



the mental health association
of new york city, inc.



THE GERIATRIC MENTAL HEALTH ALLIANCE OF NEW YORK

GERIATRIC MENTAL HEALTH:
TESTIMONY BY ALLIANCE MEMBERS
REGARDING THE NYS OFFICE OF MENTAL HEALTH'S 5-YEAR PLAN
Spring 2005

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Geriatric Mental Health:
Testimony by Alliance Members
Regarding the NYS Office of Mental Health's 5-Year Plan

This document contains testimony provided by members of the Geriatric Mental Health Alliance of New York in response to the New York State Office of Mental Health 5-Year Plan. Many people focused their testimony exclusively on geriatric mental health issues. We have provided their complete testimony. Several others noted geriatric mental health issues as part of broader testimony. We have provided the excerpts relevant to geriatric mental health.

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**The Center for Policy and Advocacy of The Mental Health Associations of New York
City and Westchester**

Michael Friedman, Chairman of the Geriatric Mental Health Alliance of New York

My name is Michael Friedman. I am the Chairman of the Geriatric Mental Health Alliance of New York—an advocacy group dedicated to improving geriatric mental health practice and policy. We now have over 700 members, three core workgroups—in NYC, Westchester, and Albany--and a number of workgroups focused on special issues such as the geriatric mental health needs of Asian older adults and of Hispanic older adults, with more information such as a workgroup on serious mental illness and aging. We sponsor a series of presentations on best practices featuring some of the most accomplished geriatric mental health and substance abuse specialists in the United States. We are also conducting focus groups, which are providing a wealth of information about the mental health needs of older adults, about best practices, and about barriers to using them. In addition, our work has contributed to the formation of geriatric mental health groups in Nassau, Rockland, Suffolk, and Warren and Washington Counties as well as in several states across the country. These groups all realize that now is the time to focus on the mental health needs of older adults.

It is hard to believe that just a year ago we testified before you and criticized OMH's Five-Year Plan because it contained only a footnote about geriatric mental health. It appeared that New York State had not yet realized how critical the mental health needs of older adults are. Since then the Office of Mental Health has made older adults a priority population, committed to develop a long-term plan, appointed a senior staff member to lead its efforts, promised to include evidence-based practices regarding geriatric mental health in its Winds of Change initiative, and devoted special attention to older adults in its suicide prevention initiative. The Commissioner has taken a personal interest in geriatric mental health issues and made a spectacular presentation to our Alliance last fall. She announced then that she would work with us to organize a roundtable to develop recommendations regarding how to integrate mental health and health services for older adults. Outside of OMH, there have been positive developments too. The State Office for the Aging (SOFA)

has designated a lead person on mental health, and the Commission on Quality of Care and the Department of Health both have begun to explore the role that they can play.

And—who would have believed it a year ago—the NYS Legislature is about to pass the Geriatric Mental Health Act, which we believe will be signed by the Governor and lead to the establishment of a services demonstrations grants program and an Interagency Geriatric Mental Health Planning Council.

Perhaps I should just say thank you and sit down.

I will say thank you. But I will not sit down. We have miles to go before we sleep, and I want to offer several suggestions to help to move the process along.

Older Adults Should Be Recognized As a Core Population

The plan classifies older adults as a “special population” along with children with depression, young adults, people with mental illness who use forensic systems of care, people with mental illness who reside in adult homes, and people who require intensive levels of care coordination. These are all important populations, but we believe that older adults should instead be viewed as a core population, along with children and adolescents and adults.

It is important to understand that older adults are a population with significant development differences from younger adults, differences that are just as significant as those children and adolescents have from adults.

It is also important to understand that over the next quarter century, the population of people 65 and older will become nearly as large a proportion of the population as are those under the age of 18. The population of older adults will grow from 13% to 20% while the population of children diminishes from 28% to 26%.

The population of older adults is not a small but important sub-population; it is a core population that deserves as much attention as children.

Need Leadership Dedicated to Geriatric Mental Health

That is why we have repeatedly called for OMH to appoint a Deputy Commissioner to head a division of geriatric mental health. This would recognize the growth of the population of older adults by allowing someone to focus exclusively on the mental health needs of this population. Although OMH's point person on geriatrics is terrific, a planning process and other necessary steps require the designation of a full-time staff with senior full-time leadership.

Establishment of a Planning Advisory Committee

We also believe that the planning process would be aided by the establishment of a planning advisory committee consisting of a mix of (1) geriatric mental health, health and aging providers; (2) advocates; (3) senior citizens; (4) academics from the fields of medicine, psychiatry, nursing, psychology, social work, and gerontology; (5) researchers, (6) clergy; and (7) others. This would provide a formal way for OMH to receive input from stakeholders, which, according to the plan, is one of OMH's major goals.

Data Needs

In order to develop a long-term plan, it will be important to pull together information regarding demographics, prevalence, utilization, current services, current funding mechanisms, service gaps and needs, and best practices. This should include information about treatment of older adults with mental illness in the health and aging services systems and in the private sector because without this information it will not be possible to make a reasonable assessment of unmet need.

It will also be important to identify legal, regulatory, structural, and financial barriers to the use of best practices and the development of innovative practices.

Roundtables

The Commissioner has proposed holding roundtable discussions regarding the mental health needs of older adults. We believe that such discussions would go far towards identifying barriers to the use of best practices and in developing policy proposals to overcome these barriers. We look forward to working with OMH to establish the roundtables. We suggest that roundtable topics include:

- integrating health and mental health, as already proposed by The Commissioner,
- community supports for aging people with severe, long-term psychiatric disabilities including new housing and rehabilitation models;
- the role of mental health services in reducing the need for institutional long-term care services such as nursing and adult homes;
- access to services with special attention to the need for home and community-based services;
- quality of care in the community and in institutions, including facilities and programs overseen by the Department of Health and the Office for the Aging as well as those in OMH's orbit of responsibility;
- serving minorities, with particular attention to issues of cultural competence;
- family support; and
- new finance models.

Quality Improvement, Workforce Development, and Public Education Initiatives

Obviously it will take some time to organize and carry out the roundtables and the inter-agency planning process. At the end of that process, NYS should be able to issue a multi-year program development plan. While this process is unfolding, we believe that OMH can, and should carry out initiatives to improve quality, provide public education, and enhance the workforce. The quality improvement initiative should include:

- Adding evidence-based practices regarding geriatric mental health to the Winds of Change program,

- Developing an interagency training initiative regarding geriatric mental health for personnel who provide health care, aging, adult protective, and entitlement services,
- Reviewing regulations for mental health programs to determine whether they are appropriate for older adults,
- Enhancing geriatric mental health research at NYS's research institutes, and
- Establishing a clearinghouse to disseminate information regarding geriatric mental health

The public education initiative should be designed to combat stigma and ageism and to provide information about mental illness, the effectiveness of treatment, and access to existing resources.

The workforce development initiative should include the creation of incentives to improve geriatric mental health education in medical, social work, and nursing schools as well as graduate programs in psychology; incentives to attract people to work with older adults with mental disorders, especially to attract minorities; and the development of new roles using paraprofessionals, volunteers, and peers.

Conclusion

I want to end where I began by acknowledging how much progress has been made over the past year and by thanking OMH for its recognition of, and rapid response to, the growing issues of geriatric mental health in an aging America. We look forward to continuing to work with you to organize a high quality system of services to meet the mental health needs of New York State's senior citizens.

Selfhelp Community Services
Becky Bigio, Clinical Manager for Behavioral Health

Good Afternoon, Deputy Commissioner Simons and distinguished panel members. My name is Becky Bigio. I am a Psychiatric Nurse Practitioner with a PhD in Counseling and am at present the Clinical Manager for Behavioral Health at Selfhelp Community Services and an Adjunct Professor at New York City College of Technology. I also act as a Consultant to other divisions of my agency on mental health issues. I want to thank you for inviting us to testify today.

Selfhelp Community Services is a non-profit organization founded in 1936 by a small group of refugees fleeing Nazi persecution. Today, while continuing to serve more than 4,000 Nazi victims, Selfhelp has become one of New York's largest and most vital geriatric and home care agencies.

Selfhelp has built an admirable record over the last 66 years. Men and women from six continents call our senior residences home. Other community agencies turn to us for training and home care workers. The City and State rely on us for programs ranging from congregate meals for seniors to support for families with Alzheimer's. Our programs have steadily expanded over the years to embrace an increasingly diverse community. Today, Selfhelp serves nearly 20,000 New Yorkers and, as a member of UJA, Selfhelp works closely with other UJA agencies on policy issues that affect our very vulnerable clients.

As Clinical Director, I have become increasingly aware of the dearth of mental health services available to help our clients cope with crisis, chronic mental disease and depression. It is clear that geriatric mental health services are not currently a high priority of the mental health establishment and therefore tend to be under-funded or, indeed nonexistent.

This is particularly problematic when we take even a cursory look at demographic projections which indicate an exponential growth in numbers and diversity of the older population by 2015. In order to serve this changing demographic we will need to not only

provide more mental health services but will in fact be charged with the responsibility of ensuring that services are culturally and ethically appropriate. This is a daunting task made even more difficult by a cultural bias against acknowledging the need for mental health services for older people. It seems difficult for the public and even government agencies to admit that older people have the same needs and problems as younger people. Just as we were late to provide education about AIDS to the over 60 population, we are slow to provide mental health services to the same group.

However, professionals in the field of mental health are all too aware of the growing needs for such services for seniors who suffer from depression, alcohol and drug addiction and other forms of mental illness that appear in the general population. Mental illness does not appear when a client turns 60.

After the tragedy of 9/11, Selfhelp was one of the agencies provided with a grant to work with the elderly who had been traumatized by the event. As Director of the Person-to-Person Program at Selfhelp, I became painfully aware of the need for more than just crisis intervention. I found that there were older people living in isolation trying to cope with increasing fears and depression and the programs created in the aftermath of 9/11 only began to touch the surface of their needs.

According to the Center for Studies of the Mental Health of the Aging, depressive illness in the elderly can take a variety of forms and therefore is sometimes difficult to recognize. Elderly persons may complain of physical pain or fears of symptoms they believe are signs of severe illness. This results in the difficulty doctors have in determining whether symptoms are based on physical problems or emotions. Another problem occurs due to the fact that medications elderly people take for age-related illnesses and the combinations of drugs they take can affect mood and cause depression. It is therefore essential that health and mental health in geriatric care be integrated and that additional medical professionals are trained in geriatrics so they are attuned to the health needs of the whole patient and not dismissive of mental health conditions leading to under-diagnosis of depression in the elderly. The current system of care provided to elderly depressed persons is inadequate, fragmented

and passive. Since so many elderly people live alone and have no one to support them, they are difficult to locate and treat.

There are too few programs available to deal with the needs of impaired seniors and those that do exist tend to be under-financed and difficult to access. Selfhelp is one of the three non-profit agencies to sponsor a Guardianship Program under contract to the Human Resources Administration Adult Protective Services program. In the early 1970s with the passage of the Title XX of the Social Security Act, the separation of welfare (cash) from social services. However, the impact was to remove the aged from easy entry into the service delivery stream. APS has generally fallen into the generic social service system though it has a predominantly aged clientele. It is not integrated with other case-finding and service delivery systems and it lacks the base of support the aging network has established. The increasing demand for services of APS is the result of the demographics of “old” aging which is composed of a diverse, dispersed population over 75 with chronic illness, physical and/or mental impairment, living alone, predominantly female and socially isolated. APS has become the referral of last resort for alcoholics, substance abusers and persons with mental impairments who are service resistant. The Guardianship Program was established under 1933’s Article 81 of the Mental Hygiene Law and is designed to satisfy the needs of an incapacitated person, either personal or financial, while at the same time tailored and limited to only those activities for which a person needs assistance. APS has identified a growing need for programs like ours but public dollars for the service have not kept pace with the need.

Affordable housing is particularly problematic for the elderly, mentally impaired. Though the Olmstead decision establishes the public responsibility to provide the least restrictive environment for the disabled, the reality of the housing market in New York is such that there is very little opportunity to locate affordable housing particularly housing with services. Adult homes have become a dumping ground for the elderly, mentally impaired who are often victimized by younger residents at worst and entirely neglected at best. The mental health needs of this population and the inability of most adult homes to meet those needs was made dramatically clear in a scathing indictment in a series of articles

in the New York Times in 2002. There must be a more humane solution to this housing dilemma.

The mental health system generally has not been preparing for the demographic shifts that will take place with the next two decades. As the number of older adults grows so will the number of older adults with significant mental health problems. However, Medicare pays only 50% of the costs of outpatient treatment and sets limits on inpatient treatment which sometimes results in premature discharges from hospitals. If they are dually eligible for Medicaid coverage most elderly people will go without mental health services because they cannot afford the co-pay required to access services. This is a result of a continuing reluctance on the part of the insurance industry and Medicare to give parity to the mental health needs of patients equal to other medical insurance.

Programs for patients with Alzheimer's disease are woefully under funded through these programs provide many of the services required to maintain mentally impaired seniors in the community. For those seniors whose medical conditions do not require a medical model of day care, accessing a non-medical model can often be financially prohibitive since the programs are under funded and require that program participants provide a co-payment. This is often impossible because, while not Medicaid eligible, they have very low incomes that barely cover basic needs. Medicare and Medicaid do not recognize these programs as a necessary service because they deal only with the mental health of a patient.

Finally, I would like to make a plea for the lifting of the moratorium on Article 31 Mental Health clinics. Selfhelp had wanted to apply for access to Article 31 licensing so that they could provide services to a multi-generational population. It is important that this option be re-opened so that our clients and others in need of these services can be served in their own communities.

I thank you again for your attention to my testimony and I will be happy to answer any questions.

F·E·G·S

A MEMBER AGENCY OF UJA FEDERATION OF NEW YORK

Amy Dorin, Senior Vice President for Behavioral Health

For many of us, it is difficult to face the fact that we will someday be counted among the elderly. In our youth-oriented culture, the elderly are not as revered as they are in many other cultures, and the richness that senior community members bring to life is not adequately appreciated. They are not properly viewed as a group that warrants specially designed services. Now is the time for us to turn this situation around.

We are all aware that the baby boom generation is aging and that seniors are becoming a growing segment of our society. According to facts compiled by Dr. Michael Friedman, the Director of the Center for Policy and Advocacy of the Mental Health Associations of NYC and Westchester, from 2000 to 2030 the 65 and older population in the US will double from 35 million to 70 million and comprise about 20% of the American population. From 2010 to 2020, the growth will be 35% from about 40 million to 54 million.

What is less well known is that from 2000 to 2030, the number of older adults with mental illnesses will double from 7 to 14 million. This group will include people who have a wide range of problems requiring intervention, from the less severe to the most seriously chronic mentally ill. Considering that the world situation today is fraught with ongoing concerns about our very existence, it is likely that additional anxiety will exist for everyone. This includes the elderly, many of whom were traumatized by war, or were immigrants who experienced trauma in their countries of origin. Given these factors, we must anticipate that the number of elderly who need assistance with mental health issues will grow significantly over the next several decades. How will the mental health system accommodate the staggering numbers of individuals and their special needs, when today, the geriatric population is rarely, barely defined as a special group, such as children or adolescents, and often bundled with the adult population at large?

F·E·G·S, a large and diverse health and human services system, reaches more than 18,000 people with mental illness a year. The F·E·G·S network of mental health services includes: clinics; day treatment programs for the chronically mentally ill; psychiatric rehabilitation programs; and case management services, at locations throughout the NY metropolitan area. Of the more than 7,000 people presently served in F·E·G·S' clinics, approximately 20% are 65 years of age or older. Many seniors are served through our clinics in Brooklyn and Rego Park where there is a large population of older Russian-speaking immigrants. In one clinic serving primarily Russian-speaking clients, about 50% are 65 years of age or over. Some are as old as 85 and struggling with depression, histories of trauma, and the complexities of being an immigrant. Some arrived in this country and could not find work, which led to clinical depression. In addition, F·E·G·S serves the very vulnerable mentally ill - often elderly people who reside in the adult homes. These homes shelter the mentally ill whose level of functioning and severity of illness precludes their admission to community residences.

We are concerned that the New York State Office of Mental Health's Five-Year Plan does not specifically highlight the needs of the elderly; rather, they are included in the generic "adult" category. We need to plan carefully and specifically for the needs of the elderly, and do so now, before the number of people in this age group increases and their many needs are upon us. Older adults with mental illness, as is the case with any population group, have a wide range of needs, necessitating a broad array of interventions. The following begins to address some of the basic issues and actions that must be taken to avoid unnecessary and expensive hospitalizations and nursing home placements, and to provide high quality and efficient services:

- Workforce issues are significant. A higher value must be placed on geriatrics within our society so that social workers, physicians, and other practitioners will want to enter the field. Reflecting the larger culture, most health professionals today shy away from entering geriatric specialties and services. Training in professional schools must include curriculum on older adults. The elderly comprise a special group, with specific developmental needs and tasks, just as children and adolescents do. Curriculum must

focus on this, as well as on the other complexities in working with an elderly population.

- Government at all levels must include geriatric bureaus and divisions within Mental Health Departments to insure a focus on geriatric care. Government must take the lead on developing a culturally sensitive and culturally competent system of mental health care for the elderly. We applaud OMH's emphasis on practice that is based in research outcomes. Evidence-based practices must be developed for geriatric mental health services.
- Mental health services must be flexibly provided, with clinicians going to the community and to the home to assist those with limited mobility. Funding for mental health services must be increased to allow for significant home-based services and crucial prescription drugs, presently not covered by Medicare. The integration of medical and mental health care, in general, and certainly in the home, is a key element of future programming.
- The consideration of possible substance abuse issues is also necessary, especially with the potential abuse of prescription medication. The prevalence of depression in the elderly, with the possibility of suicide, warrants careful evaluation and should be a standard part of a mental health-screening tool.
- A clinical understanding of trauma and how to treat it is key in serving the elderly population. For elderly Americans who fought in wars, survived the holocaust, and for immigrants who arrived late in life, the experience of trauma in their countries of origin may complicate/compromise functioning.
- Intergenerational issues are clearly highlighted with respect to the role of the caregiver. On the one hand, the elderly frequently require help from family members, many of whom may be elderly themselves. Stress on the family caregivers will be more widespread as attempts are made to keep the elderly at home. Therefore, the caregivers'

needs must be addressed as part of the delivery of services to the elderly person. Further, the elderly in many families have also become the caregiver for grandchildren when parents are absent or unable to provide parenting. In these situations, the mental health implications for the elderly caregiver and the children are potentially far reaching. Additionally, adult dependent children pose challenges because many have been "kept under the radar screen" by their now aged parents. Their complex needs as they approach 65 years of age and older also warrant special intervention.

- With growing numbers of the elderly, there is the likelihood of growing numbers who are experiencing abuse, neglect, and exploitation. Sadly, this is becoming a grave situation. Every older person has the right to be free of neglect or abuse. The Elder Justice Act, now in Congress awaiting ratification, would provide federal resources to support State and community efforts, which are dedicated to fighting elder abuse. Elder abuse needs to be addressed through prevention, detection, treatment, and intervention.

There are many issues that arise as we consider the numbers and needs of the elderly in the not so distant future. Thank you for the opportunity to submit this testimony regarding the importance of mental health services to the elderly.

Service Program for Older People, Inc.
Nancy Harvey, Executive Director

Read by

Kimberly Steinhagen, Project Coordinator of the Geriatric Mental Health Alliance of New York of the Mental Health Associations of New York City and Westchester

My name is Kimberly Steinhagen. I am the Project Coordinator of the Geriatric Mental Health Alliance of New York. I am submitting this testimony on behalf of Service Program for Older People, Inc. (SPOP). SPOP is a community based mental health agency that has served older adults for 32 years, reaching approximately 750 older adults each year. As one of the only agencies in Manhattan to focus on the mental health needs of older people, SPOP is an expert on how-to-best deliver mental health services to the under-served elderly.

SPOP's mission is to enhance the quality of life of older adults and to foster their independent living through the delivery of comprehensive mental health and supportive services, advocacy and education. Through six core programs – Adult Day Center, Clinic, Continuing Day Treatment Program, Geriatric Peer Advocacy Program, Geriatric Outreach Assessment Linkage Program, and Widowed Persons Service – SPOP's mental health professionals provide older people with the emotional support, counseling, and connection to the other crucial resources they need so that they may continue to live full and healthy lives in the community. SPOP concurs with the findings of the GMHANY report¹, cited in the OMH Statewide Plan, that services for older adults must be designed to enable them to lead satisfying lives in their community.

SPOP applauds OMH's inclusion of geriatric mental health in the 2005-2009 Statewide Plan. Given the growing numbers of older adults, a focus on older adults remains a priority if their specialized needs are to be adequately addressed.

¹*Geriatric Mental Health Policy: A Report of the Observations of Advocates, Providers, Researchers, Academics, Government Officials and Older Adults*, Geriatric Mental Health Alliance of New York, 2004.

Current mental health services dedicated to older adults remain inadequate. More than one-fifth of older adults have a mental disorder. The continued growth of the senior population, particularly among the older, frail elderly, will create an increased need for mental health services. To adequately cope with the needs of older adults, SPOP recommends the following:

- ❑ Integrating mental-health, health and aging services including effective collaboration among OMH, the Office of the Aging and the Department of Health.
- ❑ Creating a leadership position at OMH dedicated to seniors and their mental health needs.
- ❑ Developing a comprehensive plan to address the lack of access to services. Traditional delivery of services is built on the assumption that older adults will come into an office to obtain services. Unfortunately, this model is often inadequate for seniors who frequently attach a stigma to receiving mental health services, and may be physically unable to travel. In order to increase access, services need to be designed to reach older adults where they reside in the community. SPOP's Clinic outreach service, which stations social workers at senior centers and sites, combined with mental health home visits is a model for such effective access. Approximately 60% of SPOP's mental health services are delivered to homebound older adults.
- ❑ Expanding education to address the public's unfamiliarity about mental health and the stigma associated with obtaining services. As noted in the Statewide Plan, the GMHANY report recognizes that older adults and their families frequently do not seek treatment, even when it is accessible. In older adults, symptoms of mental illness are often attributed to aging, and are therefore often overlooked by primary caregivers, doctors and even caseworkers, who may lack mental health training.

SPOP thanks OMH for providing this opportunity to submit testimony.

Council of Senior Centers & Services of NYC, Inc.

Bobbie Sackman, Director of Public Policy

Kathleen Zvarych, Legal Advocate

I am Bobbie Sackman, Director of Public Policy of the Council of Senior Centers and Services (CSCS). CSCS is the central organization representing 265 member agencies providing community-based services to 300,000 older New Yorkers annually. Services include: multi-service senior centers, meals-on-wheels and on-site congregate meals, case management, home care, Naturally Occurring Retirement Communities (NORCs), transportation, adult day services, housing, counseling, caregiver services, intergenerational programs, English as a Second Language and other immigrant assistance, assistance with benefits and entitlements, educational, arts and cultural activities, health/wellness programs, and opportunities for volunteerism.

First, on behalf of CSCS, its member agencies, and the 300,000 elderly people they serve, we would like to thank the Office of Mental Health (OMH) for making geriatric mental health an official priority in its five year plan. CSCS is a member of the Geriatric Mental Health Alliance and supports the Comprehensive Geriatric Mental Health Act. When CSCS surveyed its membership of senior service providers, mental health services was listed as one of the highest needs of their senior citizen constituency. We look forward to the development of a geriatric mental health work plan as an important step to building the capacity of mental health services for older New Yorkers.

During the development of the geriatric mental health work plan, it is important to evaluate information regarding demographics, prevalence, utilization, current services, current funding mechanisms, service gaps and needs, and best practices. We support the Commissioner's proposal for a roundtable discussion on the mental health needs of seniors and would like to participate. The roundtable workgroups should not only address the integration of health and mental health services, but also consider topics such as the role of mental health services in reducing the need for institutional long-term care services such as nursing and adult homes, and the need for home and community-based mental health services. It is increasingly recognized that providing mental health services to seniors living in the

community helps them stay mentally and physically healthy and age in place. Senior citizens consider senior centers their “second home” which makes it a comfortable environment for them to receive counseling and other services. Case management agencies working with homebound elderly would be another valuable resource for providing geriatric mental health services. The roundtable discussions would also be the appropriate forum for issues of cultural competence when serving minorities with mental illness.

In addition to the geriatric mental health work plan and the roundtable discussions, it is important to address quality improvement, workforce development and public education. We recommend developing geriatric mental health training for health care, aging, adult protective, and entitlement workers. Another suggestion for quality improvement is to establish a clearinghouse to circulate information regarding geriatric mental health. Workforce development initiatives should create incentives to improve geriatric mental health education in medical, social work, and nursing schools as well as graduate programs in psychology. Finally, a public education campaign providing information about mental illness, the effectiveness of treatment, and resources, will help to overcome the stigma surrounding mental health while also combating ageism. Thank you for the opportunity to submit testimony. We look forward to working with OMH through the Geriatric Mental Health Alliance to develop capacity building measures for geriatric mental health services.

United Neighborhood Houses
Jessica Walker, Policy Analyst

Good morning, my name is Jessica Walker and I am a Policy Analyst at United Neighborhood Houses (UNH). UNH is the membership organization of New York City settlement houses and community centers. Founded in 1919, UNH's membership comprises one of the largest human service systems in New York City, with 35 agencies working at more than 300 sites to provide high quality services and activities to more than a half million New Yorkers each year. For over 85 years, UNH has worked with its members to strengthen families and improve neighborhoods throughout the City. UNH supports the work of its members through advocacy and public policy research and analysis, technical assistance and funding and by promoting program replication and collaboration among its members. Thank you for giving me the opportunity to speak today.

First, I must applaud the State Office of Mental Health (OMH) for effectively collaborating with various stakeholders, led by the Geriatric Mental Health Alliance of New York (of which UNH is a member), to make the mental health needs of older adults a priority area in this Comprehensive Plan. As you may know, depression, dementia, anxiety, and substance abuse among older adults are growing problems that too often result in functional dependence, long-term institutional care, reduced quality of life, and potentially suicide. In general, however, seniors use mental health services significantly less than any other age group.

Currently, the OMH's Comprehensive Plan offers a vital glimpse into the emerging characteristics of this population: increased racial and ethnic diversity, weakened family support structures, and fewer caregivers for a larger number of older persons needing care. Today, I would like to bring to your attention two other emerging issues of importance:

□ **Social Isolation Among Seniors**

Social isolation among seniors, commonly referred to as "senior isolation," occurs when an older adult has such limited social ties that there are few places to turn for

help or for social support when the need arises (the weakening of family support structures being just one potential cause). Senior isolation is often correlated with mental illness and can be a major obstacle to accessing treatment.

UNH recently released a groundbreaking new report entitled, *Aging in the Shadows: Social Isolation Among Seniors in New York City*. This report defines and describes the problem of social isolation among seniors, highlights the particular vulnerability of New York City seniors, gives examples of programs already in place working to combat this problem, and offers recommendations for change. The report concludes that New York City's 1.3 million older adults are at greater risk of experiencing social isolation and its detrimental effects than their counterparts nationwide. This trend is expected to worsen in the coming decades as a demographic surge in the elderly population takes hold. As a group, baby-boomers harbor even more risk factors for senior isolation than the current generation of seniors; as such, a formula for disaster exists that will require the attention of government, business leaders, and top officials across the nonprofit sector. We hope that you will incorporate this problem into your planning and continue to collaborate with stakeholders to find solutions.

□ The Need for Neighborhood Based Geriatric Mental Health Services

Despite the magnitude of the problem, seniors with mental illness often go unrecognized, undiagnosed, and untreated. Seniors who grapple with the stigma of mental illness may be less likely to seek out the treatment and services they so desperately need. Services provided in neighborhood based, normative settings (such as in the home, religious institutions, or senior centers) often overcome this stigma better than those found in hospitals, clinics, and nursing homes. Such options are often more cost-effective as well.

On the federal level, the Positive Aging Act, first introduced in Congress in 2001 and receiving renewed attention, would address the mental health needs of older adults by promoting models of care that integrate mental health services and

medical care within primary care settings and improve access to mental health services in neighborhood based settings. We hope that OMH will support this federal legislation while also incorporating such models into its own services.

Finally, we suggest that the following be included in the development of an OMH work plan regarding geriatric mental health (as recommended by the Geriatric Mental Health Alliance of New York):

- Establishment of an Ongoing Planning Process, Including:
 - a. Establishment of an interagency planning group
 - b. Establishment of a planning advisory committee
 - c. Information gathering regarding demographics, prevalence, utilization, current services current funding mechanisms, service gaps and needs, and best practices.
 - d. Identification of legal, regulatory, structural, and financial barriers to the use of best practices
 - e. Request for plans from localities.

- Establishment of Strategy Development Workgroups Involving Diverse Stakeholders on Such Topics As:
 - a. integrating health and mental health services;
 - b. community supports for aging people with severe, long-term psychiatric disabilities;
 - c. access to services
 - d. quality of care in the community and in institutions
 - e. serving minorities
 - f. family support
 - g. new finance models

- Development of a Multi-Year Program Development Plan for People with Severe, Long-Term Psychiatric Disabilities Who Are Aging, for Older Adults with Late Onset Mental Disorders, and for Family Caregivers Including:

- a. Adaptation of community support programs for older adults currently in the community and for those who could make a transition from institutional settings to the community
 - b. Adaptation of OMH's housing programs for older adults
 - c. A greater role for OMH in oversight of adult homes and nursing homes serving significant numbers of people with mental disorders
 - d. Family support
 - e. Integration of mental health, health, and aging services
 - f. Provision of mobile, home and community-based services
 - g. Provision of services to reach out to and engage minority populations
 - h. Preventive interventions, especially suicide prevention and increasing life expectancy of people with serious mental illnesses.
- Establishment of a Quality Improvement Initiative
 - a. Add evidence-based practices regarding geriatric mental health to the Winds of Change program
 - b. Establish initiatives to increase cultural competence specifically regarding older adults
 - c. Develop an interagency training initiative regarding geriatric mental health for personnel who provide health care, aging, adult protective, and entitlement services
 - d. Review regulations for mental health programs to determine whether they are appropriate for older adults
 - e. Establish a clearinghouse to disseminate information regarding geriatric mental health
 - Establishment of a Workforce Development Initiative
 - a. Create incentives to improve geriatric mental health education in medical, social work, and nursing schools as well as graduate programs in psychology
 - b. Develop incentives to attract people to work with older adults with mental disorders, especially to attract minorities
 - c. Develop new roles using paraprofessionals, volunteers, and peers

- Establishment of a Public Education Initiative
 - a. To provide information about mental illness, the effectiveness of treatment, and resources
 - b. To overcome stigma
 - c. To combat ageism and create a positive image of aging

- Research
 - a. Review of research portfolios at Nathan Kline Institute and Psychiatric Institute
 - b. Require these institutes to do more research related to geriatric mental health
 - c. Help to develop linkages with other research institutions in NYS

We appreciate the work of OMH and look forward to working with you to bring about these necessary changes.

Thank you.

The Coalition of Voluntary Mental Health Agencies, Inc.

Phillip Saperia, Executive Director

As an active member of the Geriatric Mental Health Alliance, we are delighted that OMH's Plan acknowledged the efforts of the Alliance in raising public awareness in this emerging area. We are encouraged that Commissioner Carpinello and her staff have identified geriatric mental health as a priority population. We thank OMH for meeting with the Alliance and expressing interest in initiating a roundtable discussion and a work plan concerning geriatric mental health in the coming months. We urge OMH to include a broad array of advocates, providers and consumers in developing a comprehensive plan for how to address the unique needs of seniors living with mental illnesses. Ideally, the plan should include strategies for reaching out to those aged consumers who are gay, lesbian, bi-sexual or transgendered and who battle loneliness, disaffection and stigma in addition to their illness or illnesses. We add our support to those who will testify here today about the specifics of what OMH's geriatric work plan ought to encompass.

The Mental Health Associations of New York City, Inc.

Giselle Stolper, Executive Director

We are very pleased that this year's plan announces that older adults are a priority population for OMH and that a plan will be developed regarding how to meet their needs. However, we believe that classifying older adults as a "special population" neglects the fact that over the next 25 years, older adults will become almost as large a portion of the population as children and adolescents. We believe that older adults should be regarded as a core population, like children and adolescents, and that a division headed by a Deputy Commissioner should be established as it has been for children and adolescents. There is a great deal of work to be done to plan and develop adequate services to meet the mental health needs of older adults. Without a staff dedicated to that work, how can it possibly be done?