seemed to be stemming from a sense of entrapment, feelings of helplessness and isolation and functioning in a time-disordered role (Minkler et al, 2000, Selzer, 1976).

Caregivers sense of commitment to their grandchildren causes them to revise and revamp their lives in their later adult developmental stages. Many had been looking forward to being traditional grandparents and now experience a sense of deprivation as they become parents again. This developmental dissonance was described by Kagan (1982) as being painful, protracted and life disordering as the shift occurs from one role to the next. They are asked to make numerous sacrifices which often involved relinquishing a great deal of control. They no longer have the option of living autonomously, or devoting time to leisure activities or their social support network. Some have resigned from jobs to due to the many demands of raising troubled or ill grandchildren; consequently, they have lost income and social supports, which leads to lowered self-esteem and self-image (Poe, 1992).

Often the caregiver's relationship with the biological parent has shifted as well. Issues of authority, boundaries and role reversal can create conflict and discomfort.

Grandmothers reported escalating anxiety due to a number of factors including lack of stamina, worries about the future, decreased financial resources, increased health issues, conflicts with the biological parent, dealing with their grandchild's emotional, learning and behavioral problems, and the pain and sadness experienced if they were coping with the death of their child or traumatic losses. Many of the caregivers felt ill-equipped to handle their grandchildren's problems—especially in today's society—and were unfamiliar with programs and services to help them.

There is increasing evidence that caregivers, as well as many seniors, are relying on alcohol and drugs as a means of self-medicating anxiety and depression. Substance abuse is a hidden problem among older adults, yet one that is occurring with increasing frequency. Twenty percent of adults over 65 misuse alcohol, over-the-counter medications and prescription drugs, according to Hazelden (2004).

Despite the hardships and sacrifices, many relative caregivers reported tremendous satisfaction from being active participants in their grandchild's care. They had a renewed sense of purpose in helping their grandchildren. Others felt less anxiety once the grandchildren were with them as they worried less about the child's safety and whereabouts, especially if the parent was substance abusing and/or neglecting the child (Hayslip and Patrick, 2003).

Grandparents have also coped with the numerous challenges they faced by relying on their spiritual beliefs, utilizing personal resources and having access to social supports. Grandparents in a number of studies (Langosch, 2005, Minkler et al, 2000, Cox, 2000, Musil et al, 2000) have emphasized that their spirituality and their prayers remain by far the most important coping strategy for helping them through the problems and difficulties of the caregiving role. They also develop effective coping and stress management skills by participating in caregiver support groups and psychotherapy. Many caregivers are surprised to learn that Medicaid and Medicare cover from 50-100% of the cost for therapy.

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Challenges of Mental Health Care for The Aged

By Richard Gersh, MD, Executive Deputy Chief Psychiatrist, JBFCS

Richard Gersh, MD

Five years into the twenty-first century we have already seen a glimpse into the challenges of the future of health care, including mental health. There is an expanding segment of our national community – the elderly – that has always required relatively greater resources. Technology is increasing lifespans and improving options for treatment, but also rapidly escalating the price of comprehensive care. Attempts to contain costs are forcing us to make hard choices, including who receives how much care.

Not long ago, the mental health community largely disregarded the emotional problems of older individuals. We did not distinguish the needs of older from younger patients. Individuals who developed emotional problems later in life were often seen as experiencing the normal effects of aging. Traditional psychoanalytic psychotherapy was thought to be primarily of benefit to younger, more pliable personalities. Early psychiatric medications were generally fraught with physical side effects, which could prove dangerous to the elderly.

As our understanding and recognition of geriatric mental health issues has increased, so has our ability to successfully address some of the shortcomings. For the sake of discussion, let's focus on the problems of depression and anxiety. Individuals of all ages are at risk for these problems, but the diagnosis and treatment may take on special challenges when working with the elderly.

It is normal and common to experience periods of depressed or unhappy moods and brief episodes of anxiety. However, depression and anxiety become pathological when the feelings persist, interfere with normal functioning and cannot be overcome by the individual's usual coping mechanisms. As we age, depression and anxiety are less likely to resolve without treatment. Individuals who are prone to repeated episodes of depression or anxiety may find, as they grow older, the episodes occur more frequently, with more intensity, last longer and are more difficult to resolve.

The first challenge is identifying those in need of treatment and successfully engaging them. The elderly are often particularly resistant to this, especially if they are used to dealing with less severe depression and anxiety, without help from others, namely clinicians. Increasing awareness of geriatric mental health issues, the growing field of geriatric medicine and the improving skills of primary care providers have made it more likely that an individual struggling with depression or anxiety will be identified. However, the stigma of mental illness, particularly strong in many older individuals, may prevent some from accepting a psychiatric diagnosis, engaging in psychotherapy or seeing a psychiatrist. Skilled geriatricians can overcome this resistance by framing the problem in acceptable terms and offering treatment in a familiar form.

The mental health field is now very successful at treating depression and anxiety. Research has helped us understand which psychotherapeutic techniques – such as cognitive behavioral therapy and interpersonal therapy – are most likely to produce positive results.

We now have several antidepressant medications that work by way of different neurophysiological mechanisms, allowing for changing, combining and augmenting medications until a satisfactory result is achieved. Newer antidepressants are generally safer than those used in the 1950's through the early 1980's, allowing them to be used more readily and more effectively, even in fragile elderly patients. We have refined our use of tranquilizers to treat anxiety more safely, and newer medications, including some of the new antidepressants have also proven effective at treating anxiety. However, there are times, particularly in the elderly, when the responses to psychotherapy and medications are inadequate, or these traditional measures may be unavailable due to cognitive deficiencies or medical complications. Electroconvulsive therapy has a history – albeit somewhat controversial at times –of being the single most effective treatment for clinical depression, and has been refined in recent years to improve its safety and efficacy. Newer technical procedures, such as transcranial magnetic stimulation and vagal stimulation, are showing some promise in this area as well.

Despite these advances, the elderly present special challenges that must be appreciated. Medical complications and drug interactions are more prominent concerns. Physical problems occur with increasing frequency, presenting conditions that may manifest in emotional

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There are a number of relative caregiving specific programs through out the United States that serve as best practice models to meet the needs of relative caregiving families. One such program is located at the Jewish Board of Family and Children's Services in Brooklyn, NY. The Kinship Care Program provides comprehensive services to relative caregivers, which includes a weekly support group, individual and family therapy, case management, legal consultations, information and referral and psycho-educational forums on relevant topics. For more information on the JBFCS Kinship Care program, contact Dr. Deborah Langosch at (212) 632-4760 or dlangosch@jbfcs.org. AARP offers the Grandparent Information Center, which is a national clearinghouse for information about services and programs for relative caregivers in the United States. There are over five hundred support groups for grandparents raising grandchildren and other relative children in the United States and these can be accessed through AARP's toll free number at (888) 687-2277.

Relative caregivers have come forward to raise their grandchildren and yet are faced with multiple challenges and stresses. These caregivers give so much and receive so little in terms of needed supports and services. Policy and practice needs to address the wide gaps in service that currently exist in order to best sustain and support relative caregiving families.

Dr. Langosch is Program Director of The Center for Trauma Program Innovation and The Kinship Care Program at the Jewish Board of Family and Children's Services. □

Jewish Board of Family and Children's Services offers a variety of programs for the elderly including comprehensive mental health services, day treatment and residential care. Bringing counseling and support services to community centers where seniors can more easily gain access is a primary focus. These community centers include Kings Bay Y, Riverdale Y and Shorefront Y. The agency is planning a number of new initiatives to meet the mental health needs of the elderly and recently began a Kinship care program which provides counseling and case management to grandparents and other relatives who have become the primary caregivers to children. For more information on JBFCS services to the elderly call 212-582-9100 or email admin@jbfcs.org.

Challenges from left

symptoms or involve other treatments that must be considered when using psychiatric medications. For example, anemia, underactive thyroid, pancreatic cancer and treatment with steroids can cause symptoms that appear very much like classic depression. While treatment with antidepressant medication could provide some benefit, the best practice is to appropriately treat the underlying medical condition. Antidepressant medications can also negatively interact with other medications. Even the newer, safer psychiatric medications can produce adverse reactions that will seriously compromise the general health of a geriatric patient.

Additionally, with the growing elderly population and the increasing competition for our health care dollars, there is a real risk of dwindling resources. Medicare has become the primary payer of health services for the elderly. However, Medicare has largely discriminated against psychiatric treatment. While Medicare pays eighty percent of an outpatient visit for most medical interventions – the patient is responsible for a twenty percent co-payment – Medicare pays only fifty percent for most outpatient psychiatric services. Medicare payments to doctors and hospitals have been adjusted in recent years however, generally, even if they have been raised, they are still below the rate of other health care increases. Physicians, including psychiatrists, are increasingly seeing Medicare as a poor source of payment, which is incentive for many to spend less time with elderly patients and more with patients who carry other health care coverage. Other physicians and therapists are opting out of the Medicare system, so they can charge more competitive rates to elderly patients.

There is a picture of great promise ahead clouded by continuing challenges. There is a growing need for clinicians who specialize in geriatrics care, while there are fewer resources. As with other aspects of health care for the elderly, we may soon be forced to make some important choices and decide where our priorities lie. □

Why it is Important to Diagnose Cognitive Loss and Dementia

By Mary Sano, PhD, Director
Alzheimer Disease Research Center
Mount Sinai School of Medicine
Bronx VA Medical Center

To survive daily life we need our wits about us, our thinking clear – our *cognition* intact. Thus it is no wonder that concern for memory and worry over whether we will lose cognitive ability plague us all. These worries are amplified by the unspoken but widespread belief that there is nothing to be done about such problems. The result is that many elders with genuine concerns about their memory and cognition never seek out evaluation, and there is significant under diagnosis of memory loss and dementia. One can project that this problem is particularly prominent because it occurs among the elderly for whom there is a subtle but measurable bias against use of medical resources. In fact, these impressions and biases are unfounded and an accurate diagnosis is the first step for 1) providing effective and efficient delivery of medical service, 2) maintaining the quality of life for patients and their support system and 3) focusing efforts on meaningful research. Here are some important issues.

Diagnosis is Informative. Whether cognitive impairment is assessed at a mild or severe stage, a clear diagnosis provides important information. Recent studies have demonstrated that we can detect a condition known as Mild Cognitive Impairment (MCI), and careful testing to detect an amnestic or memory deficit in this condition is highly predictive of incident dementia. There are many causes of cognitive impairment including reversible causes and static non-progressive conditions. A careful history, routine blood tests, and neuroimaging studies when indicated can identify many treatable causes. The clear diagnosis of dementia and its etiology, such as Alzheimer's disease or vascular dementia, is informative and useful for the physician and family member.

Alzheimer's disease, the most common form of dementia in the elderly, was first reported almost one hundred years ago. The signs, symptoms, and course are well known at every stage of the disease. This information can be highly illuminating to patients and caregivers. They learn that his repetitive questioning is not a deliberate attempt to irritate but rather a function of forgetting; that her withdrawal derives from embarrassment over her memory and word-finding difficulties. Strategies to address the irritating behavior or embarrassment can be offered or modeled by the healthcare provider. It is well established that functional decline will continue and the occurrence of other symptoms, such as behavioral disturbance, psychosis, and depression, are highly predictable based on the correct diagnosis. The need to manage continuing functional decline can be evaluated. At minimum, the diagnosis can permit the health care system, patient, and family to

Mary Sano, PhD

discuss the future in very practical ways. The concept of "projected needs" can be explored and the patient can be included in these discussions. Guidance can be offered to support systems, such as maintaining stable living situations with minimal environmental changes, modifying expectations for functional ability, and modifying expectations about learning

Treatments Do Exist. For the patient with a clear diagnosis of AD there is no doubt that treatments improve cognitive symptoms. Theses same benefits are being demonstrated for a growing number of other age-associated cognitive diagnoses. Whether cognitive symptoms are diagnosed at an early or late stage, it is now clear that there are benefits to be gained for cognitive symptoms from currently available treatments. In addition, current treatments show benefits in the accompanying behavioral symptoms, such as agitation or paranoia, including delaying the onset of new symptoms and diminishing existing symptoms. Even the worst case scenario indicates treatment efficacy for a minimum of 2 years which reflects a significant percent of remaining life expectancy for a disease typically diagnosed in the seventh decade or later. This knowledge should provide the motivation for clinicians, patients, and family members to persist in treatment beyond any initial side effects and to contribute considerable effort into tailoring therapeutic regimens for individual patients.

Medical Management. Awareness of a diagnosis of dementia can direct the physician in the medical management of the patient. Because dementia most commonly occurs in a population of elders who have other serious illnesses or conditions, the diagnosis should raise clinician awareness about the management of all medical conditions. When the patient's doctor realizes that dementia is present, he/she then knows that typical assumptions must be dropped; compliance with prescribed diagnostic or treatment plans for any condition cannot be assumed. Accurate reporting of symptoms cannot be expected from the patient. Physical complaints may be denied by the patient with dementia or cognitive impairment by virtue of their inability to recall the symptoms or details of their occurrence. The patient's safety may be compromised and this may require action. Careful questioning about medical conditions can help but memory impairment, the hallmark of dementia, may compromise the patient's report. Additionally, the intact language and conversational skills of a mild or moderately impaired dementia patient can give a false impression of accurate recall. As the disease progresses, reduced language skills and expected behavioral problems can mask other symptoms. Pain management, and ensuring adequate nutrition and hydration can become serious challenges.

The presence of other medical conditions often requires multiple medications. Medication regimens should consider all conditions, and efforts to simplify the number of times and the number of medications is particularly important. Important contributions to medical management include routine review of all medications for possible pharmacologic interactions and simplifying medication regimens to reduce the number of times a day medications are taken. Vascular risk factors, which are important both in vascular dementia and possibly contributing to other cognitive deficits, need to be monitored routinely and the participation of the patient in following this cannot be assumed.

Sustained Support Systems. It becomes critical to ensure that a system is in place to assist with patient management. Fortunately, the support system is often obvious because individuals with cognitive deficit are most often identified by family members or involved friends. However, in the absence of such a support network it is vital for the clinician to diagnose dementia as it will set expectations about medical management of all conditions and may initiate the process of identifying support resources. Clinicians can say with medical authority that it is important to the health and quality of life of a patient to identify a support system. Early insistence can encourage the patient to identify those they would most want to participate in their medical management and decision making.

It is estimated that family members, friends and other informal sources deliver more than 60% of care for dementia patients. Often the same age as the patient, these individuals can be fragile, and the task of caring for a dementing individual can be wearying leading to fatigue, depression and physical illness. The Alzheimer Association encourages physicians to recognize the need to provide guidance and support to the caregivers as part of the treatment of patients with dementia. Surveys estimate that more than half of all caregivers report significant depressive symptomatology. Stress and isolation are commonly reported by caregivers as well. Unaddressed, these problems can affect the caregivers' performance and, in turn, the identified patient. Many caretakers report satisfaction from education and support groups and well controlled studies have demonstrated significant benefit to patients by encouraging caregivers to get help and support.

Research and the Role for the Tertiary Medical Center. Health care professionals, as well as patients, their families, and caregivers will find help and support from the 29 Alzheimer Disease Centers (ADC) program funded by the National Institute on Aging. As part of the mandate of the NIA program, the Alzheimer Disease Research Center at Mount Sinai offers comprehensive diagnostic and consultation services, and counseling opportunities for patients and families. The clinical expertise offered by the staff at the centers often provides a valuable supplement to the care received through the community practitioner. In addition, the center sponsors a series of Continuing Medical Education. [if for lay people, spell out 'CME'] programs which are offered to the community practitioner at no charge. The most important mandate is to support translational research and our center provides a wide range of clinical studies for individuals with many types of memory complaint and dementia as well as for healthy elderly controls. Research efforts consist of longitudinal observational studies, neuroimaging and biomarker research, and clinical trials directed by government, industry and local clinician scientists. In addition, an active brain donation program provides the most critical links to disease etiology. In the area of Alzheimer's disease, current treatments are effective but are not cures and the opportunity for progress arises only out of continued research. The ADRC provides a bridge to connect patients and families to the hope for a cure. For the community practitioner, the ADRC provides a pathway for connecting clinical care and research.

Recommendations and Conclusions. Memory loss and dementia are serious and common problems that require diagnosis and management. Since self report may lead to under reporting, systematic screening may be helpful among the elderly. Questions such as "Has your memory worsened in the last year?" or "Is your memory worse than other people your age?" can identify at risk and symptomatic individuals. Clinical diagnosis should lead to identifying a support system, and management can lead to providing a safe environment which may optimize their period of independence. Help is available through local and national organizations. These can provide education, information, and services to caregivers and clinicians. Several are listed below. □

1) Alzheimer Disease Research Center at Mount Sinai Medical Center Tel: (212) 241-8329 www.mssm.edu/psychiatry/adrc/

2) The Alzheimer's Disease Education and Referral Center, a service of the National Institute on Aging (800) 438-4380. http://www.alzheimers.org

3) New York City chapter of the Alzheimer's Association. (212) 983-6906.

4) The National Alzheimer Association, provides a wide variety of free services for patients, caregivers, and families. Help is available 24 hours a day. (800) 272-3800. www.alz.org

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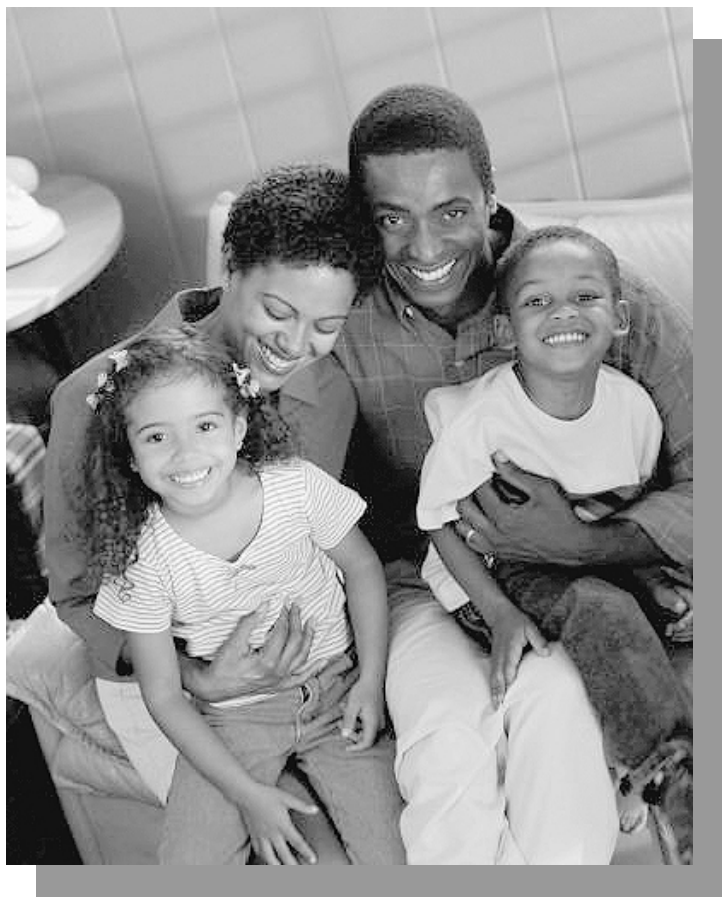

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Life Begins At 60: A New Look At The Journey To Fulfillment

By Dr. Brenda Shoshanna

As we watched the passing of Terri Schiavo, the great question of when life ends and when it begins was before us all. Unfortunately, in our culture, a deep look at the nature of life and what is means to truly alive is rare. When it does happen, it is usually confined to the body's condition – its age, health, flexibility, what it can or cannot do.

However, all great scriptures tell us that life itself is timeless, and beyond that "life" itself has little to do with age, or with activities we do or do not engage in.

In the Jewish scripture it says, "All the days of his life were fulfilled." By this it is meant that this person lived life fully, deeply, with dedication to that which was most meaningful to him. It means that this individual spirit was strong and alive, no matter the age and condition of his body. In the Jewish context, it meant that his life was filled with mitzvot, actions which connect an individual to a larger plan.

Unfortunately, in our times, there is the idea that as we grow into the sixties our life force may be diminishing, along with our capacities. So many in this age group consider themselves over the hill. Rather than seek to expand and explore, they seek familiarity, security and comfort. Their lives become based upon fear of what may happen, rather than upon the deep confidence that arises when there is faith in process of life itself.

In order to combat the fear, which sets in, it is necessary to realize that our life force comes from our spirit. It arises from the knowledge and wisdom we have absorbed and from the ways in which we now are able to share and harvest our experiences and become a source of light and wisdom to others.

As we enter our sixties and beyond, our sense of destiny or life meaning becomes sharpened. At this beautiful point in our evolution, as we are relieved of some of life's other pressures, and as our physical selves may slow down a bit, more time becomes available to contemplate, meditate, look within. We are now finally able to sort out tasks, relationships and priorities. Indeed this is a time to harvest blessings, both of to give to others and to receive ourselves.

In order to enter our later years in this frame of mind, it is helpful to explore the nature of change, why we resist it, and how to go forward bravely. In this process we must learn how adopt a meaningful and authentic vision of who we are, what we have to contribute, where we want to go.

Dr. Brenda Shoshanna

Here are some steps we can take on this journey:

1) Understand the nature of change and how to deal with it. There are dynamic laws of change, which need to be understood, including how to overcome fear of change and resistance to it.

2) Discover a meaningful, authentic vision of who we are. This step introduces us to ways of discovering our authentic selves, what it is we truly have to contribute, our deeper values and larger vision for ourselves and others. Then we can not only take new steps, but reach out to others.

3) Create a vision for where we are headed. Once we have connected with our individual purpose, we must learn to create a vision for where we are headed so our deeper values can be expressed and shared.

4) Taking a stand and inspiring others. As we seek to change it is inevitable that challenges arise. When we learn how to face these wisely the challenges only serve it strengthen our resolve and understanding. We then can take a stand naturally.

Each phase of life requires life skills, and different kinds of understanding. Unless we learn how to live these later years wisely, a sense of sorrow, depletion and often confusion takes hold. The senior years are then beset with a sense of loss, rather than fulfillment. This is guarded against if we realize that often it is only during the later years that one becomes truly ripe, ready to see beneath the veil, understand the true nature of relationships and to become at peace with all the comings and goings we are confronted by. It is during the ripe years that we are best able to connect with the true value and purpose of our time on this earth.

Dr. Shoshanna, (topspeaker@yahoo.com) is a psychologist, long term spiritual practitioner and author. This article is based upon her latest book, Living By Zen, (Timelesss Truths For Everyday Life) www.livingbyzen.com. She offers talks and workshops on relationships and faith based therapy. Some of her other books include, Zen And The Art of Falling In Love, (Simon and Schuster), Zen Miracles (Finding Peace In An Insane World), Wiley. Her website is www.brendashoshanna.com (212) 288-0028. □

As a healthcare professional, you know that for older adults with mental health conditions, getting the right kind of psychiatric treatment and follow-up can make the difference between functioning at an optimal level and enjoying life, or decreased functioning and loss of independence. That is why Bridgeport Hospital, a 425-bed teaching hospital in Bridgeport Conneciticut, offers a special Geriatric Psychiatric Inpatient Program for individuals aged 65 or older with severe depression; suicidal, homicidal, or assaultive behavior; psychosis; or other mental problems.

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People Need People for Good Mental Health: Especially in the Senior Years

By Lisa Goldenberg, LCSW
Hall-Brooke Behavioral Health Services

I love spending time with older senior citizens. Most of my work, both volunteer and paid, has been with them, and I have several good friends who are over 80. Older seniors know what is true, right and lasting.

Old age can also bring with it a multitude of problems, such as declining health and stamina, loss of a spouse, financial difficulties and increasing dependence on others. While all too many succumb to clinical depression, anxiety and self-medicating with alcohol, others instead seem to thrive despite multiple losses, medical conditions and other hardships.

I became curious: For those older seniors whose persistent smiles bring a smile to my own face, to what do they attribute their happiness? I decided to ask the Resident Services Coordinator at a senior housing complex to help me identify five happy older seniors. And these five referred me to others who they believed to be happy as well.

To understand exactly whom I was interviewing, I asked about their family histories, health and current lifestyles (after they told me their secrets to happiness.) They knew I was writing this article, answered direct questions about

Lisa Goldenberg, LCSW

their health and, in the case of medical problems, were quick to add, "Don't put that in your article." I got the sense that, had I not asked, they would not have mentioned their surgeries, chronic illnesses and disabilities. One woman politely said, "I've had quite a few surgeries, but they're over and I don't want to talk about them."

Teresa turned 89 the week I spoke with her. "I love being with people," Teresa said. "All kinds of people--black, white, green, purple ... rich, or poor...all people." Since I'd had to dodge a few of the resident complainers on my way to her apartment, I asked about dealing with difficult people (whom of course I did not have to identify by name). She replied, "I tell them that if they don't like it here then they can leave. Nobody is forcing them to live in Ridgefield's senior housing." Teresa wasn't being snide; on the contrary, she always speaks kindly of others and her reply was very matter-of-fact. "Life is being able to accept the good and the bad things," she said.

Clearly, Teresa actively contributes to her own happiness. Her family, church and the organized activities provided at the housing complex are central to her positivity. But she further enriches her life by actively seeking out friends (for example, a group of seniors who put together a Saturday canasta group and regularly meet for TV's Jeopardy), speaking her mind and seeing the best in people and situations. Before I left Teresa's apartment she phoned her friend Trudy. "Trudy, you old bat, I'm sending Lisa up to interview you," she said warmly. "And I'm sending along a piece of pie for you."

Trudy is 90 and legally blind. Her sight impairment doesn't seem to slow her down much, if at all. "I used to be a shrinking violet, now I speak up. I don't know why I used to be so reticent. I would not choose to live alone--I miss my husband and the years raising my children. But I can't change my way of living, so I accept it. I have wonderful friends. You have to keep in with people, and tell a joke now and then."

Roger, who is 81 (and will proudly tell you he'll be 82 in August), also attributes his happiness to his interactions with people: "There may be a connection between my state of happiness and my helping others and the satisfaction that comes as a result."

I've observed that Roger is among the first to volunteer to drive people to community events. He gets to the dining room just before lunch in order to help the frail residents adjust comfortably in their seats at the tables. Roger sings in two choirs and plays cello in the Danbury Symphony. He is outspoken and forthright in his attitudes and opinions. And though he had two CT scans the week we spoke and some past medical procedures, he volunteers that he is blessed with good health. His glass is always half-full.

Anna is 85. "I like to be with people--I don't like to be alone all the time." Her knitting club makes items for a cancer organization and needy children in the area. "My day-to-day happiness

see People on page 45

People from page 44

results from my great collection of friends."

I also spoke with fellow older seniors Joyce, Irene, Ed, Ann and Bernie. These interviews also suggested that social connections, a positive attitude, speaking up, and the opportunity to help others, contribute significantly to the recipe for happiness.

Of course, not all older seniors are in a position to be socially active or to make a contribution to their household or the community. Many, in fact, are isolated.

Furthermore, I often hear frustrated adult children tell about their elderly relatives who "refuse to go anywhere or do anything." I believe that, with a little more encouragement (maybe even insistence) and offers of transportation, this "refusal" can be overcome.

Senior centers, always a place for socializing, are becoming more and more attractive in Fairfield County. In addition to social events, many now have academic classes (a nice way to meet people) in such subjects as history, genealogy, piano, photography, and computers. The Senior Center in my town also has a "Distinguished Speakers Series," which one can attend solo (but while you're there, why not make some friends?). Your relative refuses to go alone? Many home care agencies have companions who can be hired on an hourly basis (usually a two-hour minimum). These companions can provide the much needed social interaction while linking the older senior to social activities that may lead to friendships.

For the delightful older seniors with whom I spoke, the best medicine doesn't come from the pharmacy but from other people. It is the joy of being useful and welcome. To paraphrase one now near-senior, "People who need people are the happiest people in the world."

Lisa Goldenberg, LCSW, is a Treatment Coordinator for Hall-Brooke Behavioral Health Services in Westport, Conn., and an EAP representative (through Hall Brooke) for Pitney Bowes. She has 25 years experience counseling individuals and families. Much of her work has been in the field of gerontology. She is also a commissioner with the Ridgefield Housing Authority, which allows her to know many wonderful senior citizens at the congregate and independent living sites. Hall-Brooke is a wholly-owned subsidiary of St. Vincent's Health Services of Bridgeport, Conn., and is affiliated with the Department of Psychiatry of Columbia University's College of Physicians and Surgeons. □

Social Work from page 32

A Look Toward the Future Needs of The Elderly

Queen's multicultural community requires that providers be multi-lingual as well as culturally competent. We expect that in the future this will continue to be an issue for social work practice. "End of Life Care," as well, has become a prominent issue as many elderly experience chronic and terminal illness and require behavioral health services to reduce the stressors on them and their families. This includes a variety of legal, and individual preference issues such as advanced directives, wills, funeral arrangements, planning for institutional or independent living with added supports. Increased Home-Based Mental Health Services, including case management, are crucial to ensure access to required services for the elderly client. Adult Medical Day and Social Programs can improve daily medical oversight, bathing, and meals to insure proper nutrition, cognitive remediation and social supports. They also serve as a respite for caregivers. Spirituality often is overlooked, but exploration into clients' beliefs and faith can be an excellent source of support and can be incorporated into social work interventions.

For the elderly, the three D's are Delirium, Dementia, and Depression. Each is prevalent, and negatively impacts on daily functioning and quality of life; emotionally and physically. Services in medical and mental health programs need to increase focus on improving cognitive skills by helping clients compensate for increasing cognitive deficits.

Our seniors have a long history of life experience and lessons to share. Our mental health services need to grow and adapt to the changing needs of our growing elderly population. This is essential, humane, and imperative in providing quality care, comfort and a continued sense of dignity to the valued elders in our communities. □

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Older Adults from page 1

Despite progress in clinical research, unrecognized, or untreated depression, Alzheimer's disease, alcohol and drug misuse and abuse, anxiety, late-life schizophrenia, and other conditions can be severely impairing, even fatal. In the United States, the rate of suicide, which is frequently a consequence of depression, is highest among older adults relative to all other age groups (Hoyert et al., 1999).

In addition to mental disorders that emerge in late life, it is also critically important to understand that people who have had ongoing psychiatric disabilities since they were young are aging and that new psychosocial needs emerge as they get older.

The clinical challenges mental disorders in old age present are often exacerbatedby the manner in which they both affect and are affected by general medical conditions or by changes in cognitive capacities.

Another complicating factor is that many older people, disabled by or at risk for mental disorders, find it difficult to afford and obtain needed medical and related health care services.

Late-life mental disorders also can pose difficulties for the burgeoning numbers of family members who assist in caretaking tasks for their loved ones (Light & Lebowitz, 1991).

There is much misunderstanding about thoughts of death in later life. Depression, serious loss, and terminal illness trigger the sense of mortality, regardless of age.

Coping With Loss and Bereavement

Loss of a spouse is common in late life. About 800,000 older Americans are widowed each year. Bereavement is a natural response to death of a loved one. Its features, almost universally recognized, include crying and sorrow, anxiety and agitation, insomnia, and loss of appetite (Institute of Medicine [IOM], 1984). This constellation of symptoms, while overlapping somewhat with major depression, does not by itself constitute a mental disorder. Only when symptoms persist for 2 months and longer after the loss does the DSM-IV permit a diagnosis of either adjustment disorder or major depressive disorder. Even though bereavement of less than 2 months' duration is not considered a mental disorder, it still warrants clinical attention (DSM-IV). The justification for clinical attention is that bereavement, as a highly stressful event, increases the probability of, and may cause or exacerbate, mental *and* somatic disorders.

Bereavement is an important and well-established risk factor for depression. At least 10 to 20 percent of widows and widowers develop clinically significant depression during the first year of bereavement. Without treatment, such depressions tend to persist, become chronic, and lead to further disability and impairments in general health, including alterations in endocrine and immune function (Zisook & Shuchter, 1993; Zisook et al., 1994). Several preventive interventions, including participation in self-help groups, have been shown to prevent depression among widows and widowers, although one study suggested that self-help groups can exacerbate depressive symptoms in certain individuals (Levy et al., 1993).

Bereavement-associated depression often coexists with another type of emotional distress, which has been termed *traumatic grief* (Prigerson et al., in press). The symptoms of traumatic grief, although not formalized as a mental disorder in DSM-IV, appear to be a mixture of symptoms of both pathological grief and post-traumatic stress disorder (Frank et al., 1997a). Such symptoms are extremely disabling, associated with functional and health impairment and with persistent suicidal thoughts, and may well respond to pharmacotherapy (Zygmont et al., 1998). Increased illness and mortality from suicide are the most serious consequences of late-life depression.

Many older adults experience loss with aging—loss of social status and self-esteem, loss of physical capacities, and death of friends and loved ones. But in the face of loss, many older people have the capacity to develop new adaptive strategies, even creative expression (Cohen, 1988, 1990). Those experiencing loss may be able to move in a positive direction, either on their own, with the benefit of informal support from family and friends, or with formal support from mental health professionals.

The life and work of William Carlos Williams are illustrative. Williams was a great poet as well as a respected physician. In his 60s, he suffered a stroke that prevented him from practicing medicine. The stroke did not affect his intellectual abilities, but he became so severely depressed that he needed psychiatric hospitalization. Nonetheless, Williams, with the help of treatment for a year, surmounted the depression and for the next 10 years wrote luminous poetry, including the Pulitzer Prize-winning *Pictures From Bruegel,* which was published when he was 79. In his later life, Williams wrote about "old age that adds as it takes away." What Williams and his poetry epitomize is that age can be the catalyst for tapping into creative potential (Cohen, 1998a).

The dynamics around loss in later life need greater clarification. One pivotal question is why some, in confronting loss with aging, succumb to depression and suicide—which, as noted earlier, has its highest frequency after age 65—while others respond with new adaptive strategies. Research on health promotion also needs to identify ways to prevent adverse reactions and to promote positive responses to loss in later life. Meanwhile, despite cultural attitudes that older persons can handle bereavement by themselves or with support from family and friends, it is imperative that those who are unable to cope be encouraged to access mental health services. Bereavement is not a mental disorder but, if unattended to, has serious mental health and other health consequences.

Mental health is a key component of well-being in old age. Sadly, it has not become a major focus of our nation's efforts to address the needs of older adults. I hope that this issue of *Mental Health News* will contribute to a greater appreciation of the mental health needs of our society's seniors.

Credits: Mental Health: A Report of the Surgeon General, (1999) □

Protecting from page 5

(presumably style deficient) straight male into a ideal self now worthy for full attention and consideration in our society.

What is the message of these shows? That differences between individuals are not to be tolerated.

These shows are about intolerance (and even contempt) for those who are different and in some way deficient: nose too big, weigh too much, tie doesn't match your shirt, wrong hairstyle, talk with an accent etc. Other popular shows delight in Contestants being voted off the island or from competition for the beautiful woman or man because they do not have what it takes. The emphasis is on the satisfaction of a primitive superiority on the part of the viewing audience over those who can not compete successfully. To me we are seeing the underbelly of our society in the popularity of these programs. They would not thrive if they do not enjoy interested audiences who share their perverted and intolerant world vision. The Third Reich and the Roman Empire fell under the weight of their false sense of superiority and delight in their control over individuals perceived as weak and marginalized.

For most individuals who suffer from Schizophrenia, Autism, Mental Retardation and other severe and persistent brain disorders their joining elderly age groups will leave them only more dependent. We have already seen widespread abuses in Psychiatry under the banner of Managed Care or cost containment where those who are most needy are increasingly denied needed care. For some it is quite cost effective to believe that the disabled do not have lives worthy of living. If they reach the point that they can not feed and hydrate themselves it might become cost effective to withhold life sustaining food and hydration—or perhaps they may arrive at a more proactive and " final solution !"

As advocates for the Mentally Ill let's choose life and not death for those who might be different (not deficient) and need our help and kindness.

Joseph A. Deltito, M.D. is a Clinical Professor of Psychiatry at New York Medical College and has an office practice for psychopharmacological consultations and forensic psychiatry in Greenwich, Connecticut. He is a frequent commentator on Fox News, CNN, and Court TV. Dr. Deltito serves on the Clinical Advisory Board of Mental Health News. □

Specialized from page 33

to the SOP Social Worker. This "transfer of trust" by senior center participants is the key to the acceptance of mental health services among this population.

At each site, the SOP Social Worker spends approximately one hour daily coordinating mental health services with the concrete, medical, and other support services that are provided by site staff or by agencies in the vicinity of the senior centers. The Social Worker informally functions as the mental health expert within the "team" of people assisting the older person and is available to staff to address mental health issues. The SOP Social Worker partners with the senior site staff to help diagnose mental illness and provide mental health counseling to prevent further deterioration and improve quality of life.

Seniors who are referred to the SOP Social Worker receive a comprehensive evaluation including an Individual Treatment Plan that details specific treatment goals and time frames to accomplish these goals. The Social Worker also conducts periodic assessments of each client's progress. Seniors who become SOP clients generally present with diagnoses of depression, anxiety, substance abuse (of alcohol and prescription drugs), and problems associated with early and moderate-stage dementia. They also commonly suffer from social isolation, often brought on by medical or psychological illness.

The program's success rests on its ability to effectively bridge the gap between social service and mental health provider. When Social Workers collaborate with senior center staff, older adults receive prompt intervention and the required mental health services, preventing further isolation and deterioration. This unique partnership of mental health providers and direct care staff, combined with community and home-based treatment, facilitates the diagnosis of mental illness and ensures the provision of services to the under served, hard-to-reach elderly. □

Graying from page 33

programs that could potentially target older schizophrenic persons.

Regrettably, mental health care has not been a core component in most proposals.

Future efforts to assist older schizophrenic persons must focus on implementing models for the integration of mental health and medical services, the creation of more appropriate home and community-based long-term care, the development of rehabilitation services that encourage age appropriate levels of independence, the promotion of innovative approaches to financing services, and ensuring that programs are age and culturally sensitive.

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Whitehouse from page 5

dirty old man, psycho, weak, runs in the family, can't teach an old dog"; For mental health specialists we hear "shrink, witch doctor, not a real doctor"; Regarding treatment we hear "touchy-feely, just ventilation, not reliable, doesn't really work, not cost effective, all one needs is to pray"; And finally, the science is considered "soft" and "psychosocial" rather than hard and "biomedical".

If one accepts that mental illness is the major threat to wellbeing in late life and that stigma is the major obstacle preventing the translation of health science to health practice, what should we expect form the Whitehouse Conference on Aging? We need leadership at the national level to combat stigma and move the legislation forward. Leadership is the second biggest problem. We have a well developed "follower-ship" of advocacy organizations, providers, consumers, and economically vested interests. And the baby boomers, who ultimately will be the greatest beneficiaries, are generally more accepting of mental health care and research.

But given the competing imperatives that will be brought to the Conference we need a commitment that mental health will be among the top if not the chief priority among the recommendations. The character of the leader we need is someone who will champion the issue. For example Franklin Delano Roosevelt advocated services and fund raising to conquer polio which would have crippled a substantial number of the baby boomers in the 1950's had he not begun to champion the issue in the 1930's. Nancy and Maureen Regan have been selfless and outspoken regarding Alzheimer's disease. Michael J. Fox has made Parkinson's disease a much more sizeable priority of the NIH. Celebrity status, public appeal, and genuine commitment are critical attributes but the political investment made prominent by a Presidential appointment is essential.

In closing, my priorities for the Whitehouse Conference on Aging are 1) recognize that mental illness is the major threat to the health and wellbeing of older Americans, 2) accept that stigma associated with mental illness, not cost is the major obstacle to improved mental health in late life, 3) appoint a national champion, appointed by the President of the United States to publicly attack the problem of stigma and move the bipartisan legislative agenda. What we do for our seniors today we do for ourselves tomorrow. For the baby boomers among us, this is no cliché.

Dr. Kennedy is with the Department of Psychiatry at Montefiore Medical Center. □

Dey Center from page 35

confused about all the medication they are given. Often doctors treating the same person do not speak with one another which begs several questions: Who is in charge of the patient's health care? Who is responsible for communicating with various doctors to ensure that they each are familiar with the patient's overall medication profile? At ADHCs, the nurses assume this responsibility. They oversee the administration and monitoring of medications, along with arranging and coordinating all health care appointments. A participant on psychotropic medications may even have his bloods drawn at the Center by a phlebotomist.

At the ADHCs, psychiatric labels or diagnoses do not define the person, Because ADHCs treat the whole person, other non-mental health problems are equally addressed. When a Medicaid card becomes inactive or when a home attendant is needed, a social worker is available to help. A dietician is there to consider nutritional issues. Physical therapy, to ease pain, is available daily.

Isolation is sometimes the "best friend" of mental illness. Therefore, the days at ADHCs are rich and stimulating with an ever-present feeling of community. At the Village Adult Day Health Center, which is operated by Village Care of New York and is located in Manhattan's Greenwich Village, we also use alternative interventions such as yoga, tai chi, and massage therapy, along with a more traditional approach. People begin to look and feel better and pay more attention to their hygiene, grooming, and general appearances. With psychotherapy and group therapy also available on site, these services appear less threatening since they are integrated into the regular programming.

ADHCs are excellent models in the treatment of mental illness. In these programs, persons are educated about their psychiatric illness, which is presented to them as a chronic condition, in the same vein as other ongoing problems such as diabetes and hypertension. This changes their perception and may be a contributing factor in the improvement we see among participants with mental health conditions in ADHCs.

To learn more about this important resource, and to visit, call (212) 337-5871 or write to sheilam@vcny.org. Sheila Merolla, LCSW, MSW, is the Director of the Village Adult Day Health Center in Manhattan, which is part of Village Care of New York's Senior-Choices care network. She is Fellow from the Brookdale Center on Aging and has been in the field of geriatrics for more than 20 years. □

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