

Improving the System of Care for Older Adults With Mental Illness in the United States

Findings and Recommendations for The President's New Freedom Commission on Mental Health

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The President's New Freedom Commission on Mental Health was created to evaluate the quality and effectiveness of the nation's mental health service delivery system, to identify unmet needs and barriers to services, and to provide recommendations on methods for improving the mental health system. A health policy analysis was prepared for the Commission examining the organization, delivery, and financing of mental health services for older Americans. The author identified three healthcare themes, including 1) access and continuity of services; 2) quality; and 3) workforce and caregiver capacity. From among these areas, 10 policy issues and recommendations were proposed. (Am J Geriatr Psychiatry 2003; 11:486-497)

The President's New Freedom Commission on Mental Health was established under George W. Bush on April 29, 2002, to study the quality and effectiveness of the United States' public and private mental health service delivery system and to identify methods for improving services for individuals with mental illness. Fifteen subcommittees were established to evaluate a range of topic areas, including acute care, children and families, co-occurring disorders, consumer issues, criminal justice, cultural competence, employment and income support, evidence-based practices, homelessness and housing, Medicaid, medication issues, rights and engagement, rural issues, suicide prevention, the mental health interface with general medicine, and older adults. These subcommittees encompass a lifespan

perspective with special attention to subgroups who have unmet needs and are underserved by the current system of care. Older adults were highlighted as an underserved population in need of urgent attention.¹

One in four older adults has a significant mental disorder. As shown in Figure 1, by the year 2030, the number of older adults with major psychiatric illnesses is predicted to reach 15 million.² The growth in this subgroup will significantly affect the mental health and general healthcare service delivery systems. Older adults with mental illness are at increased risk, compared with younger adults, for receiving inadequate and inappropriate care.³ Without adequate and effective treatment, mental disorders in older persons are associated with significant disability and impairment, including impaired independent

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and community-based functioning, compromised quality of life, cognitive impairment, increased caregiver stress, disability, increased mortality, and poor health outcomes.⁴ Older adults with mental health problems also have higher utilization and costs of healthcare services,^{5,6} but providing effective mental health services can result in cost offsets.⁷

Future growth of the population of older adults with mental illness is predicted to overwhelm available mental health services for older persons. Without significant reforms in the system of care, the projected shortfall in providers with expertise in geriatrics and the inadequate financing for geriatric mental health services will converge to create a future healthcare crisis.²

METHODS

The 22 members of the President's New Freedom Commission on Mental Health were directed to evaluate the quality and effectiveness of mental health services in the United States, to identify unmet needs and barriers to services, and to advise the President on methods for improving the mental health system for adults and children with serious mental illness or

emotional disturbances. Commission members were directed to identify services that could be disseminated to diverse settings, and to develop policy options that promote integration of effective treatments into clinical practice, improve service coordination, and improve community integration for individuals with mental illness.⁸

To inform the deliberations of the Older Adults Subcommittee, a health policy analysis was prepared. The Subcommittee consisted of five commissioners, including the co-chairs Anil Godbole and Frances Murphy.¹ Preparation of this analysis included a review of relevant literature on mental health services and mental health policy on older adults with a specific focus on the organization, delivery, and financing of mental health care. Also, this analysis was informed by the Surgeon General's Report on Mental Health,⁴ the Administration on Aging report on Older Adults and Mental Health,⁹ and health policy documents developed by advocacy and professional organizations.

RESULTS

Ten major policy issues were identified and grouped under three overarching themes: 1) access and continuity of services, 2) quality, and 3) workforce and caregiver capacity. Following an overview of each identified issue, policy recommendations were developed, based on a review of possible actions, with members of the Commission's Subcommittee on Older Adults.

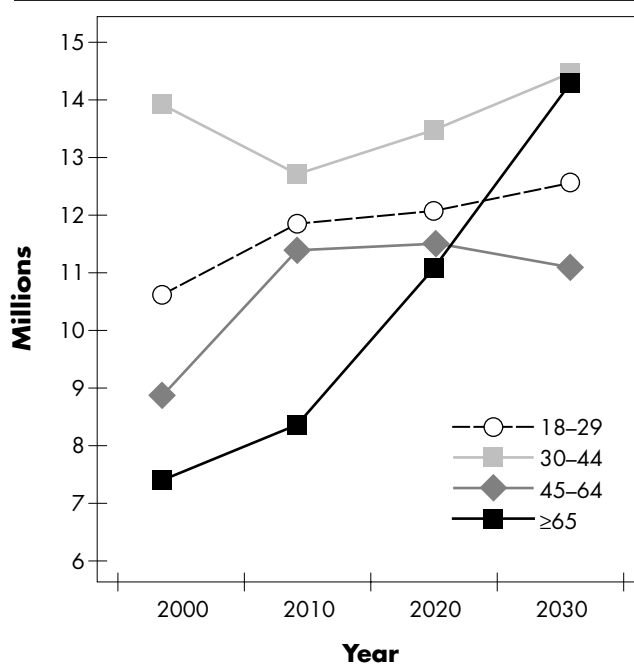
Access and Continuity of Services

Significant system, financial, and consumer barriers limit access and continuity of appropriate mental health care for older adults. Four policy issues were identified warranting reforms: matching services to the needs and preferences of older adults; fragmentation of the system of care; coverage for mental health services and prescribed medications; and stigma associated with mental disorders and aging.

Issue: A Mismatch Between the Current System of Care and the Needs and Preferences of Older Adults

Current financing and systems of care are oriented toward providing mental health services in hospitals,

FIGURE 1. Estimated prevalence of major psychiatric disorders by age-group



nursing homes, or specialty mental health outpatient clinics, despite older adults' preferences for services in community- and home-based settings.¹⁰ Approximately half of all Medicare mental health expenditures are allocated for inpatient, hospital-based services,¹¹ and the majority of Medicaid funds are directed toward institutional long-term care services.¹² This funding and policy bias persists, despite the recent *Olmstead* decision by the U.S. Supreme Court, finding that unwanted or unnecessary placement of individuals with disabilities in nursing homes violates the Americans With Disabilities Act.¹³

Medicare financing policies also fail to support contemporary models of supervision, coordination, and management of community-based providers. Although care management models that integrate mental health providers into the primary care setting to provide same-day mental health services show promise in enhancing access and quality of care,¹⁴ current Medicare payment mechanisms do not support care supervision and coordination (except for acute home care and hospice care) and prohibit payment for two separate visits on the same day.

Several additional factors can substantially affect accessibility and utilization of mental health treatment. Common barriers to providing equitable and appropriate care include fragmented or unavailable services (lack of bilingual and bicultural staff); negative attitudes by consumers toward conventional mental health services; and issues of mistrust, fear, and discrimination.¹⁵ Also, limited mobility and perceived stigma associated with treatment in a psychiatric clinic underscore the importance of developing outreach services that detect and treat mental health problems in settings where older adults live, spend time, or seek services.

Issue: A Fragmented System of Mental Health Care for Older Persons

The mental health system for older adults encompasses multiple service sectors and providers, including nursing homes, hospital-based care, other long-term care, primary care, specialty mental health services, home and hospice care, criminal justice, aging-network services, and family and peer providers. This array of providers and service delivery settings is poorly coordinated and difficult for consumers to navigate.⁹

Nursing homes have become the "de facto" system of institution-based mental health care for older adults. Most older adults in nursing homes have a significant psychiatric or behavioral problem.¹⁶ Despite the high prevalence of mental illness, at least half of nursing homes report inadequate access to psychiatric services.¹⁷ Estimates also suggest that 30% to 56% of assisted-living facility residents have a mental health problem, yet current payment mechanisms do not accommodate providing mental health care within assisted-living facilities, and mental health outreach services are limited.¹⁸ Rates of mental illness are also high among home health care populations, but specialized psychiatric services are rare.^{19,20}

Most older adults who receive mental health services are treated in primary health care settings.²¹ Approximately one-third of older primary care patients have significant mental health symptoms.²² In general, older persons are more likely to seek mental health services from their primary care provider because of stigma associated with specialty mental health services and the convenience of receiving care in their own physician's office.⁴ However, the many competing demands involved in brief medical visits provided in primary care present a major challenge to appropriate diagnosis and treatment of mental health problems among older adults.^{23,24}

Integration of medical and mental health treatment is an effective and efficient approach to coordinating psychiatric and general health care and has been associated with decreased healthcare utilization.^{7,25} Three large multisite studies have shown increased access and favorable results of integrated mental health treatment for older adults in primary care settings.²⁶⁻²⁸ Although integrated care challenges conventional healthcare models that deliver mental health services separately from general medical care, it can increase communication between providers, reduce stigma and medical expenditures, and avoid providing separate treatment of medical and psychiatric problems, which can result in substandard care.²⁹

Issue: Co-Payments, Prescription Coverage, and Rate Adjustments

A significant barrier to providing adequate and appropriate care is created by a payment system that

was established to support acute, hospital-based care of medical disorders. Current Medicare payment policy discriminates against individuals with psychiatric disorders by requiring a 50% co-payment for psychologically-based services, in contrast to a 20% co-payment for medical and surgical treatments. This policy persists despite the impact of mental illness on healthcare costs and outcomes and an evidence base that supports the effectiveness of a variety of interventions.^{4,30} As of the summer of 2002, there were 35 states that had enacted parity laws prohibiting discrimination in insurance and managed-care coverage of mental disorders. Despite concerns that parity would overwhelm state budgets, state parity laws applied to managed-care and non-Medicare services have raised expenditures by less than 5% and result in minimal increases when implemented within an existing integrated-service network.³¹ However, current legislation does not apply to Medicare, which is the primary provider of health insurance for older adults.

The lack of a prescription drug benefit under Medicare presents another crucial barrier to providing appropriate care for older adults. Overall, the cost of medications for older persons has increased by 18.5% annually, compared with a 2.3% average general inflation.³² Older adults take up to six medication prescriptions,³³ and psychiatric medications are among the most costly.³⁴ Although most Medicare beneficiaries have a supplemental insurance program, approximately one-third are unable to afford any coverage for medications and are forced to pay out-of-pocket.³⁵ As of June 2003, House and Senate bills for a prescription drug benefit include substantial co-payments (\$250 to \$275), annual premiums (approximately \$420), and partial coverage ranging from 50% to 80% of costs. Lower-income beneficiaries may be eligible for subsidized premiums, and more comprehensive coverage occurs for out-of-pocket costs exceeding approximately \$3,500.³⁶ Overall, these proposals would offer partial relief, but retain considerable out-of-pocket costs for senior citizens.

Medicare reimbursement policy initiatives have further undermined the capacity of older persons to attain services. Physicians' costs, as measured by the Federal Medical Economic Index, have gone up an average of 2.2% per year over the last 12 years, whereas Medicare payment rates have gone up, on average, 1.1% per year. The discrepancy between

costs and payments has been associated with physicians' and other providers' declining to re-enroll as providers under Medicare.³⁷ At the same time, the number of available Medicare HMOs is also declining because of inadequate payment rates. During the 1990s, enrollment in Medicare HMOs increased by 30% to 40% per year until reaching its peak in 1999, with over 16%, or 6.35 million beneficiaries, enrolled. However, changes in Medicare payment policy resulting from the 1997 Balanced Budget Act have been associated with the abandonment of the managed Medicare market by many carriers. Between 1998 and 2002, withdrawal from the market resulted in a 4-year decline of 2.2 million beneficiaries enrolled in Medicare HMOs.^{38,39}

Issue: Stigma Associated With Mental Illness and Advanced Age

Older adults experience the double jeopardy of a culture that traditionally has stigmatized mental illness and advanced age. Older adults are less likely than younger persons to self-identify mental health problems or seek specialty mental health services.⁴⁰ This problem is further compounded by family members and professional providers who share the misperception that mental disorders are a "normal" part of aging.⁴¹ Without addressing stigma, systemic reforms designed to improve access are unlikely to be successful.

POLICY RECOMMENDATIONS FOR IMPROVING ACCESS AND CONTINUITY OF SERVICES

Recommended health policy reforms that correspond to the identified policy issues relating to access and continuity of services are summarized in Table 1.

Quality

The importance of providing quality healthcare services is highlighted by currently inadequate and inappropriate care of older persons. Four areas were identified with implications for policy reform: the gap between research knowledge and clinical practice in usual care settings; inadequate funding and resources devoted to research on mental health and

aging; inadequate attention to the development of interventions that promote full recovery from psychiatric illness; and a lack of preventive interventions and services for older adults.

Issue: The Gap Between Research on Effective Interventions and Clinical Practice

One of the most significant challenges facing geriatric mental health service delivery is the “expertise gap” that reflects the failure to incorporate research findings on effective interventions into usual care settings. The quality of health care currently provided to older adults with mental disorders stands in stark contrast to progress made over the last decades with regard to effective treatments for late-life mental disorders.^{4,9,30} The evidence-base is most developed for interventions addressing late-life depression and dementia, although effective treatments and service models have been identified for a variety of disorders.³⁰ However, clinical practices do not change simply through the identification and dissemination of

treatment guidelines or descriptions of evidence-based practices.^{42,43} System-change interventions that modify the process of care are needed in order to improve patient outcomes.⁴⁴ Evidence-based medicine is designed to link research and practice with clinical education and decision-making processes with the goal of optimizing the quality of care for individual patients.³⁰ A systems-based approach for implementing evidence-based practices includes the development of decision-support materials and changes in the process of service delivery, in conjunction with training, monitoring, and incentives to follow evidence-based protocols.^{44,45}

Issue: An Inadequate Research Infrastructure Dedicated to Mental Health and Aging

There is an urgent need for research that focuses on identifying the most cost-effective interventions and on developing effective methods for improving the quality of health care in usual care settings. A major priority is research that identifies the most

TABLE 1. Issues and recommendations for improving access and continuity of care

Issue	Recommendation
<i>A mismatch between the current system of care and the needs and preferences of older adults</i>	<p>Outreach and integrated services</p> <ul style="list-style-type: none"> • Direct CMS to revise payments to support integrated mental health services in primary care, residential settings, and senior service programs. • Allow same-day medical and mental health procedures. • Integrate mental health screening and outreach in routine senior services. • Support care management, care plan oversight, and other case management models through payment mechanisms that coordinate home and community-based services. • Design reimbursement policies that support outreach programs, including multidisciplinary outreach, residential support, crisis services, and telemedicine. • Deliver services by clinicians with culturally appropriate training and backgrounds.
<i>A fragmented system of mental health care for older persons</i>	<p>Service coordination</p> <ul style="list-style-type: none"> • Direct CMS, the AoA, and other relevant federal agencies to develop mechanisms to coordinate funding resources and community-based services across different service providers, agencies, and payers delivering mental health, medical, social, and long-term care services to older persons with mental disorders.
<i>Co-payments, prescription coverage, and rate adjustments</i>	<p>Medicare co-payment, prescription coverage, and rate adjustments</p> <ul style="list-style-type: none"> • Eliminate discriminatory 50% co-payments under Medicare for psychological services, and implement 20% co-payments consistent with medical procedures and services. • Enact a comprehensive Medicare prescription drug benefit that ensures access to safe and effective psychiatric medications. • Develop Medicare reforms that address the growing gap between provider costs and rates of payments that are associated with physicians and managed-care systems declining to re-enroll as providers for Medicare beneficiaries.
<i>Stigma associated with mental illness and advanced age</i>	<p>Stigma and cultural sensitivity</p> <ul style="list-style-type: none"> • Develop and implement a public education campaign under HHS, AoA, and other appropriate agencies promoting public and professional awareness that mental disorders in older adults are a public health problem that can be prevented and treated. • Technical assistance could be provided to states on increasing knowledge of late-life mental disorders through public information campaigns. • Encourage and support partnerships between federal agencies, foundations, and advocacy organizations to implement strategies that reduce stigma. • Incorporate age-appropriate mental health services into education and clinical practice.

Note: CMS: Center for Medicare and Medicaid Services; AoA: Administration on Aging; HHS: Health and Human Services.

effective approaches to implementation and dissemination of model programs within the complex service-delivery system for older persons. Continued investigations of inadequately or poorly studied high-risk elderly subjects are also needed, including research on older persons with severe mental illnesses and those with at-risk alcohol use.⁴⁶

Improving service quality for older persons will necessitate a continued and increased investment of research dedicated to mental health and aging. However, as shown in Figure 2, recent trends suggest that NIMH funding of research for mental health and aging may be decreasing relative to total expenditures for newly funded grants.⁴⁷ Furthermore, recruitment and retention of junior investigators in geriatric mental health has been low. Between 1992 and 2001, only 46 investigators received early-career awards from NIMH designed to support the next generation of researchers, and fewer than half of this group (43.5%, or 20/46) proceeded to the status of independent investigator with a subsequent major research grant.⁴⁸

Issue: Services That Promote Full Recovery From Mental Illness in Late Life

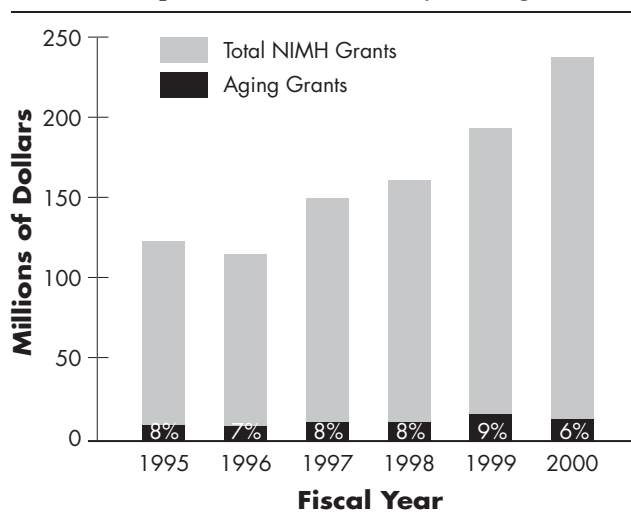
Mental health services have traditionally focused on symptom-reduction. However, residual symptoms and chronicity can be associated with significant disability and poor quality of life,⁴⁹ which may be exacerbated in the presence of co-occurring medical illness or physical disability associated with aging. Mental health consumers are increasingly advocating

for services that extend beyond symptom-reduction to support the development of skills to achieve personal goals and to improve self-efficacy and self-reliance. Goals of recovery include improved coping skills; social success; personal accomplishment; development of self-confidence, well-being, and optimism; and the development of collaborative relationships with treatment professionals.⁵⁰ Collaboration can be facilitated by models of shared decision-making that provide patients with objective information on different treatments and incorporate patient preferences and values.⁵¹

Issue: Lack of Preventive Interventions and Services

The current healthcare system lacks adequate prevention and screening programs for late-life mental illness. Crucial targets for prevention in older persons include excess disability associated with mental illness, premature institutionalization, suicide, depression, alcohol or medication misuse, and preventable medical disorders associated with cognitive impairment.^{2,4} Effective models include identification of causal risk factors, development and pilot-testing of interventions, large-scale implementation of interventions, and evaluation of their effectiveness.⁵² Consistent with Institute of Medicine prevention guidelines,⁵³ efforts are needed at the level of universal, selective, and indicated prevention. Universal prevention includes education of the public, the media, and healthcare providers on mental health and aging. Such efforts include addressing the stigma associated with mental illness, as well as providing information on the identification and effective treatment of depression, suicidal behaviors, alcohol misuse, memory disorders, and other mental health problems affecting older persons. Efforts aimed at selective prevention target specific characteristics that place older adults at greater risk—social isolation, physical disability, inadequate pain management, alcohol or medication misuse, bereavement, and other situational or medical risk factors. Finally, indicated prevention provides identification and treatment of early signs or symptoms of mental health disorders. These efforts include screening, or case identification, for older adults in primary care,⁵⁴ long-term care,⁵⁵ and other settings where older adults commonly spend time, including residential and community settings.^{56,57} However,

FIGURE 2. Expenditures for NIMH newly funded grants



screening alone is not an effective preventive strategy unless it is matched with follow-up services or treatment.⁵⁸

POLICY REFORMS AIMED AT IMPROVING THE QUALITY OF MENTAL HEALTH SERVICES

Policy recommendations that respond to the need to improve the quality of mental health services provided to older adults are summarized in Table 2.

Workforce Capacity and Enhancing Supports for Family and Peer Caregivers

The ability to provide effective mental health treatment to older persons is impeded by a shortage of healthcare providers with adequate training in geriatrics and mental illness. Issues in this section focus on the need to increase the number of healthcare providers with specialized training in the treatment of mental disorders in older adults and the need to support informal caregivers.

Issue: The Shortage of Professional Providers With Expertise in Mental Health and Aging

The proportion of the population over age 65 will increase from 12.4% of the U.S. population in 2000 to 20% by the year 2030.⁵⁹ This demographic shift is predicted to worsen the current shortfall in healthcare providers with geriatric expertise to crisis proportions. There are currently 2,285 American psychiatrists with subspecialty certification in geriatric psychiatry.⁶⁰ However, estimates suggest that adequately meeting the current need would require approximately 4,000 to 5,000 geriatric psychiatrists providing patient care⁶¹ and 2,000 physician and non-physician faculty members providing training in geriatric psychiatry.⁶² There is also a shortage of general practitioners with geriatric certification. Recommendations call for 20,000 physicians with geriatric certification, or 2.5 geriatricians/1,000 older patients, yet only 9,000 are certified.⁶³ Also, only 3% of American Psychological Association members have geriatric patients as their primary workload, although 69% provide psychological services to older adults.⁶⁴ Extrapolation of these data indicates that over 14,800

TABLE 2. Issues and recommendations for improving quality of care

Issue	Recommendation
<i>A gap between research on effective interventions and practice</i>	<p>Implementation of evidence-based practices</p> <ul style="list-style-type: none"> Federal research and regulatory agencies should sponsor a national campaign to disseminate and implement geriatric evidence-based mental health practices in routine service-delivery settings, including aging network, long-term care, primary care, and other settings where older adults receive services. This effort should build upon established methods and current initiatives aimed at implementation of evidence-based mental health services for younger adults.⁴⁵
<i>An inadequate research infrastructure dedicated to mental health and aging</i>	<p>Mental health and aging research</p> <ul style="list-style-type: none"> Direct congress to increase funding to NIMH, CMHS, AHRQ, NIA, and other federally supported research agencies for research on the causes of mental illness and on effective mental health interventions and services for older adults. Enhance research infrastructure (e.g., designate an Aging Branch at NIMH). Require the inclusion of persons age 65+ in federally funded research studies. Support training mechanisms for early-career investigators in mental disorders of aging, including: loan forgiveness programs, training supplements to existing RO-1 grants, early-career development awards, undergraduate research programs, and support for centers of excellence that prioritize research training and mentoring.
<i>Need for services that promote full recovery from mental illness in late life</i>	<p>Promotion of full resolution of residual symptoms and recovery</p> <ul style="list-style-type: none"> Develop interventions to eliminate residual symptoms of mental illness in older persons. Incorporate consumer preferences in shaping the goals of mental health treatment. Direct healthcare regulatory agencies, providers, and educators to ensure active involvement of older adults and their families in treatment-planning and decision-making. Direct publicly funded social, acute, and long-term care services toward maximal independent functioning and integration in community activities (i.e., vocational, social).
<i>Lack of preventive interventions and services</i>	<p>Screening and prevention</p> <ul style="list-style-type: none"> Identify the prevention of mental disorders in older persons as a public health priority by state and federal agencies. Prevention efforts should include universal, selective, and indicated components, including public education, outreach, and targeted interventions. Prevention and screening programs reimbursed by private health insurance programs and Medicare should include mental health, cognitive screening, and education on health behaviors associated with mental well-being.

Note: CMHS: Center for Mental Health Services; AHRQ: Agency for Healthcare Research and Quality; NIA: National Institute on Aging.

psychologists perform some work with older adults, equating to 3,100 full-time-equivalent (FTE) psychologists. However, recommendations suggest that 5,000 to 7,500 FTE psychologists are needed.²

Despite these insufficiencies, there is little emphasis on geriatric training in American medical schools and in graduate training programs. The United States has fewer than 600 medical school faculty (of 100,000 faculty members) with specialization in geriatrics;⁶³ only six of the 144 U.S. medical schools have full geriatric departments,⁶⁵ and over 40% of medical schools surveyed in 1998–1999 reported that their geriatric curriculum was inadequate.⁶⁶ In 1999, only 2.7% of family practice and internal medicine graduates entered geriatric medicine fellowships, and only 9% of general psychiatry residents entered geriatric fellowships.⁶⁷ Between 1996 and 2002, the number of geriatric family and internal medicine training positions increased from 222 to 394, and the number of geriatric psychiatry residency positions increased from 82 to 137. However, as shown in Figure 3, only 69% of geriatric medicine fellowships and 61% of geriatric psychiatry fellowships were filled in 2002.^{65,68}

There is also a lack of geriatric training among nursing providers. Fewer than 1% of the 2.56 million registered nurses are certified in geriatrics.⁶³ Moreover, among the 70,000 to 80,000 advanced-practice nurses, only 4,200 (about 5.6%) received gerontological certification between 1991 and 2001.⁶⁹ Among the

4,000 members of the American Psychiatric Nurses Association, only 16% have a subspecialization in geriatrics.⁷⁰

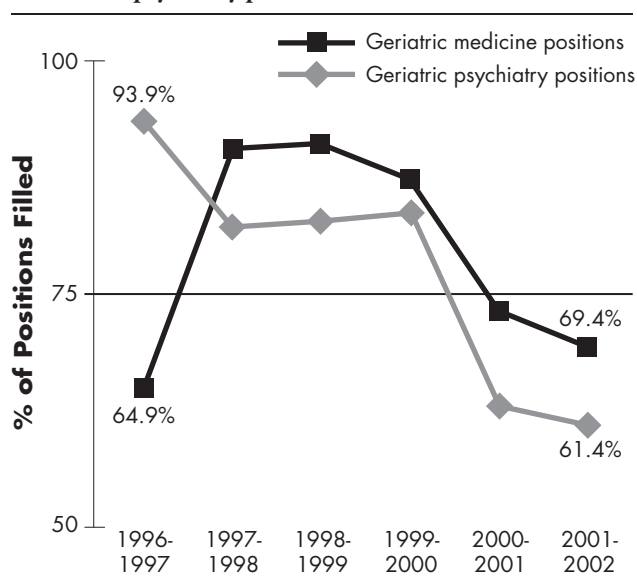
Several factors contribute to the shortfall in recruiting residents to pursue geriatric medicine or geriatric psychiatry. According to a recent survey, financial payment for geriatric psychiatric care has the most negative influence on interest in geriatric psychiatry among residents attending AAGP meetings between 2000 and 2002.⁷¹ Financial factors include the growing income gap between geriatric medicine and psychiatry, compared with other medical specialties, economic dependence on complex and inadequately reimbursed Medicare payments, and inherent biases in fee-for-service payment for the types of activities and services provided. Also, Medicare's teaching and supervision guidelines, with respect to documentation and other requirements, further limit teaching (especially in home and nursing-home settings) and contribute to less-favorable training experiences.

Issue: The Need for Enhanced Support and Services for Family and Peer Caregivers

Informal caregivers account for a large component of the healthcare workforce by providing long-term care to the majority of older adults with dementia, physical disabilities, or mental disorders. Caregiving by family members has been directly associated with lower rates of costly services for older adults with mental disorders.⁷² However, caregiving also can take a toll on the mental health of family members and has been associated with increased risk in the caregiver of developing depression, poor health, and substance abuse.^{4,73}

Several interventions have been designed to support caregivers, including counseling, support groups, respite services, skills training, and family-directed treatments.⁷² These interventions provide technical assistance on improving coping skills and attend to the mental health needs of caregivers. Successful interventions reduce caregiver burden, stress, depression, and family conflict, and increase caregiver competence and social support. These programs can delay nursing home placement by up to a year,⁷⁴ thereby decreasing formal healthcare expenditures.

FIGURE 3. Percent of first-year geriatric medicine and psychiatry positions filled



POLICY REFORMS DIRECTED AT INCREASING THE WORKFORCE OF GERIATRIC PROVIDERS AND ENHANCING SUPPORTS FOR FAMILY AND PEER CAREGIVERS

Recommendations for addressing a future shortfall in providers of services for older adults with mental disorders include a systematic assessment of the workforce needs and the identification of mechanisms to recruit and train future professionals, as well as the promotion of supportive services and interventions for family and peer caregivers. A summary of these recommendations is provided in Table 3.

CONCLUSIONS

A critical assessment of the service delivery system for older adults identifies substantial shortcomings across key domains, including access to services, quality of care, and the adequacy of the current and future workforce. The current system of care is fragmented and generally fails to correspond to the preferences, needs, and goals of many older adult consumers. Other major barriers to appropriate care include inadequate financing and reimbursement of services for providers, as well as barriers for consumers that include discriminatory co-payments for psy-

chological services and a lack of prescription drug benefits under Medicare. Public funding of services is also being eroded for the most disabled and financially challenged patients under current plans to cut Medicaid expenditures because of unprecedented deficit budgets in the majority of states. Quality of mental health services for older persons lags behind services for younger adults, despite a growing evidence-base supporting the effectiveness of a variety of interventions and services for late-life mental disorders. Finally, the research and service infrastructure is woefully inadequate to meet the projected demand for interventions, services, and trained providers needed to address the growing number of older adults with mental disorders.

Policy reforms are indicated that respond to each of these crucial areas. Some of the recommendations identified in this analysis consist of reorganization and restructuring of existing services or shifting of current priorities and resources. Such efforts include regulatory reforms that promote integrated services, public education campaigns aimed at eradicating stigma, and initiatives that support the implementation of evidence-based practices. Other policy reforms are unlikely to occur in the absence of dedicated financial reforms and appropriations, including Medicare and Medicaid reforms, and development of an adequate research and service infrastructure dedicated to older adults with mental disorders. Despite

TABLE 3. Issues and recommendations for developing workforce capacity and caregiver support

Issue	Recommendation
<i>A shortage of professional providers with expertise in mental health and aging and in geriatrics</i>	<p>Increase the number of providers with expertise in mental health and aging.</p> <ul style="list-style-type: none"> • A systematic evaluation should be undertaken to evaluate future workforce needs with respect to healthcare providers trained in geriatric psychiatry and in allied professions. Specific attention is warranted in identifying factors that contribute to the failure of geriatric residency programs to fill training slots and to create strategies to improve recruitment into geriatric specialty training programs. • Explore incentive programs, including loan repayment programs and increased authorization of graduate medical education (GME) payments. • Required training in geriatrics should be expanded for long-term care nurses, certified nursing assistants, and other allied professionals in addressing psychiatric disorders and behavioral symptoms of dementia. • Approaches to increasing the number of providers with geriatric mental health training include early educational awareness of geriatrics as a potential healthcare career path,⁷¹ development of multidisciplinary training environments for aging and mental health; increasing provider competencies through information-technology mechanisms; and increasing the proportion of educational programs with training in the identification, assessment, and management of late-life mental disorders.
<i>A need for enhanced support and services for family and peer caregivers</i>	<p>Enhance caregiver and peer support services</p> <ul style="list-style-type: none"> • Mental health services should be incorporated into current programs designed to support caregivers. • Enhance educational programs on home-based management of mental disorders and increased knowledge on aging, dementia, mental health, caregiving skills, resources, and options of care. • Provide enhanced support services, direct care services, and mental health services for family caregivers. • Increase the number of peer-support programs by promoting partnership between federal programs and advocacy organizations and directing state and county health systems to support development of peer-support programs.

current pressures on legislative budgets to limit growth in healthcare expenditures, the anticipated "graying of America" will inevitably incur substantial acute and long-term costs. Without targeted policy reforms, future generation of young and old Americans will tragically bear the economic and social costs of excess disability, diminished quality of life, and a healthcare system overwhelmed by an epidemic of mental disorders of aging.

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