



SSA BULLETIN

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BEHAVIORAL HEALTH IS KEY TO LONG-TERM CARE REFORM

By Kimberly A. Williams, LMSW and Michael B. Friedman, LMSW

Over the last few years, there has been a lot of rhetoric about, and some movement towards, reforming the long-term care system at both the state and national levels. The thrust of reform is to improve the quality of life for people with disabilities and their families by helping people to live where they prefer – most often in the community. The expectation is that the proposed reforms will reduce costs. Unfortunately, the various reform initiatives neglect the vital role behavioral disorders play in institutional placement, and how critical addressing these disorders is to long-term care reform efforts.

But why is behavioral health so essential to long-term care reform? It's key for a number of reasons:

1. ***A significant percentage of individuals in the long-term care system have behavioral disorders, and many do not get appropriate assessment and treatment services, if at all.***

In home health care, about 19% of individuals have dementia, 14% have major depression and 11% have minor depression. Only 22% of those with major depression are getting treatment. More than half of the population in adult medical day programs are people with serious and persistent mental illness. In fact, some of these programs are recruiting for this population because most of these individuals have co-occurring physical disabilities and/or dementia, and virtually all of them are Medicaid eligible. In assisted living facilities, about 68% of residents have dementia, 19% have mood disorders, 13% have anxiety, and 12% have psychotic disorders. Only 50% of these individuals are getting complete treatment, and there are indications of the overuse of psychiatric medications. Over half of individuals in nursing homes have behavioral disorders. According to CMS, 50% have dementia, 21% have depression, 12% have anxiety, and 6% have schizophrenia. Other studies have found that fewer than half of individuals with serious mental illness in nursing homes get appropriate pre-admission screening. In addition, only 35% of providers follow recommendations for mental health treatment, and fewer than one-fifth of residents needing services are getting treatment.

2. ***Mental and behavioral problems are major contributors to placement in nursing and adult homes.***

In fact, mental illness is often the decisive factor in admission to a nursing home. Paid caregivers and service providers report that the people they are least able to serve in the home are those with mental disorders and behavioral problems such as hoarding, wandering, abusiveness, dangerous conduct, non-compliance, and annoying behavior. Caregivers also report difficulty getting access to needed alternative services, such as housing for people with co-occurring mental and physical disabilities.

3. ***Remaining in the community usually depends on families, but they are at high risk for depression, anxiety, and physical illness which can lead to "burn out".***

With very little caregiver support available, families are often forced to turn to institutional settings. One study found that nearly half of caregivers cite behavior problems as a major reason for placement often because of the impact the behaviors have on them. However, effective caregiver support models can reduce depression and/or anxiety in family caregivers and delay placement in nursing homes about 18 months.

4. ***A shortage of housing and of community and home-based services for people with co-occurring physical and serious mental disorders means there are no alternatives to institutional care.***

As people with serious and persistent mental illness age and develop physical disabilities, they often shift into the long-term care system due to lack of appropriate services in the mental health system. One study found 500,000 people with serious mental illness in nursing homes in the U.S. According to CMS data, the percentage of nursing home residents aged 22-64 with serious mental illness has increased from 6% to 9% between 2002 and 2008. Nursing home personnel have confirmed this trend of serving more people with serious mental illness.

5. ***The prevalence of mental illness in nursing homes is increasing.***

From 1999 to 2005, the number of people admitted to nursing homes with mental illnesses, especially depression, grew to exceed admissions of people with only dementia by 50%. Another study shows that from 1999-2004 there was an increase of people with mental disorders in nursing homes from 27% to 34%. Why is this increase occurring? One reason is there are fewer beds in state psychiatric centers. According to Bartels, nearly 90% of older adults with serious and persistent mental illness in institutions are in nursing homes. Another reason is the growth of alternatives, such as assisted living, except for those who are most behaviorally challenging. In addition, the use of nursing homes for physical rehabilitation is resulting in the silting up of people with serious mental illness and perhaps substance abuse due to lack of appropriate housing in the community. And finally, there has been a movement to develop neuro-behavioral units in nursing homes for placement of individuals with challenging behaviors.

The evidence is clear. To reduce rates of institutionalization, we must address the behavioral health needs of people at risk of placement or already in institutions and family caregivers at risk of "burn-out".

Therefore, as we continue to reform long-term care, we must have goals to address behavioral health needs. They should include:

- **Housing alternatives** to institutions for people with co-occurring physical and mental disabilities
- **Support for family caregivers**
- **Greater availability of behavioral health services**, especially in home and community settings for people needing long-term care
- **Improved quality of services** for people with co-occurring mental and physical disabilities requiring long-term care
- **Integration of behavioral health, physical health, and aging services**
- **Workforce improvements**, including better basic training regarding behavioral health for long-term care staff in the community and in institutions and cadres of behavioral health specialists in long-term care services
- **Restructuring financing mechanisms** to promote integrated home and community-based long-term care

Given our current economic climate, it will be challenging to reach these goals in the next few years. That is why the Geriatric Mental Health Alliance of New York is pursuing legislation that would require the state to begin to pay attention to these needs now. The legislation, entitled *The Behavioral Health and Long-term Care Act*, calls for the state to conduct a study of behavioral disorders in long-term care and to develop a plan for the expansion of services to address the behavioral health needs of individuals currently in, or eligible for, long-term care and the needs of their family caregivers. The Act is an important next step as a policy initiative to elevate the pivotal role of behavioral health in long-term care. We hope you will support it.

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**Geriatric
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ADDRESSING THE MENTAL HEALTH NEEDS OF OLDER ADULTS IN "AGE-FRIENDLY COMMUNITIES" *A Guide for Planners*

By
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INTRODUCTION

Over the next 25 years the population of older adults in the United States will double and the proportion of the American population which is 65 and over will grow from 13% to 20%. There will be, that is, roughly the same number of older adults as there are children.

Many local communities are now engaged in efforts to prepare for the growth of the older adult population by making their cities, towns, villages, and neighborhoods better places to grow old. These efforts, known as "livable communities," "age-friendly cities," and "cities for all ages" focus on needs and amenities such as appropriate housing, a safe and walkable environment, supportive services, social and recreational opportunities, accessible high quality health services, and adequate transportation. Unfortunately, these efforts rarely address the importance of mental health for older adults, who cannot realize their potential to age well if they suffer from significant mental or substance use disorders.

This guide is designed for planning and advocacy groups involved in developing age-friendly communities to help them to (1) understand mental and substance abuse problems among older adults, (2) know the key components of addressing geriatric mental health in an age-friendly community, and (3) assess how well their community is meeting the mental health needs of its older residents.

MENTAL HEALTH IS VITAL TO LIVING WELL IN OLD AGE

Old age is a period of life that can have great fulfillment. One can engage in new activities that s/he never had time for earlier in life, or spend time with family and friends or give back to one's community or start a new career. An age-friendly community helps to foster these opportunities in old age by creating a safe, accessible environment to grow old and by offering ways for older adults to be engaged in their communities.

But if older adults do not have their mental health, aging well becomes very challenging.

Approximately 20% of adults 65 and older experience a mental and/or substance use disorder in any given year. Often when people think about mental illnesses among older adults, they think about dementia or depression. In fact, older adults suffer from many different kinds of mental disorders. In addition to dementia and depression, older adults may have anxiety disorders, psychoses, long-term psychiatric disabilities, and substance abuse problems. These disorders can lead to decreased quality of life for older adults and their family members.

- **Depression and anxiety** sometimes lead to social isolation and contribute to high suicide rates among older adults.

- **Dementia**, which includes significant memory loss and cognitive impairment, can also bring challenging behavioral issues.
- **Anxiety disorders** (including paranoia), which are the most common mental illnesses in old age, can result in placement out of the home.
- **People with long-term psychiatric disabilities** such as schizophrenia, are at high risk for premature death due to chronic health conditions, accidents, and suicides.
- **Behavior problems** such as angry abusiveness or poor personal hygiene can make people unwelcome in places that provide social opportunities.
- **Substance abuse** among older adults is mostly of alcohol and of prescription and non-prescription medications. But the use of illegal substances is on the rise and is expected to continue to rise as the baby boom generation becomes the elder boom.
- The **transition from middle to old age** brings with it a variety of role changes and experiences that are emotionally challenging such as retirement, loss of family and friends, and dealing with mortality.
- **Family caregivers**, who are frequently older adults themselves, are at high risk of developing anxiety, depression, and physical disorders.

Mental disorders also complicate health conditions, lead to increased utilization of medical services, increase health care costs as well as result in higher mortality rates. Mental and behavioral disorders also result in premature and, in some cases, unnecessary and avoidable institutionalization.

Because of the impact that mental illness has on older adults and those around them, it is obvious that *mental health* is necessary to living well in old age, and should, therefore, be a central component to developing a community that is hospitable to older adults. This includes not only providing access to treatment services but also ensuring that the other components of an age-friendly community model are accessible and welcoming to older adults with mental and/or substance use problems.

KEY MENTAL HEALTH COMPONENTS IN AN AGE-FRIENDLY COMMUNITY

An age-friendly community that adequately addresses the mental health and substance use needs of its older residents should include the following:

Information, Referral, and Assistance about mental health and substance abuse services for older adults and their family members that is telephone and/or internet-based. This

includes assessment of the individual's needs and guidance about how to manage the situation as well as referral to needed services and supports.

Mental Health and Substance Abuse Outreach and Education to help older adults and their family members understand mental and substance use disorders, know about available treatments and services, and know where to go for help.

Mental Health Promotion and Illness Prevention to help older adults maintain mental health and to prevent the development of, exacerbation of, or to recover from, mental or substance use disorders. Other components of an age-friendly community such as social, recreational, and vocational activities as well as promoting healthy eating and exercise help to contribute to good mental health. In addition, it is important to address social isolation, caregiver stress, stigma and ignorance about mental illness, and more.

Supports to Help Older Adults Age in the Community and Avoid Institutionalization in Nursing and Adult Homes

Older adults with mental and/or substance use disorders are vulnerable to institutional placement, but proper community-based supports can help them live in their own communities and to achieve their maximum potential. This includes affordable alternative housing models that provide adequate on-site supports, particularly for those with both physical and mental disorders; home and community-based providers that are trained and empathic to dealing with behavioral problems; and supports for family caregivers.

Access to Mental Health and Substance Abuse Services for older adults includes offering services in the home and in community-based settings, such as senior housing, senior centers, and primary care offices, where older adults are more likely to go for help for other reasons. Services also need to be affordable and bilingual, and free or low cost transportation should be available.

Integration of Mental Health and Substance Abuse Services: Given that most older adults are not comfortable going to a setting labeled 'mental health' or 'substance use' because of the stigma attached to it, it is absolutely critical to integrate mental health and substance abuse services into settings where older adults go for other reasons. This includes integrating such services in the following locations.

- Primary Care: Most older adults go to their primary care doctor and that is often where they first present with a mental or substance use problem. However, few physicians are skilled at detecting and treating mental and substance use disorders. Screening for such disor-

ders and having behavioral health professionals on-site to provide treatment lead to successful outcomes.

- **Long-term Care:** This includes home health care, adult medical day care, residents for frail elders, assisted living facilities, lifecare communities, and nursing homes. This also includes telephonic information, assistance, and access to long-term care services. Most of these services generally do not adequately address behavioral health issues. Integrating mental health and substance abuse treatment services into these settings would result in improved quality of life for these individuals.
- **Aging Service System:** This includes senior centers, senior housing, naturally occurring retirement communities (NORCs), social adult day care, and adult protective services. These settings offer opportunities for mental health education, screening, and on-site treatment or well-developed linkages with mental health and substance abuse services.

Family Support: Families provide the majority of support for people with disabilities and are vulnerable to “burning out.” Needed supports include respite, counseling, support groups, and crisis intervention.

Cultural and Linguistic Competence: In order to effectively serve minorities, mental health and substance abuse services should be culturally competent, which includes, among other things, providing effective outreach and engagement, providing services in the individual’s primary language, and offering services in neighborhoods where minority elders live.

Civic Engagement: Should include opportunities for older adults to participate in helping roles to aid in addressing the mental health and substance abuse needs of older adults such as by serving as professionals, paraprofessionals or as peers—who may have personal experience with a mental illness or substance abuse problem, which can often be very powerful in engaging someone into treatment.

Finance: Currently, there is not enough funding for geriatric behavioral health services. However, there is some existing funding that is untapped. There are providers who have not fully capitalized on current funding streams because they do not have complete understanding of how best to organize, and bill for, services so they can generate more revenue. Ensuring optimal funding from Medicare and Medicaid and working with local public and private entities that might provide funding for behavioral health services is key to financing care.

Local Planning: Local efforts to plan an age-friendly community should include representation from the behavioral health sector in order to help foster the development of education, programs, and services to meet the behavioral health issues of older residents.

BEHAVIORAL HEALTH QUESTIONNAIRE

The purpose of the questionnaire below is to determine how well your community is prepared to deal with the mental health and substance abuse needs of its older residents and to help guide you as to where your community might need to place additional resources so that mental illnesses and substance abuse problems experienced by elders can be adequately addressed. In completing this questionnaire, **it will be optimal to consult with the local mental health and/or substance abuse department and relevant providers** to ensure greater accuracy of the answers.

Once the survey is complete, you may have identified areas where there is a need for improvement. In most cases, it will be useful to discuss these issues with the local aging, health, mental health, and substance abuse departments and/or with appropriate service providers. For assistance with local geriatric behavioral health planning, contact **The Geriatric Mental Health Alliance of New York at 212-614-5753 or center@mhaofnyc.org.**

Information, Referral, and Assistance

1. Does your community have a telephone and/or web-based information and referral service?

YES NO Don't Know

2. Does the service include information and referral about:

⇒ mental health services?

YES NO Don't Know

⇒ substance abuse services?

YES NO Don't Know

3. Does the service provide assistance in addition to information and referral?

YES NO Don't Know

4. Does your community have telephone-based crisis intervention?

⇒ 24/7?

YES NO Don't Know

⇒ Part-time?

YES NO Don't Know

Note additional information about information, referral, and assistance:

Mental Health and Substance Abuse Outreach and Education

5. Does your community provide outreach and education about:

⇒ mental illness and emotional challenges of aging?

YES NO Don't Know

⇒ substance abuse?

YES NO Don't Know

6. If yes, does the outreach and education take place in community settings?

YES NO Don't Know

7. Does your community provide outreach to older adults who are homebound?

YES NO Don't Know

Note additional information about outreach and education:

Mental Health Maintenance and Promotion

8. Does your community offer meaningful activities such as paid or volunteer work, physical, and/or creative activities to older adults?

YES NO Don't Know

9. Does your community provide opportunities to develop meaningful relationships for older adults?

YES NO Don't Know

10. Does your community promote good nutrition and/or exercise?

YES NO Don't Know

11. Does your community have ways to allow older adults with mental illness to address their spiritual needs?

YES NO Don't Know

12. Does your community provide "brain fit" activities such as computer-based games to help improve memory?

YES NO Don't Know

Note additional information about mental health maintenance and promotion:

Supports to Remain in the Community

13. In your community, does the home and community-based workforce (home health, case management, adult protective service workers, etc.) have adequate skills to deal with behavioral issues?

YES NO Don't Know

14. Does your community have housing alternatives to institutions for older adults who have co-occurring physical and mental and/or substance use disabilities?

YES NO Don't Know

15. Does your community offer support for family caregivers? If yes, what kind of support, e.g. telephone, respite, counseling, support groups?

YES NO Don't Know

Access to Mental Health and Substance Abuse Services

16. Does your community have an adequate range of:

⇒ mental health services (i.e. crisis, inpatient, outpatient)?

YES NO Don't Know

⇒ substance abuse services (i.e.. crisis, inpatient, outpatient)?

YES NO Don't Know

17. Do people needing mental health or substance abuse services generally receive them?

YES NO Don't Know

18. Are there long waits for service?

YES NO Don't Know

19. Are services offered in the home?

YES NO Don't Know

20. Are services offered in community based settings (e.g. primary care, senior centers, naturally occurring retirement communities (NORCs), senior housing, and houses of worship)?

YES NO Don't Know

21. Is there accessible affordable transportation to and from the facility(s) where treatment is provided?

YES NO Don't Know

Note additional information about access to mental health and substance abuse services:

Integration of Services

Primary Care

22. Does your community integrate behavioral health services into primary care? If yes, check below the ways care is integrated.

	Mental health	Substance abuse
Screening in primary care	_____	_____
Well-trained primary care providers	_____	_____
Co-location of health and behavioral health providers	_____	_____
Integrated teams of health/behavioral health providers	_____	_____
Care management	_____	_____
Telepsychiatry (using telephone or video for consultation)	_____	_____

Note additional information about integration of behavioral health care into primary care:

Long-term Care

23. Does your community integrate behavioral health services into long-term care? If yes, check below the locations where care is integrated.

	Mental health	Substance abuse
Home health care	_____	_____
Adult medical day care	_____	_____
Adult homes	_____	_____
Assisted living facilities	_____	_____
Lifecare communities	_____	_____
Nursing homes	_____	_____

24. Do the integrated services use a multi-disciplinary team approach?

YES NO Don't Know

25. Is staff education/training offered to improve knowledge about behavioral health and to reduce staff turnover?

YES NO Don't Know

Note additional information about integration of behavioral health care into long-term care:

Aging Services

26. Does your community use community gatekeepers (e.g. meals on wheels workers, police officers, hairdressers, etc.) to identify mental health and/or substance use problems among older adults?

YES NO Don't Know

27. Does your community have a neighborhood-based network (formal or informal) that addresses mental health and/or substance problems?

YES NO Don't Know

28. Does your community provide mental health and/or substance abuse education and screening in aging service programs (e.g. senior centers, NORCs, social adult day programs, senior housing, and case management)?

YES NO Don't Know

Note additional information about integration of behavioral health care into aging service programs:

Minorities

29. Does your community provide mental health and/or substance abuse outreach and education to minorities?

YES NO Don't Know

30. Does your community provide bilingual mental health and/or substance abuse services?

YES NO Don't Know

31. Does your community offer services in minority neighborhoods?

YES NO Don't Know

32. Does your community offer opportunities to enhance the cultural competence of mental health and/or substance abuse providers?

YES NO Don't Know

Note additional information about minorities:

Civic Engagement

33. Does your community offer opportunities to engage older adults to help address behavioral health issues among other older adults? If yes, check the ways in which older adults are engaged.

YES NO Don't Know

- Retired mental health professionals to provide treatment
- Paraprofessional roles (e.g. mental health/substance abuse screening)
- Peer-to-peer service models (e.g. friendly visitors, peer counselors)

Note additional information about civic engagement:

Finance

34. Do mental health and/or substance abuse providers in your community have competence in generating revenue?

YES NO Don't Know

35. Do non-mental health/substance abuse community based organizations link with organizations that can bill Medicare, Medicaid, and other insurance?

YES NO Don't Know

36. Does the community provide local subsidies to support the financing of behavioral health services?

YES NO Don't Know

37. Are there efforts to foster public-private partnerships?

YES NO Don't Know

Note additional information about finance:

Local Systems

38. Is there behavioral health representation on your age-friendly community planning/advisory council?

YES NO Don't Know

39. Have there been efforts to collaborate with the mental health and/or substance abuse systems (e.g. develop programs, provide education, etc.)?

YES NO Don't Know

Note additional information about local systems:

ABOUT THE GERIATRIC MENTAL HEALTH ALLIANCE OF NEW YORK

The Geriatric Mental Health Alliance of New York (GMHA-NY) was founded in January 2004 with the goal of advocating for changes in mental health practice and policy that are needed to improve current mental health services for older adults and to develop an adequate response to the mental health needs of the elder boom generation. The Alliance's goals are to: 1) advocate for improvements in public policy regarding geriatric mental health and 2) provide information, public education, professional and paraprofessional training, and technical assistance regarding state-of-the-art practices in geriatric mental health. The Alliance works primarily in New York State, but it also offers training and technical assistance in geriatric mental health service, funding, and advocacy nationwide.



Mental Health Association of New York City

GMHA-NY FUNDERS

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June 8, 2010

Letter of Support
Behavioral Health and Long-term Care Act
(A.7027-C/S.3341-C)

I am writing in support of the **Behavioral Health and Long-term Care Act (A.7027-C/S.3341-C)**, a bill to lay the groundwork for addressing the behavioral health needs of older adults with disabilities and their family caregivers in NYS's long-term care system.

With the passage of health care reform legislation, there is a unique opportunity to ensure that NYS's long-term care system adequately responds to the mental health and/or substance use problems of older adults receiving, or in need of, long-term care and the needs of their family caregivers. Failure to do so will impede the state's long-term care reform initiatives. By promoting a planning process, this legislation takes a vital step towards assuring the availability of, and access to, behavioral health services for elders with disabilities and their caregivers in NYS's long-term care system.

Enactment of The Behavioral Health and Long-term Care Act will enable New York to lead the nation on behavioral health and long-term care.

I urge the legislature to enact this important legislation.

Sincerely,

MENTAL HEALTH NEWS™

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PARANOIA IS A BARRIER TO AGING IN THE COMMUNITY

By Michael B. Friedman, LMSW, Lisa Furst, LMSW and Kimberly Williams, LMSW

Mrs. C lived alone in the apartment in which she and her husband had raised their children. She had always been a bit distrustful. The butcher put his thumb on the scale. A teacher had it in for a daughter who wasn't doing well in school. But after her husband died, she became increasingly suspicious of everyone. She double checked the pills she got from the pharmacist. She refused to hire a new cleaning woman when the one she had had for years retired. Her daughter visited. "You bitch," she screamed, "You stole my diamond ring." The daughter was tolerant to a point but eventually insisted that her mother have help in the home, in part so she didn't have to face her mother's abuse every day. "You say my daughter sent you," the mother yelled through the door when the worker arrived. "Does she want you to kill me?" She did not open the door. Eventually, Mrs. C had to go to the hospital for treatment of pneumonia. Her daughter and the social worker agreed that, given her growing physical disabilities and her refusal of help at home, she should be in a nursing home. Mrs. C did not want to go, but she didn't have the strength to fight. She never went home again.

None of us wants to spend the last days of our lives in an institution. Sadly, many of us do. We don't say this to criticize nursing homes, all of which provide a kind of care that can be very difficult to provide outside an institutional setting and some of which provide very good care that makes life better for their residents. We say that ending one's life in a nursing home is sad simply because it is not what we want for ourselves.

There are many reasons why so many of us do not get to die at home in the company of the people we love. Lack of family or close friends, very severe illness, inability to take basic care of ourselves, lack of wealth—these are all reasons why we may not be able to live out our days as we want.

But—as we have been pointing out for some years now—mental and behavioral problems are among the major reasons for institutionalization. We have learned this from numerous conversations with people who work hard to help older, disabled adults to remain in their homes. Home health aides, personal care assistants, case managers, adult protective service workers, geriatric care managers, and family caregivers have all told us that the people they find most difficult to help to stay in their homes are those with mental and behavioral problems. They also tell us that of all of these, perhaps the most difficult problem they contend with is paranoia.

We want to be clear that they, and we, are not using "paranoia" as a technical diagnostic term. We are using it with its ordinary English meaning—suspiciousness, distrust, the sense that someone is out to get you. We are referring to a range of behaviors from people who are always reading between the lines and looking for ulterior motives on the one hand to people who believe that the CIA is transmitting signals to steal their thoughts and to implant ideas in their minds and

who, therefore, cover their heads with aluminum foil on the other. It is a range, that is, from a personality trait to full-blown psychosis.

Paranoia can be a very serious problem even among older adults who are able to manage well enough to survive without much help. They may be able to do their own shopping and cooking, to keep their homes reasonably clean, to get to doctors when they need to see them. But often they become increasingly socially isolated because of their suspiciousness. Some become convinced that their home is broken into when they are out, that family members are stealing from them or, at the extreme, trying to poison them. Family and friends become increasingly scarce under these circumstances. Sometimes paranoid people call the police or aging services programs for protection, but they reject help that is offered because what they are offered is not protection but care and support. They would have to acknowledge their irrationality if they accepted the help offered. Obviously, they become a great challenge to service programs, police, landlords, and others.

For older adults who are paranoid and lack the basic skills they need to survive independently such as the ability to manage their finances, to get out for food and other necessities, to prepare meals, to keep themselves and their homes passably clean, and so forth—for these people, distrust of those who offer help is a life-threatening problem.

What can be done to help people who are paranoid to remain in the homes they want to live in? There is, we are sorry to say, no easy answer. However, there are some steps that could be taken that would make a very big difference.

1. Specialization and training for people who try to provide help in the home: Rejection of help generally is regarded as a problem in the person who rejects help, as of course it is to some extent. But the truth is that some people are better than others at engaging people who are paranoid. People who take accusations, especially abusive accusations, personally are generally not good with people who are paranoid. People who get angry quickly are not so good with people who are paranoid. People who are impatient to get their jobs done, people who want things done the “right” way, people who demand respect—these are people who will have a hard time working with those who are paranoid. Those who understand the emotional root of distrust and abusiveness, who do not take it personally, who have high tolerance for socially inappropriate behavior, whose sense of self-respect comes from within—such people often do better at engaging people who are paranoid.

This is why we strongly recommend that home care organizations, adult protective services, and case management programs for older adults should develop cadres of specialists to go into the homes of the people who have significant mental and behavioral problems and that special training should be provided regarding mental and behavioral challenges. It's good to find staff who are naturals at engaging people who are paranoid. But training to understand emotions, in the value of patience, in the importance of respect, and in techniques of helping someone quiet down and accept help can make a very big difference. It should be required for all who work in the home.

2. Access to mental health and health professionals with expertise about older adults with mental disorders: Unfortunately, most mental health and health professionals do not have nearly enough knowledge about older adults or about practices that work (aka “evidence-based practices”). This is a very serious problem, which we have every reason to believe will get worse as the population of older adults explodes and the number of geriatric psychiatrists and other mental health professionals as well as the number of gerontologists declines. What is needed is a workforce development initiative that includes appropriate education in professional schools, training for those already in the workforce, a vast effort to recruit new geriatric professionals, and the development of ways to incorporate retired professionals (with updated training) into the service system.

3. Research: More information about paranoia (in the ordinary sense of the word) is also critical. We have been distressed to discover that paranoia receives little attention in the geriatric mental health research community. By far most research focuses on depression, which is very important, of course, and should continue to be supported. But research, we believe, especially research that is funded by the government, should be closely connected with public policy goals. Long-term care reform—largely providing home-based care instead of institutional care—is presumably one of the primary components of health care reform in general—as a matter of both cost containment and basic humanity. It is clear that paranoia is a major barrier to aging where we choose in the community, and research should be organized to help overcome this barrier.

(Michael Friedman is Chair of the Geriatric Mental Health Alliance of New York, a project of The Mental Health Association of New York City. Kimberly Williams is Director of the Alliance. Lisa Furst is Director of the Alliance's Training and Technical Assistance Center. The opinions expressed in this article are theirs and do not necessarily reflect the views of the Mental Health Association. They can be reached at center@mhaofnyc.org. For more on geriatric mental health visit: www.mhaofnyc.org/gmhany.)