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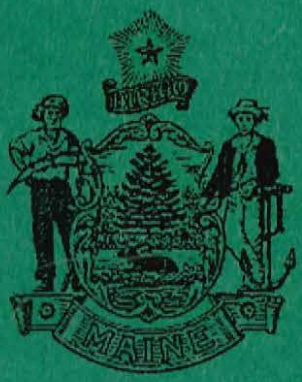
Mental Health Services for the Elderly in Maine:

A Status Report

January 2000



By

The Joint Advisory Committee on
Select Services for Older Persons

Prepared for
Department of Mental Health, Mental Retardation and Substance Abuse Services
Lynn F. Duby, Commissioner
&
Department of Human Services
Kevin Concannon, Commissioner

For Submission to
The Health & Human Services Committee,
Maine State Legislature

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2000

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MENTAL HEALTH SERVICES FOR THE ELDERLY IN MAINE: A STATUS REPORT

Executive Summary

> *"... individuals are asked to fit into programs or facilities rather than programs or facilities adjusting themselves to fit the individuals."*
>
> *-- A mental health service provider*

Introduction

While emotional problems and mental disorders are not a consequence of aging, their incidence does increase with age. Further, such conditions are underreported and undertreated.

"Disability due to mental illness in individuals over 65 years old will become a major public health problem in the near future..."

The just-released *Mental Health: A Report of the Surgeon General* states that "...a substantial proportion of the population 55 and older—almost 20 percent of this age group —experience specific mental disorders that are not part of "normal" aging. Unrecognized or untreated, however, depression, Alzheimer's disease, alcohol and drug misuse and abuse, anxiety, late-life schizophrenia, and other conditions can be severely impairing, even fatal."

The report continues that "there are effective treatments for many of the mental health challenges that older adults suffer." Appropriate treatment not only impacts mental health, but often overall health by "improving the interest and ability of individuals to care for themselves and follow their primary care provider's directions and advice, particularly about taking medications."

Older persons can benefit from the same types of mental health and substance abuse services as younger individuals. However, the circumstances associated with aging require specialized program design. Older persons are more likely to be living alone. Denial, shame and reticence about mental illness and substance abuse problems often make the elders less likely to seek help. In addition, poor health, impaired mobility and diminished social supports make it difficult for many older persons to use community mental health centers or other outpatient services.

Last session, Representative Judy Powers, at the request of elder mental health and aging services providers, sponsored *LD 1760, Resolve, to Create the*

Commission to Study the Provision of Mental Health Services to the Elderly. The Health and Human Services Committee heard and considered LD 1760. As an alternative to passage of the bill, the Committee asked the Departments of Human Services (DHS) and Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to work with the Joint Advisory Committee on Select Services for Older Persons (JAC) to study this issue and report back. The JAC is a group of individuals representing both public and private agencies, who have met regularly since 1984 to advise both Departments about the service needs of older persons and to make policy recommendations.

Although substance abuse and dementia are not considered mental illnesses, the JAC felt that both substance abuse and dementia are significant related problems. It is not unusual for individuals to have two or three of these conditions simultaneously. Further, the behaviors resulting from substance abuse and dementia are often similar to those of some mental illnesses and as a result, treatment approaches can be difficult to determine. The JAC believes it is more productive to take a holistic approach to elder mental health needs. Such an approach creates the best foundation for effective treatment.

People aging with mental retardation have been excluded from this report, even though they may also have mental health needs, because they are the subject of a separate report to be submitted to the Legislature.

Two surveys and related data analysis were completed by the DMHMRSAS:

- A survey of mental health service providers,
- A survey of substance abuse service providers, and
- A compilation of public comments.

To gather additional data for the report, the Edmund S. Muskie School of Public Service, University of Southern Maine, conducted a survey and an analysis of data from:

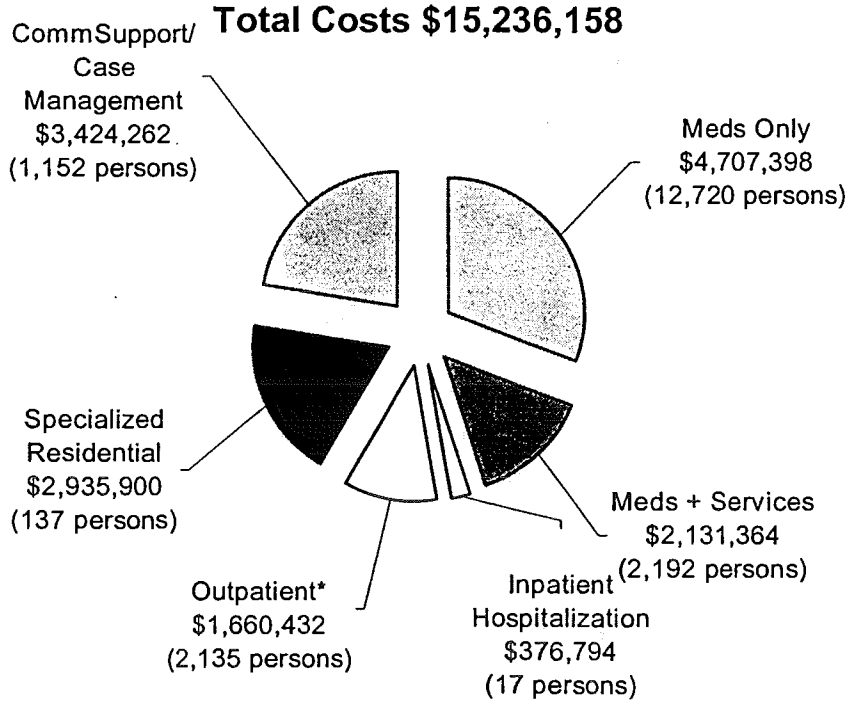
- Agencies that serve older persons but do not provide mental health or substance abuse treatment
- Maine Medicaid claims data, and
- Maine's long-term care assessment system (MECARE).

The source of the Muskie data were 1998 Medicaid Claims and DMHMRSAS Expenditures.

Funding and Service Data

In FY98, 14,912 elderly persons received mental health services costing $15,236,150 paid by Medicaid and DMHMRSAS administered state funds (does not include mental retardation, substance abuse or dementia specific services). The overwhelming majority of these individuals, 12,720 or 85%, received medications only. (See Figure 1.)

Figure 1
COSTS OF MENTAL HEALTH SERVICES FOR MAINE'S ELDERLY FISCAL YEAR 1998



Source: 1998 Medicaid Claims and DMHMRSAS expenditures. Please note that persons served may have received more than one service.
**Includes Medicaid portion of outpatient services and psychogeriatric services.*

Conclusions

The research included surveys and analysis of existing data. Some key themes emerged are:

- There is little recognition of the unique needs of older persons in existing mental health and substance abuse policies and systems.

- Older persons, their families, and health and social service providers, often deny or don't recognize mental health and substance abuse problems among older people.

- Mental health problems are pervasive and often go untreated in nursing and residential care facilities, as well as in home care.

- The responsibility for needs assessment, budgeting, program development, and delivery of publicly-funded mental health services is dispersed throughout DHS and DMHMRSAS. The lack of coordination creates confusion, and results in barriers to services for both providers and consumers. This is true at the state and regional levels.

- Older persons with coexisting dementia and mental illness present significant challenge to the service systems, especially when they have difficult behaviors.

- Accurate and up-to-date information about mental health services for older individuals is difficult to obtain or is not available.

- Not all services are available statewide.

- The most significant needs include:
  - Home-based mental health and substance abuse services;
  - Case management;
  - Additional professionals with expertise in geriatrics;
  - More training and support relating to geriatric issues for service providers and for caregivers;
  - Making psychogeriatric teams available statewide and expanding current services offered to include substance abuse services;
  - Supportive interpretive services for older persons for whom English is not their primary language, or who are hearing impaired;
  - Substance abuse programs specifically for older persons.

- Persons with late-onset mental illness are less likely to use traditional mental health services than those with chronic mental illness. Additionally, poor health, impaired mobility, and lack of social supports

make it difficult for many older persons to use traditional mental health services.

- Based on an analysis of Medicaid claims data, approximately 86% of older consumers with a mental health diagnosis receive psychotropic medication without counseling or other supportive services. In addition, approximately 33% of these older persons are receiving psychiatric medications without a corresponding documented psychiatric diagnosis.

Recommendations

Policy

1. The Department of Human Services (DHS) and Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) must jointly address the specific mental health and substance abuse needs of older Mainers, jointly committing to establish coordinated and comprehensive policies for addressing the mental health and substance abuse needs of older Mainers. Policies should acknowledge that older adults have unique health, social, mental health and substance abuse needs, and therefore require specialized services.

2. Designate a single Agency with the responsibility for coordinating services for older persons with health, mental health, and substance abuse needs. At a minimum, establish an inter-departmental committee of individuals in policy-making positions to facilitate and integrate the services of multiple providers

3. Require both Departments to submit integrated plans and budgets as a means of addressing the complex and fragmented systems of care for older adults. Require integrated plans at the regional level, involving departmental regional offices, area agencies on aging, community mental health, and health services providers.

4. Assure the continuation of the Joint Advisory Committee on Select Services for Older Persons, and authorize it to monitor and advise the Departments on policies, needs assessments, planning, resource allocations, and service delivery.

5. Establish a work group to address the study findings of the high number of persons receiving psychotropic drugs who have no documented diagnosis of mental illness.
    - Does prescription drug use for the over 60 population follow a pattern – are they offered drugs but few supportive services?
    - Have older persons been offered supportive services and refused them or was the option not considered? If they refuse them, why?
    - What is actually being delivered as "medication monitoring"? Anecdotally we've heard it varies from place to place.

More Effective Use of Existing Resources

1. Review the current range of services reimbursed under the State Medicaid plan to determine if the best use is being made of state and federal dollars in meeting the medical and mental health needs of older persons.

2. Determine the most appropriate and effective staffing needed for the psychogeriatric teams. Enhance all existing teams to include substance abuse expertise. Consider delegating to the Joint Advisory Committee the task of appropriate staffing determination.

3. Review policies, program eligibility, and service delivery requirements to eliminate barriers to effective service delivery resulting from conflicting regulations. Reduce the voluminous amounts of paper work required at intake and throughout the service delivery process, (e.g., release of information forms, sign off on rights of recipients). While confidentiality and consumer rights are important, excessive concern about them often become barriers to effective service delivery.

4. Identify a lead case manager when an individual needs services from multiple systems and providers. This is critical for clients with complex problems without a clear primary cause (e.g. is it dementia or mental illness?) and when individuals present with difficult behaviors. Placements are especially difficult to arrange and maintain.

5. The Departments should encourage and support collaboration and cross-training strategies internally and among service providers.

6. Include standards and requirements regarding cultural competence in contracts with providers. Cultural competence involves respect for not only a person's race or ethnic background but also qualities such as age, gender, level of acculturation and sexual orientation.

7. Enhance DMHMRSAS Management Information Systems to track services provided to older adults.

8. Support providers to be creative in methods for working with older adults. Research supports that once engaged in treatment of any kind, older persons do as well or better than other age groups.

Quality Assurance

1. Design outcome measures and performance indicators for service providers need to reflect the special circumstances of older adults; e.g. indicators based solely on employability are not always appropriate.

Public Education

1. Increase community education activities about positive aging in general, older persons, and older persons with mental health and/or substance abuse services needs. Promote images of aging that are both realistic and positive.

2. Require the Departments to jointly develop:
   - an updated comprehensive web page of statewide resources with links to other information sources
   - printed materials regarding available services
   - Public Service Announcements aired on a regular basis

3. Require departmental contractors to include information describing the services they provide to older person in all of their informational material, both printed and on line.

With Additional Resources

1. Require that mental health needs be addressed in developing home care plans for older persons who have either a diagnosis or an indicator of mental illness.

2. Expand eligibility criteria for in home services to include incapacitating mental illness and dementia that impair people's ability to care for themselves.

3. Provide more geriatric mental health training available to people working with the elderly, from physicians, nurses, social workers and mental health professionals to CNA's and PCA's in all settings.

4. Expand the range of services offered by psychogeriatric teams statewide and include substance abuse expertise.

5. Offer technical assistance in identifying and accessing all available or potential resources, including Medicare, which may be significantly underutilized.

6. Develop Geriatric Assessment Units where an older individual with issues related to possible mental illness, dementia, substance abuse, or medical problems can be evaluated by a knowledgeable and trained professional. Working with the individual, family, or support system, the assessment teams can recommend a plan of care that meets the individual's medical and psychosocial needs.

7. Identify facilities that are willing to provide specialized care to older individuals with challenging behaviors. Offer reimbursement rates that allow for adequate staffing, training, and services. Establish outcome standards as part of the reimbursement system. These facilities need to provide private rooms; specific and individualized programming based on behavior rather than diagnosis, and is designed for a small number of persons.

8. Conduct further study of housing options and resources, to assure more housing and services that enable people to age in place.

MENTAL HEALTH SERVICES FOR THE ELDERLY IN MAINE: A STATUS REPORT

Introduction

> *"Understanding the older adult is vital. Older adults were formed in a different era with different standards. They are reluctant to reveal anything about themselves to outsiders. Communication with others about themselves and their problems is considered a weakness and an inability to handle their own affairs..."*
>
> *-- A Service Provider*

Older persons are living longer, and are increasing in absolute numbers and as a percentage of the general population. While emotional problems and mental disorders are not an intrinsic part of aging, they frequently increase with age. As the Surgeon General's report notes: "...a substantial proportion of the population 55 and older—almost 20 percent of this age group —experience specific mental disorders that are not part of 'normal' aging. Unrecognized or untreated, however, depression, Alzheimer's disease, alcohol and drug misuse and abuse, anxiety, late-life schizophrenia, and other conditions can be severely impairing, even fatal; in the United States, the rate of suicide, which is frequently a consequence of depression, is highest among older adults relative to all other age groups (Hoyert et al., 1999)."

"The mental health needs of elderly Americans are likely, over time, to 'overwhelm an already inadequate...system.'"

Older persons benefit from the same basic types of mental health and substance abuse services as do younger individuals. However, circumstances associated with aging require specialized program design. Poor health, physical frailty, impaired mobility and diminished social supports make it difficult for many older persons to travel to community mental health centers or other locations where outpatient services are available. Denial, shame and reticence about mental illness and substance abuse problems are typical, and make elders even less likely to seek help.

There are effective treatments for many of the mental health challenges that older adults suffer. Appropriate treatment not only impacts mental health, but often overall health, as the Surgeon General's report notes, by "...improving the interest and ability of individuals to care for themselves and follow their primary care provider's directions and advice, particularly about taking medications."

Older persons with serious mental health problems who require mental health services fall into two distinct groups. The first group includes those who

have a long-standing chronic mental illness. Most of these individuals have been patients at the Augusta Mental Health Institute (AMHI), the Bangor Mental Health Institute (BMHI), Spring Harbor (formerly Jackson Brook) or Acadia psychiatric hospitals. AMHI consent decree class action members are included in this group.

Older persons with longstanding chronic mental illness are more likely to be recipients of mental health services than older persons with late onset mental illness, and are more apt to be Medicaid eligible, because many have been disabled during their adult working years. Stigma, inability to pay for treatment, and lack of transportation are less likely to be barriers to service. These individuals receive the majority of Medicaid-funded mental health services (excluding medications).

However, as individuals with chronic mental illnesses age, their ability to access site-based services may be jeopardized by poor health and limited mobility. Tolerance for psychoactive drugs may decrease as individuals age, due to changes in the body, and because deteriorating health may result in a need for additional medications, with an associated probability of drug interactions.

The second group, significantly larger in number, consist of older persons with late onset mental illnesses, typically depression and anxiety disorders. It is this group which has the more limited access to existing community mental health services as a result of both personal and systemic barriers.

"Mainers over age 65 have the highest suicide rate of any group in the state. Suicide is the leading cause of injury death for Mainers age 65-74 and the second leading cause of injury death for those 75-79."

Systemic barriers for all older Mainers with mental health needs include a fragmented service system, lack of appropriately trained providers, and, as the Surgeon General's report states, "specific problems with Medicare, Medicaid, nursing homes, and managed care." Individuals with late onset mental illness are less likely to receive services unless they have been admitted to a private or public psychiatric hospital for treatment. As a rule, it is an individual's history of institutionalization, rather than treatment needs, that determines the availability of publicly-funded services.

Untreated mental illness may have serious consequences. Depression, for example, responds well to early intervention but left untreated, it impairs resistance to and recovery from serious mental and physical conditions. A 1991 study associates suicide in older men more frequently with untreated depression and substance abuse than with chronic illness, terminal illness or isolation from family.

Personal barriers to access for elders with late onset mental illness include denial, fear of the stigma associated with being labeled mentally ill or a substance abuser, limited personal finances, and lack of transportation.

Also, there are older individuals with co-existing dementia and mental illness, who present a significant challenge to the service system because of difficult behaviors. These include behaviors that are aggressive, sexually inappropriate, or verbally abusive. There are no facilities designed to serve this population for either emergencies or long-term placement. Although these individuals may not be significant in number, they do consume an inordinate amount of resources and staff time. Responding to these situations is further complicated because the responsibility for service delivery is undefined and a clear protocol for treatment does not exist.

None of these issues are new. The 1984 Report of the Task Force on Mental Health Services to Elderly Persons identified a number of critical issues that still exist. These included:

- Lack of a comprehensive, integrated mental health care system for elderly persons in Maine, resulting in inadequate or no service for significant numbers of older persons.
- The types and availability of services varied from region to region, from urban to rural settings, and there was no continuum of care.
- Lack of a comprehensive, integrated implementation plan for mental health programs and services.
- Limited access to mental health services unless one had previously been institutionalized or sought treatment at a community mental health center.
- Reliance on palliative rather than active treatment for geriatric mental health problems.
- Reliance on diagnosis rather than behavior to determine treatment plans.

The 1984 report recommended:

- Coordinated planning and service delivery by state and regional mental health agencies and organizations serving older persons;
- Expanded outreach and advocacy programs;
- Extending mental health services to the homebound;
- Housing, residential care and nursing care facilities tailored to the needs of mentally ill senior citizens;
- Better access to transportation; and
- Increased public education efforts.

Beginning in 1985, the Legislature appropriated funding for expanded geriatric services. However, budget shortfalls in the early 1990s reversed the momentum of the previous decade. Some programs were cut, and insufficient funds limited the possibility of extending programs to all areas of the state.

Subsequent reviews by the JAC also addressed the status of mental health services for Maine's older population. Each of these reviews reiterated the findings and confirmed the policy recommendations of the 1984 Report. Common themes included fragmentation of services, lack of adequate data for planning purposes,

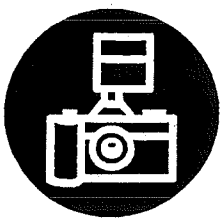
lack of coordination between DHS and DMHMRSAS, and lack of appropriate services for older persons who are too frail to leave their homes or who are reluctant to seek services out of fear of being stigmatized as mentally ill. The critical issues identified in 1984 have not been adequately addressed.

Early in 1999, State Representative Judy Powers, working closely with providers of mental health and other services for older Mainers as well as consumer representatives, sponsored *LD 1760, Resolve, to Create the Commission to Study the Provision of Mental Health Services to the Elderly.* The Health and Human Services Committee (HHS Committee) heard and considered LD 1760. As an alternative to passage of the bill, The HHS Committee asked the Departments of Human Services (DHS) and Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to work with the Joint Advisory Committee on Select Services for Older Persons to study this issue and report back.

The HHS Committee asked that the report address "the mental health service needs of the elderly, the extent to which services are available and unavailable; and any information on disparities in unmet need by geographic region, service setting, or residential setting." Although substance abuse and dementia are not considered mental illnesses, the JAC felt that both substance abuse and dementia are significant related problems. It is not unusual for individuals to have two or three of these conditions simultaneously. Further, the behaviors resulting from substance abuse and dementia are often similar to those of some mental illnesses and as a result, treatment approaches can be difficult to determine. The JAC believes it is more productive to take a holistic approach to elder mental health needs. Such an approach creates the best foundation for effective treatment. However, for the sake of clarity, mental health, cognitive impairments, and substance abuse are also sometimes discussed as discreet topics.

The terms "residential care facility," "nursing facility" and "home-based care" are used often in this report. A nursing facility is one in which residents have limited levels of functioning, are capable of only limited self-care and require regular nursing interventions. Residential care facilities (formerly known as boarding homes) are those in which residents have a higher level of functioning, and do not require skilled nursing interventions. Home-based care is defined as in-home services provided to assist elders with the activities of daily living.

Finally, in an effort to reflect a human focus throughout this report, quotes have been included from a number of survey respondents. Sources are not identified in order to preserve their confidentiality.



STATISTICAL SNAPSHOTS

TABLE 1:
OLDER AMERICANS IN THE U.S.

- People 65 years of age and older accounted for 12.7% of the U.S. population in 1998.
- By 2030, older adults will represent 20% of the total population.
- The number of older adults has increased by 10.1% since 1990, compared to an 8.1% increase for the general population.
- Elders are living longer. In 1998, the 65-74 age group was eight times larger than in 1990. The 75-84 group was 15 times larger. The 85+ group was 33 times larger.

TABLE 2:
THE MENTAL HEALTH NEEDS OF OLDER AMERICANS

- The reported incidence of mental illness in adults over 60 varies. Estimates range between 18% and 25%. The just-released mental health report from the Surgeon General states that the incidence of mental illness in adults age 55+ is about 20%.
- Suicide rates are highest among elders. Twenty percent (20%) of all suicide occurs among people over 65. This represents an increase of 9% since 1980. Maine's average suicide rate for elders is nearly three times that of adolescents.
- A 1991 study correlated major depressive disorder among nursing home residents with a 59% increase in the likelihood of death within one year. Several studies show a correlation between depressive symptoms and, in the words of one study, "a spiraling decline in physical and psychological health."
- Major depression among elders is under recognized and undertreated. As many as 9 out of 10 older persons who have depression do not get treatment. Suicide among elders is typically associated with depression.
- About 1%-5% of the population 65 years or older is alcoholic and about 10%-15% of those seeking medical help have alcohol-related problems. One-third (1/3) of older adults who have alcohol problems did not abuse alcohol in their earlier years.
- Surveys indicate that as many as 11% of elderly patients admitted to hospitals exhibit symptoms of alcoholism, as do 20% of elderly patients in psychiatric wards and 14% of patients seen in hospital emergency rooms.
- Elderly men and women with current or former drinking problems have worse overall health and poorer mental health then their peers who have never had a drinking problem. (Dec. 99, Journal of Drug and Alcohol Abuse)

TABLE 3:
DEMOGRAPHIC PROFILE OF MAINE ELDERLY
(1990 CENSUS DATA)

	TOTAL POPULATION		ELDERLY POPULATION	
Total	1,227,928	100.0%	163,160	13.3%
Male	597,850	48.7%	65,205	40.0%
Female	630,078	51.3%	98,184	60.2%
Live alone, Age 65+, Male	N/A	N/A	10,159	6.2%
Live alone, Age 65+, Female	N/A	N/A	38,663	23.7%
Individuals with Incomes Below Poverty Level	128,355	10.5%	21,368	13.1%

TABLE 4:
MAINE ELDERLY - POPULATION INCREASE OVER TIME

YEAR	TOTAL POPULATION	ELDERLY POPULATION (65-100)	ELDERLY AS % OF TOTAL POPULATION
1970	993,722	114,496	11.52%
1990	1,227,928	163,160	13.29%
2010	1,325,281	196,862	14.85%
2020	1,405,969	270,549	19.24%

TABLE 5:
MAINE ELDERLY WITH MENTAL HEALTH DISORDERS - POPULATION INCREASE OVER TIME

YEAR	ELDERLY POPULATION (65-100)	ELDERLY POPULATION WITH MENTAL HEALTH DISORDER
1970	114,496	22,441
1990	163,160	31,979
2010	196,862	38,585
2020	270,549	53,028

Current Mental Health and Substance Abuse Services for the Elderly in Maine

> *When we have had an issue with the elderly, primarily mental (health) issues, we have gone round and round the system trying to determine who can help with the particular issue. Everybody seems confused. Including us!*
>
> *-- A Senior Housing Provider*

Mental health services for Maine's elders are provided by institutions and individuals in both the private and public sectors and in a variety of locations. Most services are delivered in settings which serve the general population, including primary care providers, hospital emergency rooms, and psychiatric hospitals.

Both AMHI and BMHI had units that were licensed as nursing homes, to care for the significant older populations that had medical needs in addition to their mental health needs. During the past several years, both institutions determined that many of these individuals' needs were primarily medical and could be met in community nursing facilities. These would provide a less restrictive environment, closer to families or other natural supports.

For a few years, the remaining older residents at AMHI were housed in a special geropsychiatric unit, but gradually these residents were also placed in community based facilities. The geropsychiatric unit is now closed. Older individuals admitted to AMHI are now placed with the general population.

Relocation efforts at BMHI have taken longer. Many individuals went to local nursing or residential care facilities. Others who met the eligibility criteria, moved into three nursing facilities with special services. The movement of elderly individuals to safe, less restrictive settings continues. At present, there remains one unit with a capacity of 20, whose residents are all elderly.

Three nursing facilities receive supplemental funding from DMHMRSAS for additional staffing and training. They are Gorham Cottage in Gorham (17 beds), Hawthorne House in Freeport (18 beds) and Mt. St. Joseph in Waterville (18 beds). To be accepted into these special units, an individual must pass the MED 2.0 assessment (Maine's long-term care assessment tool) done by Goold Health Systems. The individuals must also meet DMHMRSAS requirements. These include having a diagnosed mental illness, a need for specialized mental health treatment, or having challenging behaviors that require special intervention. These units usually have waiting lists.

At this time, neither of the state institutions is licensed to provide nursing level care. If an individual in a nursing facility has a mental illness that becomes

acute and he or she needs intensive psychiatric care, treatment must be sought at a psychiatric unit within a community hospital. This is not always possible because space may not be available and because some hospitals refuse to accept these referrals.

In addition, DMHMRSAS provides supplemental funding for three residential care facilities that care for older or medically needy individuals with mental illnesses. These are Wilson Street in South Portland (6 beds), Meadowview in Orono (8 beds) and another unit at Mt St. Joseph's in Waterville (16 beds).

At present, psychogeriatric teams are the only other state-funded geriatric-specific service. These teams are community-based, multi-disciplinary teams that provide such services as assessments, counseling, medication monitoring, referrals, or other services to elders in a variety of settings. Teams vary in size from one individual to approximately seven. Often, team members work on a part-time basis only. Services vary from team to team, and none provide substance abuse services. The current budget allocation for psychogeriatric teams statewide is $931,172. The funding for the team ranges from $9,611 to $293,882.

Listed below are the agencies that provide psychogeriatric services and the areas they cover:

Region I

Community Counseling Center; greater Portland area only
Counseling Services, Inc.; York County

Region II

Health Reach Network, Senior Support Services; Kennebec & Somerset Counties
Mid-Coast Hospital Elder Services; Coastal Area from Damariscotta to Freeport
Mid-Coast Mental Health Center; Waldo, Knox and Lincoln Counties
Tri-County Mental Health Center; Androscoggin, Franklin and Oxford Counties

Region III

Aroostook Mental Health Center, Mobile Geriatric Team; Central and Southern Aroostook County
Community Health and Counseling Services, Elder Service Program; Penobscot and Piscataquis Counties
Northern Maine Medical Center Aftercare Program; Northern Aroostook County
Washington County Psychotherapy Associates, Mobile Geriatric Team; Penobscot, Piscataquis, Washington and Hancock Counties
Washington County Psychotherapy Associates, Elder Care Program; Hancock and Washington Counties

Table 6 on the next page is a summary of the services provided by those agencies, as well as the areas and settings in which services are available.

Table 6: PsychoGeriatric Services Offered in Maine

Services	Region I		Region II									Region III				
	Cumb *	York	Andro	Frank	Kenn	Linc	Knox	Oxf	Sag	Som	Waldo	Aroos	Piscat	Pen	Han	Wash
Assessments/Evaluations	X				X	X	X			X	X	X	X	X	X	X
Behavioral Planning						X	X				X	X	X	X		
Case Management (limited)	X															
Consultations	X				X	X				X		X	X	X	X	X
Individual Counseling:																
Home	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X
Nursing Facility	X		X		X	X	X			X	X	X			X	X
Residential Care Facility	X				X					X		X			X	X
MR Waiver Home												X				
Medication Consultation						X	X				X					
Outreach	X															
Psychiatric Day treatment	X															
Psychiatric Evaluation						X										
Referrals													X	X	X	X
Training & Support for staff:																
Nursing Facility	X		X		X					X		X				
Residential Care Facility	X				X					X		X				
All Services offered to Residential Care Facilities if attached to a Nursing Facility.													X	X	X	X

*** Available in greater Portland and Freeport to Brunswick only**

When psychogeriatric teams began more than ten years ago, their work was limited to conducting assessments and evaluations in nursing facilities, and making treatment recommendations. Over the last decade, the demand for their expertise has increased dramatically. Maine now has ten psychogeriatric teams serving individuals in nursing care facilities, group homes, and in their own homes. Yet, funding has not expanded along with the increased demand for psychogeriatric teams services. The result is long waiting lists and significant service gaps. For example, as of November, 1999, five agencies reported that a total of 77 individuals were on waiting lists. These included 25 at Community Counseling Center in Region I, 16 at Tri-County Mental Health in Region II, 15 at Northern Maine Medical Center Aftercare Program in Region III, 13 at Community Health and Counseling Services in Region III, and 8 at Washington County Psychotherapy Associates in Region III.

Psychogeriatric teams service gaps statewide include:

- No services in Western Cumberland County
- Only limited services in Southern Aroostook County.
- Only limited services in outer Kennebec and Somerset Counties
- Limited services to nursing homes in Sagadahoc and Lincoln Counties
- No in-home services in Northern Aroostook County
- Only limited in-home services in Franklin or Oxford Counties
- No services in nursing homes in York County
- No services in nursing homes in Franklin or Oxford Counties
- No or limited services to boarding home residents in Penobscot, Piscatiquis, Hancock, Washington, Waldo, Knox, and parts of Lincoln Counties.
- Only limited counseling services to individuals in nursing homes in Penobscot and Piscataquis Counties
- Only limited counseling services to individuals in nursing homes or in their own homes in outer Hancock and Washington Counties

In addition to gaps in psychogeriatric teams services, mental health providers have identified other service gaps including a lack of transportation, too few trained geriatric professionals, and a lack of psychiatric and other in-home visits and supports.

Substance abuse service providers typically provide a continuum of care to anyone who requests services. There are no programs specifically designed for the substance abusing older adult. The results of the substance abuse service provider survey suggest that a majority of the agencies provide staff with training in working with elders. However, few of the agencies report actually treating this population. This is because this population does not seek out traditional services. Denial, shame and reticence about being labeled a substance abuser as well as impaired mobility, and poor health all work against the present system successfully providing treatment to this population.

It is extremely difficult to estimate the number of elderly who suffer from substance abuse problems. Some elderly problem drinkers have a life-long history of abusing alcohol and are familiar with, and well-known to, the system. Another group, those with late onset alcoholism, is more difficult to identify because their drinking is disguised. A third group includes individuals who abuse prescription and over-the-counter drugs. The use of substances may be a coping mechanism to deal with loss, loneliness, depression and isolation.

Funding and Service Data

Although all available **state-administered** funding data has been captured and analyzed, it is still difficult to get a comprehensive picture of mental health expenditures for the following reasons

- All adults in Maine, including elders, are eligible to access the full range of adult mental health services provided by DMHMRSAS, but the use of these services by the elderly is not tracked;
- Data are not available for elderly mental health services paid for by private insurers or out-of-pocket;
- Information about the total cost of Medicare mental health benefits in Maine, and the total number of Medicare beneficiaries receiving outpatient or inpatient mental health services, was not reviewed for this report;
- While an analysis of Medicaid claims data is useful, it must be kept in mind that only a small percentage of elderly persons are eligible for Medicaid; and
- Data do not include substance abuse services.

In FY98, 14,912 elders received mental health services (excluding mental retardation services), costing $15,236,150 via Medicaid and DMHMRSAS administered state funds. The overwhelming majority of these individuals, 12,720 or 85%, received medications only. See below for service and cost breakdown.

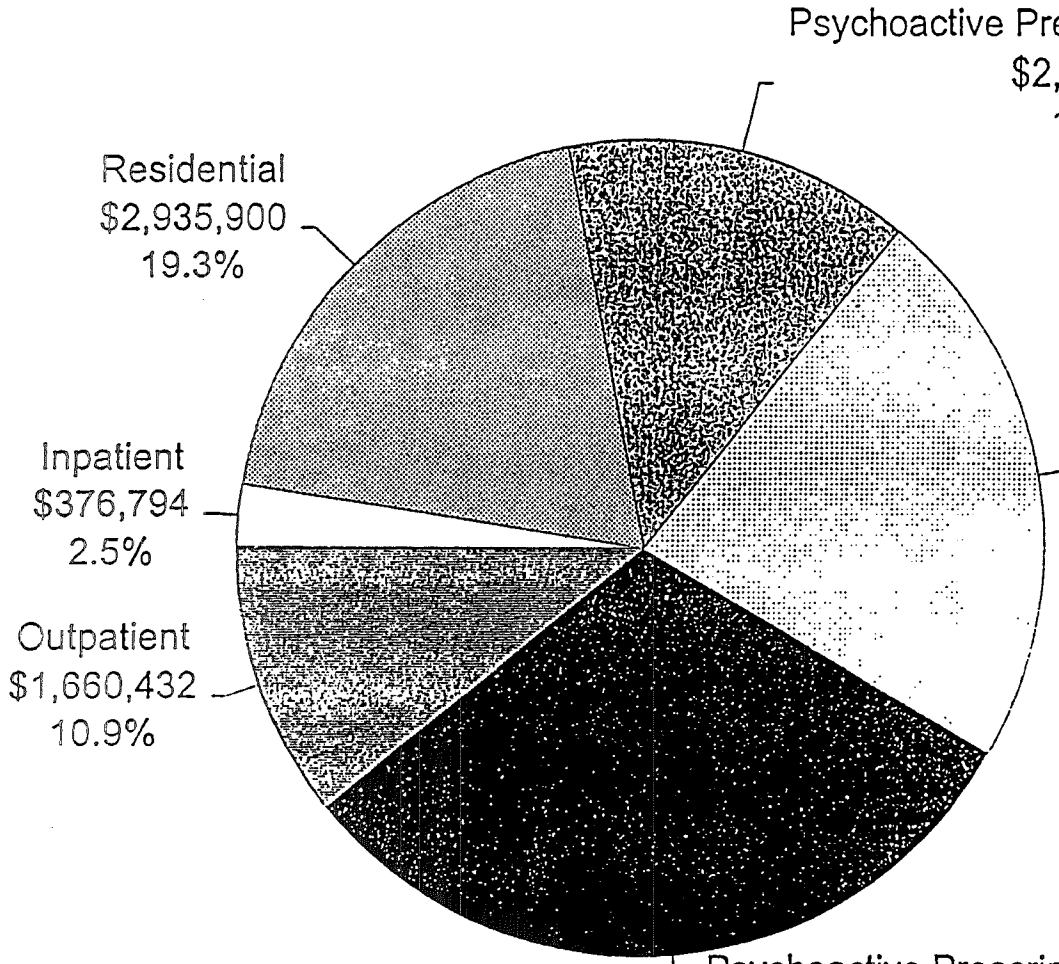
TABLE 7:
MENTAL HEALTH SERVICES AND COSTS FOR MAINE'S ELDERS, 1998

Individuals Served	Services	Costs	Funding Source
		$13,890,759 $1,345,397	Medicaid DMHMRSAS (General Funds)
14,912		**$15,236,158**	
12,720	Medications Only	$4,707,398	Medicaid
2,192	Medications + Services	$2,131,364	Medicaid
14,912		**$6,838,762**	
17	Inpatient	$376,794	Medicaid
1,554 581	Outpatient Psychogeriatric Services	$729,260 $931,172	Medicaid DMHMRSAS (General Funds)
2,135		**$1,660,432**	
68 69	Residential Residential Facilities/ Group Homes	$2,521,503 $ 414,397	Medicaid DMHMRSAS (General Funds)
137		**$2,935,900**	
1,152	Community Support/ Case Management	$3,424,262	Medicaid
1,152		**$3,424,262**	

Table 8

Mental Health Services Expenditures for Elderly Recipients

(Total Expenditures = $15,236,140, N = 14,912)



Based on Calendar Year 1998 Medicaid recipients age 60 and over with a diagnosed mental illness or a pharmacy claim for psychoactive drugs.

The Medicaid program is the largest source of publicly-funded elderly mental health services, accounting for $13,890,753 in FY98. Maine's Medicaid program is administered by DHS, and covers the cost of outpatient and inpatient mental health services and prescription drugs for the 16% of older Mainers who received Medicaid benefits. No recent comprehensive review of Medicaid policies and expenditures has been undertaken to determine how well they meet the needs of older persons with mental illness.

The Home Base Care (HBC) and Medicaid Waiver programs are also sources of funding for mental health services when the need for such services is identified and included in the consumer's care plan during the assessment process.

Although 55% of older persons assessed at home for HBC or the Waiver program have either a diagnosis or indicator of mental illness, HBC and Waiver funds are rarely used to purchase mental health services.

Medicare, which is administered directly by the federal government, provides limited coverage for inpatient and outpatient mental health services for persons age 65 and over. Co-payment for outpatient Medicare-reimbursed services varies greatly from 20% to 50% depending on type of provider and service. Reimbursement rates for outpatient services are set by Medicare and are substantially less than providers' normal fees. Medicare also covers inpatient psychiatric care, but there is a 190-day lifetime benefit cap. Medicare does not cover prescription drugs.

Medigap, a private supplemental insurance available to Medicare recipients through a number of insurance companies, covers the Medicare co-payments (less an annual $100 deductible). However, the cost of this insurance and the deductible are often not within the reach of older adults who have limited incomes and are not Medicaid-eligible.

There are no substance abuse programs specifically funded for elders. Medicare funding of substance abuse services is even more limited than for mental health services.

Surveys and Data Analysis

The Edmund S. Muskie School of Public Service, University of Southern Maine, was asked to conduct a survey and analyze several sources of existing data. They surveyed several Maine agencies that serve elders (exclusive of mental health and substance abuse providers) regarding the perceived mental health needs of their clients, analyzed demographic and health characteristics of older adults receiving Medicaid-funded mental health and related services, and studied long term care assessment data.

Additional studies were undertaken by the DMHMRSAS. Two surveys targeted mental health and substance abuse providers respectively and addressed older adult mental health service provision. In addition, a statewide toll-free phone number was set up for anyone to call with concerns or comments to be included in DMHMRSAS' assessment of the mental health needs of elders. This was done as an alternative to public forums, which in recent years seem to draw fewer and fewer participants.

Summary of Studies

Following are summaries of studies. For more detail, please see the Appendix.

A Survey of Mental Health Service Providers

A questionnaire was mailed in August 1999 to all 90 DMHMRSAS-contracted mental health providers across the state to elicit provider opinions about existing and needed services. Forty-five (45) surveys, or 50%, were completed and returned.

A Survey of Substance Abuse Providers

This survey, conducted during the fall of 1999, was designed to gather information from providers about existing and needed services. Ninety-eight (98) questionnaires were sent to licensed substance abuse treatment agencies across the state of Maine, with 49 agencies, or 50%, responding.

A Compilation of Public Comments

A statewide toll-free phone number was set up during the month of October 1999 for the public to call DMHMRSAS in Augusta with concerns or comments regarding the mental health needs of the elderly. This was publicized through flyers flyers that were distributed to providers across the state. A total of 23 calls were received.

A Survey of Agencies Serving Older Persons (non-mental health or substance abuse)

In the fall of 1999, the Muskie School surveyed by mail 680 professionals at 537 locations that serve older people. These included area agencies on aging, home health and homemaker providers, hospitals, elderly housing managers, Adult Protective Services (a division of DHS/BEAS), and shelters for homeless persons. This survey sought to identify the perceptions of these providers regarding the mental health needs of their elderly clients, including the need for and availability of services, and barriers to access. Thirty-one (31%) percent of the agencies to whom surveys were mailed completed and returned them.

An Analysis of Maine Medicaid Claims Data

Maine Medicaid payments for 1998 were analyzed to provide a snapshot of older Medicaid beneficiaries with diagnoses of mental illness. Factors such as beneficiary age, diagnosis and co-occurring diagnoses, and sources, uses and costs of services, were studied.

An Analysis of Long-Term Care Assessment Data (nursing facility, residential care, and in-home care)

The Muskie School sought to study the prevalence of mental health diagnoses in the long-term care population as well as indications of undiagnosed

mental health conditions and selected demographic factors. To do so, the Muskie School analyzed the long-term care assessments of elderly individuals in Maine seeking admission to nursing homes or requesting in-home services during 1998 (funded through various sections of the Medicaid program and the state funded Home Based Care program). Standard functional assessments are completed by registered nurses. Assessments done in residential care facilities (formerly known as boarding homes), which are similar but differ slightly, were also reviewed. A total of 26,045 assessments were evaluated.

Findings by Study

Following are key findings by study. Tables with more complete data can be found in the Appendix.

A Survey of Mental Health Service Providers

This survey asked licensed mental health service providers to identify existing and needed mental health services (exclusive of substance abuse services). Findings were as follows:

- The most common service offered to individuals over 60 was medication management. This was provided to 1,647 individuals by 14 agencies, or 31% of responding providers. The second most common was case management (938 individuals) provided by 18 agencies, or 40% of respondents. The third was individual therapy (749 individuals), provided by 24 agencies, or 53% of respondents.
- Less than 20% of the agencies providing individual therapy indicated that they provide aging-related training to their staff.
- Intensive case management is a service directly provided by DMHMRSAS. As of December 27, 1999, the number of active cases across the state was 466 with five of those individuals over the age of 60. As of December 28, 1999, the AMHI class membership totaled 3,498. Of these, 384 are aged 60 or over.
- Sixty percent (60%) of the respondents reported that the most critical service gaps were insufficient PT services and in-home supports of all kinds.
- Seven of the ten most often cited needed services are or can be delivered as in-home services.
- There were few waiting lists for the mental health services indicated as most needed (exclusive of substance abuse and PTs).

A Survey of Substance Abuse Providers

This survey asked licensed substance abuse providers to evaluate existing and needed substance abuse services. Findings, which were similar those of the mental health providers survey, were as follows:

- 79% of responding agencies indicated the percentage of elderly served by their current caseload is between 1% and 10%. No agency indicated they had an elderly case load of over 20%.

- Fifty-five percent (55%) of responding agencies said their services were not very or somewhat effective, 35% said they are moderately effective, and 10% said they were very effective.
- Fifty-nine percent (59%) of the respondents indicated that their staff received training specifically related to serving elders. However, a need for more training was also indicated.
- Sixty-five percent (65%) of responding agencies indicated they are not familiar, or are only somewhat familiar, with programs/counselors who specialize in providing services for the older person. When asked if these services were available in their community, 40 agencies (80%) said "yes," while seven agencies (14%) said "no." In addition, providers noted that there were not enough specialized elderly services, that resources (such as money) are limited; that waiting lists for services are long, and that services are difficult to find and access.
- Providers were asked to identify systemic barriers preventing elders from receiving needed substance abuse services. The most serious barriers were a lack of assistance in accessing services; limited insurance coverage for services; and lack of home-based outreach services. .
- Providers were asked to rank personal issues that might prevent elders from seeking substance abuse services. The issues rated most serious were denial or lack of awareness of having a substance abuse problem, unwillingness to admit a need for help or ask for help; and stigma associated with substance abuse treatment.

A Compilation of Public Comments

Comments were taken via a toll-free number that was set up to provide the public with an opportunity to express their concerns about issues and needs. A total of 23 calls were received, over a one month period, from most regions of the state. About half of the callers stated they were calling on behalf of themselves, and others said they were calling on behalf of a parent. Slightly more than half of those that called stated that had previously attempted to get help, and almost as many said they had found it difficult to do so. The major issues cited by callers were:

- The costs of medication;
- The fact that neither the public nor, in some instances, agencies providing services to elders are aware of all the available services to elders;
- Isolation (there are few day or evening activities available to elders);
- A need for more and better respite for caregivers;
- The fact that providers, primary care physicians, and family care providers need better training in older adult issues, as well as better information about existing services and how to access them.
- The lack of :
  - transportation;
  - support groups;
  - medical and dental services;
  - daycare or partial hospitalization;
  - any substance abuse services for elders;

A Survey of Agencies Serving Older Persons (non-mental health or substance abuse)

This survey asked providers in a variety of settings -- ranging from adult protective services to hospital social work departments to homeless shelters -- to identify serious problems in the older adult mental health service delivery system and to recommend corrective action. Respondents self-selected (chose to respond to the survey), and thus are not necessarily a statistically representative sample.

Respondents were asked to estimate the number of older clients they serve with *serious* mental health, memory disorder, or substance abuse problems. ("Serious mental health problems" were defined as "persistent disturbances of mood or thinking," such as depression, anxiety and other symptoms). There was a wide range of responses among provider segments. For example, Adult Protective Services reported that 62% of their clients suffered from a serious memory disorder while RSVP/SEARCH provider stated an incidence of only 2%. However:

- Overall, respondents reported that 9% suffered from a serious mental health disorder, 24% suffered from a memory disorder, and 1% from substance abuse.
- When asked to estimate the percentage of individuals receiving treatment for these conditions, an average of all respondents noted that for mental health conditions, 16% of clients were definitely receiving treatment, and 8% were definitely not receiving treatment. For 76% of their clients, respondents weren't sure if treatment was being received.
- Respondents stated that 10% were receiving treatment for memory disorders, 8% weren't receiving treatment, and they weren't sure if 82% were receiving treatment.
- For substance abuse, treatment was being received by a reported 25% of clients, treatment was not being received by 28%, and respondents weren't sure about 46%.

Respondents were asked to rank potential problems in the mental health service and substance abuse delivery systems that might keep clients from receiving needed care. To accomplish this, respondents were asked to rate 11 key issues using a scale of one to three (most serious to least serious). The most frequently mentioned issues in mental health services (exclusive of substance abuse) were:

- A lack of home-based mental health or substance abuse services,
- Limited insurance coverage (including limited Medicaid or Medicare reimbursement), and
- A lack of community providers trained in older adult services.

The most frequently mentioned issues in substance abuse services (exclusive of other mental health interventions) were:

- A lack of home-based mental health or substance abuse services,
- Limited insurance coverage, and
- A lack of separate, specialized mental health or substance abuse services for older adults were rated most highly for substance abuse.

Next, Respondents were asked to consider personal problems older adults might face that might keep them from receiving needed services. They were presented with 11 key issues, and asked to rate them on the same one to three scale. In both the mental health and substance abuse categories, the issues rated the most serious were the same. These were:

- Denial or lack of awareness of a problem, stigma associated with receiving services or a fear of being identified as mentally ill or a substance abuser, and
- An unwillingness of older adults to ask for or accept help.

A list of key services that could help older adults with mental health or substance abuse needs stay in their current living situations was presented. Respondents were asked to rank these using the same one to three scale. In both the mental health and substance abuse categories, the top three responses were the same (though their ranking was slightly different). These were:

- In-home mental health or substance abuse services;
- Case management; and
- Availability of 24-hour-a-day/7-day-a-week services.

Finally, respondents were asked an open-ended question: "What is the one thing that would most help reduce the unmet mental health or substance abuse needs of the older adults?" Several themes emerged:

- More in-home services
- More public and client education
- Greater availability of services in general
- More money for services

An Analysis of Maine Medicaid Claims Data

This section provides highlights from the analysis of Medicaid claims data for beneficiaries age 60 and older residing in all settings. These data focus on beneficiaries with a diagnosed mental illness or pharmacy claim for mental health-related medications, and who had claims for services submitted to Medicaid in 1998, (unless otherwise specified).

- Approximately 23% (or 7,892) of the 34,140 Medicaid beneficiaries age 60 and older had a diagnosed mental illness in 1998; 1,434 or 4% of older beneficiaries had diagnosed mental illness and diagnosed dementia, while 228 older beneficiaries (under 1%) had a diagnosed mental illness and diagnosed mental retardation.
- Using a broad definition of mental health problems, including use of psychotropic medications and/or behavioral health services, and diagnoses of dementia and substance abuse, in addition to diagnosed mental illness, an additional 9,632 older beneficiaries (28%) have a mental health-related problem.
- Of the 17,524 older Medicaid beneficiaries identified using the broader definition, 6,954 (40%) received nursing facility services under Medicaid.

- Traditional behavioral health services, such as counseling and evaluation, billed to Medicaid for older adults are provided infrequently. For example, services provided by psychiatrists (such as counseling and evaluation) were provided to only 8% of older adults beneficiaries who had a diagnosed mental illness.

An Analysis of Long-Term Care Assessment Data (nursing facility, residential care, and in-home care)

This study looked at assessment data for 17,668 residents of nursing facilities, 2,506 individuals in residential care facilities, and 5,871 consumers of home-based long term care services. All of these individuals were high-risk adults age 60 and older. Analyses of data provide information on met and unmet mental health needs and help estimate the prevalence of mental illness among this population. Findings were as follows:

- Diagnosed mental illness was more common among older adults in residential care facilities (38%) than among long-term care (LTC) consumers served in nursing facilities or in their own homes (27% and 26% respectively).
- Using the broader definition of mental illness discussed earlier which includes dementias, the percentage of long term care consumers with problems increases significantly. Seventy-six (76%) percent of all residential care consumers, 68% of nursing facility residents, and 56% of long-term care consumers served at home, have mental health problems.
- Among LTC consumers with a diagnosed mental illness (excluding dementia), the most frequent diagnosis was depression. Between 20% and 22% of consumers of LTC in all three settings had a diagnosis of depression.
- The second most frequent mental health diagnosis among LTC consumers was anxiety disorder. Among nursing facility residents, 7% were diagnosed with an anxiety problem, while 9% of residential care consumers and 10% of home care consumers had diagnosed anxiety disorders.
- Among consumers in residential care facilities, diagnoses of schizophrenia were nearly as prevalent as diagnosed anxiety disorders, with 8% and 9% diagnosed with schizophrenia and anxiety disorders, respectively.
- Use of medications (anti-depressants, anti-anxiety, anti-psychotics, or hypnotics) to treat LTC consumers with mental health problems ranged from 18% of consumers receiving home care, to 20% and 24% of residential care and nursing facility residents, respectively.
- Fewer than 4% of these high-risk consumers also received other treatment, such as counseling.
- Among those included in the more broadly defined group, 24% to 27% of long term care consumers had an indication of mental illness but no diagnosis of mental illness.
- Difficult behaviors such as physical and verbal aggression, displayed by LTC consumers in each setting, also provide insight into the challenges

of providing adequate assistance to older adults with mental health and related problems. In general, a greater percentage of these consumers in residential care and nursing facilities had "problem" behaviors, compared to home-care consumers.

Conclusions

Following is a synthesis of the key themes that emerged from the surveys and data analyses:

- There is little recognition of the unique needs of older persons in existing mental health and substance abuse policies and systems.

- Older persons, their families, and health and social service providers often deny or don't recognize mental health and substance abuse problems among older people.

- Mental health problems are pervasive and often go untreated in nursing and residential care facilities, as well as at home.

- It is very difficult to determine the full range of available resources and unmet needs because older persons with mental health needs are not tracked as a special population. This is true statewide and regionally.

- The responsibility for needs assessment, budgeting, program development, and delivery of publicly-funded mental health services is dispersed throughout DHS and DMHMRSAS. Also, the lack of coordination creates confusion, and results in barriers to service for both providers and consumers. This is also true at the state and regional levels.

- Older persons with both mental illness and dementia present a significant challenge to the service system especially when they have difficult behaviors.

- Services cannot be analyzed or compared because definitions and delivery methods vary from department to department, region to region, and provider to provider.

- Accurate and up-to-date information about mental health services for older persons in Maine is difficult to access or is not available

- Not all services are available statewide. The most significant needs include:
  - Making psychogeriatric teams services available statewide, and expanding services to include substance abuse services.

- Home-based mental health and substance abuse services;
- Case management;
- Additional professionals with expertise in geriatrics;
- More training and support relating to geriatric issues for service providers and for caregivers;
- Mental health services for older persons for whom English is not a primary language, or who are hearing impaired;
- Substance abuse services specifically for older persons.

- Persons with late-onset mental illness are less likely to access traditional mental health services than those with chronic mental illness. Poor health, impaired mobility, and lack of social supports make it difficult for older persons to use traditional mental health services.

- Medicare's low reimbursement rates and restrictions in private insurance policies limit the availability of mental health services for older Mainers.

- Medicare is a federally-administered program and data were not analyzed. However, Medicare may be significantly underutilized; despite its limitations, it is an important potential source of payment for services.

- Based on Medicaid claims data, approximately 86% of older consumers with a mental health diagnosis receive psychotropic medication without counseling or other supportive services. In addition, many older persons are receiving psychiatric medications without a diagnosis.

- There are no substance abuse services tailored to or funded specifically for older adults by DMHMRSAS's Office of Substance Abuse (OSA).

- Services provided at home alleviate access barriers, and appear to be effective in helping older Mainers with depression and anxiety, and other mental illnesses.

- Cultural awareness should be part of all existing programs and program development efforts.

APPENDIX A

SENATE

JUDY PARADIS, DISTRICT 1, CHAIR
GEORGETTE B. BERUBE, DISTRICT 21
BETTY LOU MITCHELL, DISTRICT 10

JANE ORBETON, LEGISLATIVE ANALYST
DIANE POTTER, COMMITTEE CLERK

HOUSE

THOMAS J. KANE, SACO, CHAIR
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ELAINE FULLER, MANCHESTER
MICHAEL W. QUINT, PORTLAND
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DANIEL B. WILLIAMS, ORONO
GLENYS P. LOVETT, SCARBOROUGH
TARREN R. BRAGDON, BANGOR
LOIS A. SNOWE-MELLO, POLAND
THOMAS F. SHIELDS, AUBURN

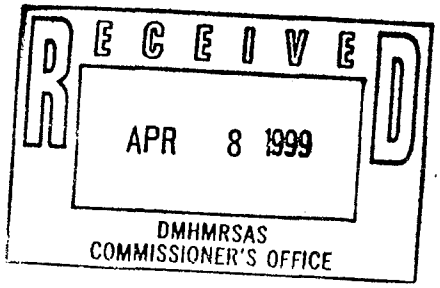
STATE OF MAINE

ONE HUNDRED AND NINETEENTH LEGISLATURE

COMMITTEE ON HEALTH AND HUMAN SERVICES

cc: Katie
Susan
Theresa
Lisa W

April 5, 1999



Commissioner Kevin W. Concannon
Department of Human Services
11 State House Station
Augusta, ME 04333

Commissioner Melodie J. Peet
Department of Mental Health, Mental Retardation and Substance Abuse Services
40 State House Station
Augusta, ME 04333

Re: LD 1760, Resolve, to Create the Commission to Study the Provision of Mental Health Services to the Elderly

Dear Commissioner Concannon and Commissioner Peet,

The Health and Human Services Committee has heard and considered LD 1760, Resolve, to Create the Commission to Study the Provision of Mental Health Services to the Elderly. The committee has voted "ought not to pass" on the resolve and is interested in having the Department of Human Services study this issue and report back to the committee by January 1, 2000.

The committee is interested in having the two departments work with the Joint Advisory Committee on Select Services for Older Persons to study this issue and report back to the committee. The committee is interested in the mental health service needs of the elderly, the extent to which services are available and unavailable, and any information on disparities in unmet need by geographic region, service setting, or residential setting of the older person.

The committee requests that the Departments of Human Services and Mental Health, Mental Retardation and Substance Abuse Services jointly staff the study. The Joint Advisory Committee is urged to invite those who supported this legislation to participate in the work.

Committee members request that when meetings are convened for the purposes of this inquiry they be notified and invited to attend.

Thank you for your assistance.

Sincerely,

Judy A. Paradis, Senate Chair

Thomas J. Kane
House Chair
G:\OPLALHS\COMMTTEE\HUM\CORRESP\3-31HU5.DOC

APPENDIX B

Joint Advisory Committee for Select Services for Older Persons
238 State Street
Twin City Plaza
Brewer, ME 04412

April 21, 1999

Kevin Concannon, Commissioner
Department of Human Services
State House Station 11
Augusta, ME 04333-0011

Melodie Peet, Commissioner
Department of Mental Health, Mental Retardation and Substance Abuse Services
State House Station 40
Augusta, ME 04333-0040

Re: LD 1760, Resolve to Create the Commission to Study the Provision of Mental Health Services to the Elderly

Dear Commissioners Concannon and Peet:

The Joint Advisory Committee on Select Services for Older Persons (JACSSOP) looks forward to working with DHS and DMHMRSAS to study the mental health needs of the elderly as outlined in Sen. Paradis and Rep. Kane's letter of April 5, 1999.

With your assistance, we hope to prepare a well researched, credible report which will be used as a basis for service and budget development. Please tell us if there are particular issues which you believe should be addressed in the report so we can be sure to include these.

Both Departments currently provide staff support of excellent quality but limited availability. We hope that their time commitment will be increased with the elderly mental health study designated as a priority. In addition, we will need the Departments' assistance to collect, compile and analyze consumer and service data. This is critical because JACSSOP is a volunteer committee with no staff or resources of its own. It would also be helpful to have a budget of $6000 for public meetings, mileage reimbursement, publications, preparation of charts and graphs, etc.

We invite you and your staff to attend JACSSOP meetings which are held the second Friday morning of each month from 9:00 to 11:00 at BEAS. The next meeting will be May 14, 1999. If you have questions or would like additional information about JACSSOP or the elderly mental health study process, please contact me at (207) 941-2865 or redowney@eaaa.org.

Sincerely,

Roberta Downey
Chairman, JACSSOP

Cc: Members, JACSSOP
Chris Gianopoulos, BEAS
John Baillargeon, BEAS
Susan Wygal, DMHMRSAS
Theresa Turgeon, DMHMRSAS
Joint Standing Committee on Health and Human Services

University of Southern Maine
Edmund S. Muskie School of Public Service
Health Policy Institute

MAINE OLDER ADULTS MENTAL HEALTH NEEDS SURVEY

This survey is part of a study requested by the Legislature to assess the mental health and substance abuse needs of older adults. The purpose of the survey is to describe the **unmet mental health and substance abuse needs among people age 60 and over**. We ask that you complete this survey and return it in the enclosed postage paid reply envelope. While your individual responses will be kept confidential, they will be combined with others so that the aggregate results can be reported to the Legislature. Thank you for your co-operation.

Your Name (optional): _____

Your Title (optional): _____

Name of your agency or organization (required): _____

1. ❑ I have direct contact with the older adults (age 60 and over) served by my agency.
   ❑ I supervise persons who have direct contact with the older adults served by my agency.
   *(If neither statement applies to you, then please forward this survey to someone **in your same agency** who does work with older persons.)*

2. ____ Approximately how many different older adults do **you** (or your staff) currently directly serve?

3. Thinking about those older adults whom you or your staff currently directly serve, please estimate below the number who you feel have a serious mental health problem, memory disorder, or substance abuse problem. For the purposes of this survey, we define *serious mental health problems* as persistent disturbances of mood or thinking, including any one of the following:
   - *persistent sadness or depression;*
   - *persistent anxiety or severe nervousness;*
   - *unreal beliefs, fears, or perceptions;*
   - *seeing or hearing things that are not present; or*
   - *very unusual, bizarre, or aggressive behavior.*

   In the three columns below, we ask you to please estimate the number of older adults that you (or the staff you supervise) serve who have a serious *mental health* problem (as described above), a serious *memory disorder* (i.e. Alzheimer's or other dementia), or a serious *substance abuse* problem.

Mental Health	**Memory Disorder**	**Substance Abuse**	
____	____	____	a. The number of older adults in Question 2 who have a serious problem.

Note: If a person has multiple problems (for example: both mental health and *substance abuse), then please count that person in all the categories that apply.*

____	____	____	b. The current number in line a. who are receiving treatment for their problem.
____	____	____	c. The current number in line a. who are definitely not receiving any treatment.
____	____	____	d. The current number in line a. about whom you are unsure as to whether they are being treated.

This survey was adapted from "The New Hampshire Elderly Needs Survey," developed by Stephen J. Bartels, M.D., et.al., of The New Hampshire-Dartmouth Psychiatric Research Center, (Lebanon, N.H.: 1995).

4. Below, we list potential problems in the **mental health service and substance abuse delivery systems** that might keep older adults from receiving needed care. Please read through all the choices, and then indicate the three (3) most serious problems in each column by ranking them from "1" (for the most serious) to "3" (for the third most serious). *Please mark only three items in each column.*

Example	Mental Health	Substance Abuse	
____	____	____	a. lack of separate, specialized mental health or substance abuse services for older adults.
3	____	____	b. inconvenient locations for mental health or substance abuse services
____	____	____	c. cost of obtaining mental health or substance abuse services
____	____	____	d. negative attitudes of mental health or substance abuse providers toward older adults, or a reluctance to serve older adults
____	____	____	e. lack of home-based mental health or substance abuse services
____	____	____	f. narrow eligibility criteria for older adult mental health services, e.g. exclusion of Alzheimer's
____	____	____	g. no one to assist older adults in arranging services
1	____	____	h. limited insurance coverage for these services; limited Medicaid or Medicare reimbursement to providers
____	____	____	i. lack of community mental health or substance abuse providers who are trained in elder services
2	____	____	j. long waiting times to get an appointment with a mental health or substance abuse provider
____	____	____	k. other _____

5. Below, we list potential **personal problems** older adults might face in their own lives that might keep them from receiving needed mental health or substance abuse care. Please read through all the choices, and then indicate the three (3) most serious problems in each column by ranking them from "1" (for the most serious) to "3" (for the third most serious). *Please mark only three items in each column.*

Mental Health	Substance Abuse	
____	____	a. denial or lack of awareness of having a mental health or substance abuse problem
____	____	b. older adults themselves who have negative attitudes toward mental health care or substance abuse services
____	____	c. family members who have negative attitudes toward mental health or substance abuse services
____	____	d. stigma associated with receiving services; fear of being identified as mentally ill or as a substance abuser
____	____	e. lack of awareness, among older adults, of the availability of services
____	____	f. unwillingness of older adults to ask for or accept help
____	____	g. little confidence, among older adults, that services will help them
____	____	h. fear of out-of-pocket expenses associated with receiving services
____	____	i. difficulty getting to services because of limited transportation
____	____	j. difficulty getting to services because of limited physical mobility and poor health
____	____	k. other _____

6. Below, we list several services that could help older adults with mental health or substance abuse needs to stay in their current living arrangements. Please read through all the choices and then indicate the three (3) services you believe are most needed in each column by ranking them from "1" (for most needed) to "3" (for the third most needed). *Please limit your rankings to only three services in each column.*

Mental Health	**Substance Abuse**	
____	____	a. in-home mental health or substance abuse services
____	____	b. availability of 24-hour-a-day / 7-day-a-week services
____	____	c. family support groups
____	____	d. respite support to families
____	____	e. adult day services
____	____	f. case management
____	____	g. assistance in establishing legal guardianship / payee
____	____	h. other _____

7. What is the one thing that would most help reduce the unmet mental health or substance abuse needs of the older adults? Please elaborate and use the back of this page or additional pages if necessary.

Once you have completed the questionnaire, please return it in the enclosed postage paid reply envelope, or mail it to:

Al Leighton
Muskie School of Public Service
Univ. of Southern Maine
P.O. Box 9300
Portland, ME 04104-9300

Please remember that your individual answers will be kept confidential. We appreciate your help.

APPENDIX D

Maine Older Adult Mental Health Needs Survey — Fall 1999

Summary of Responses by Type of Service Provider

Question 5 *Please rank the three most serious potential problems in the **mental health** service delivery system that might keep older adults from receiving needed care.*

All Provider Types	AAA Outreach	AAA Senior Meals	Adult Protective Services	Home Care / Home Health	Hospital Social Worker / Discharge Planner	Legal Services	Local Housing Authority	Long Term Care Ombudsman	RSVP / SEARCH	Senior Housing / Retirement Community	Shelters / Food Kitchens	Problems
			2nd			2nd		1st			2nd	a. lack of separate, specialized mental health or substance abuse services for older adults.
												b. inconvenient locations for mental health or substance abuse services
	2nd	1st					2nd		3rd	2nd	1st	c. cost of obtaining mental health or substance abuse services
												d. negative attitudes of mental health or substance abuse providers toward older adults, or a reluctance to serve older adults
1st		2nd	1st	1st	1st	3rd	1st	2nd	2nd	1st		e. lack of home-based mental health or substance abuse services
								3rd				f. narrow eligibility criteria for older adult mental health services, e.g. exclusion of Alzheimer's
								3rd			3rd	g. no one to assist older adults in arranging services
2nd	1st	3rd		2nd	3rd	3rd			1st		3rd	h. limited insurance coverage for these services; limited Medicaid or Medicare reimbursement to providers
3rd			3rd	3rd		1st				3rd	3rd	i. lack of community mental health or substance abuse providers who are trained in elder services
	3rd				2nd		3rd					j. long waiting times to get an appointment with a mental health or substance abuse provider
												k. other _____
214	20	14	33	22	24	2	7	4	6	66	16	Number of completed responses

Maine Older Adult Mental Health Needs Survey — Fall 1999

Summary of Responses by Type of Service Provider

Question 6 *Please rank the three most serious potential problems older adults might face in their own lives that might keep them from receiving needed* ***mental health*** *care.*

All Provider Types	AAA Outreach	AAA Senior Meals	Adult Protective Services	Home Care / Home Health	Hospital Social Worker / Discharge Planner	Legal Services	Local Housing Authority	Long Term Care Ombudsman	RSVP / SEARCH	Senior Housing / Retirement Community	Shelters / Food Kitchens	Problems
1st	1st	1st	1st	1st	2nd	1st	1st	1st	3rd	1st	1st	a. denial or lack of awareness of having a mental health or substance abuse problem
				2nd		3rd		2nd				b. older adults themselves who have negative attitudes toward mental health care or substance abuse services
												c. family members who have negative attitudes toward mental health or substance abuse services
2nd	2nd	1st	3rd	3rd	1st	2nd	2nd			2nd	2nd	d. stigma associated with receiving services; fear of being identified as mentally ill or as a substance abuser
								2nd	1st		3rd	e. lack of awareness, among older adults, of the availability of services
3rd			2nd				3rd		1st			f. unwillingness of older adults to ask for or accept help
												g. little confidence, among older adults, that services will help them
	3rd	1st			3rd			2nd		3rd		h. fear of out-of-pocket expenses associated with receiving services
									3rd			i. difficulty getting to services because of limited transportation
									3rd			j. difficulty getting to services because of limited physical mobility and poor health
												k. other _____
214	20	14	33	22	24	2	7	4	6	66	16	Number of completed responses

Maine Older Adult Mental Health Needs Survey — Fall 1999

Summary of Responses by Type of Service Provider

Question 7 *Please rank the three services you believe are most needed to help older adults with* ***mental health*** *needs to stay in their current living arrangements.*

All Provider Types	AAA Outreach	AAA Senior Meals	Adult Protective Services	Home Care / Home Health	Hospital Social Worker / Discharge Planner	Legal Services	Local Housing Authority	Long Term Care Ombudsman	RSVP / SEARCH	Senior Housing / Retirement Community	Shelters / Food Kitchens	Services
1st	1st	1st	1st	1st	1st	2nd	1st	2nd	1st	1st	1st	a. in-home mental health or substance abuse services
3rd		2nd	2nd		2nd		3rd		2nd	2nd		b. availability of 24-hour-a-day / 7-day-a-week services
												c. family support groups
	2nd	3rd		2nd	3rd			3rd	2nd		3rd	d. respite support to families
						3rd			2nd			e. adult day services
2nd	3rd		3rd	3rd		1st	2nd	1st		3rd	2nd	f. case management
												g. assistance in establishing legal guardianship / payee
												h. other _____
214	20	14	33	22	24	2	7	4	6	66	16	Number of completed responses

Maine Older Adult Mental Health Needs Survey — Fall 1999

Summary of Responses by Type of Service Provider

Question 5 *Please rank the three most serious potential problems in the* ***substance abuse*** *service delivery system that might keep older adults from receiving needed care.*

All Provider Types	AAA Outreach	AAA Senior Meals	Adult Protective Services	Home Care / Home Health	Hospital Social Worker / Discharge Planner	Legal Services	Local Housing Authority	Long Term Care Ombudsman	RSVP / SEARCH	Senior Housing / Retirement Community	Shelters / Food Kitchens	Problems
3rd	2nd		2nd		3rd		2nd	3rd			2nd	a. lack of separate, specialized mental health or substance abuse services for older adults.
	2nd					3rd						b. inconvenient locations for mental health or substance abuse services
	2nd	1st							2nd	2nd	1st	c. cost of obtaining mental health or substance abuse services
												d. negative attitudes of mental health or substance abuse providers toward older adults, or a reluctance to serve older adults
1st	1st	1st	1st	1st	2nd		1st	1st	3rd	1st		e. lack of home-based mental health or substance abuse services
												f. narrow eligibility criteria for older adult mental health services, e.g. exclusion of Alzheimer's
		3rd						3rd			3rd	g. no one to assist older adults in arranging services
	2nd			2nd	1st	2nd	3rd		1st			h. limited insurance coverage for these services; limited Medicaid or Medicare reimbursement to providers
2nd			3rd	3rd		1st		2nd		3rd	3rd	i. lack of community mental health or substance abuse providers who are trained in elder services
												j. long waiting times to get an appointment with a mental health or substance abuse provider
											3rd	k. other _____
214	20	14	33	22	24	2	7	4	6	66	16	Number of completed responses

Maine Older Adult Mental Health Needs Survey — Fall 1999

Summary of Responses by Type of Service Provider

Question 6 *Please rank the three most serious potential problems older adults might face in their own lives that might keep them from receiving needed* ***substance abuse*** *care.*

All Provider Types	AAA Outreach	AAA Senior Meals	Adult Protective Services	Home Care / Home Health	Hospital Social Worker / Discharge Planner	Legal Services	Local Housing Authority	Long Term Care Ombudsman	RSVP / SEARCH	Senior Housing / Retirement Community	Shelters / Food Kitchens	Problems
1st	1st	1st	1st	1st	1st	1st	1st	1st	1st	1st		a. denial or lack of awareness of having a mental health or substance abuse problem
			3rd	2nd		3rd					2nd	b. older adults themselves who have negative attitudes toward mental health care or substance abuse services
												c. family members who have negative attitudes toward mental health or substance abuse services
2nd	2nd			2nd	2nd	1st	2nd			2nd	1st	d. stigma associated with receiving services; fear of being identified as mentally ill or as a substance abuser
		3rd						2nd			3rd	e. lack of awareness, among older adults, of the availability of services
3rd		2nd	2nd		3rd	3rd	3rd		2nd			f. unwillingness of older adults to ask for or accept help
												g. little confidence, among older adults, that services will help them
	3rd							2nd	3rd			h. fear of out-of-pocket expenses associated with receiving services
										3rd		i. difficulty getting to services because of limited transportation
												j. difficulty getting to services because of limited physical mobility and poor health
												k. other _____
214	20	14	33	22	24	2	7	4	6	66	16	Number of completed responses

Maine Older Adult Mental Health Needs Survey — Fall 1999

Summary of Responses by Type of Service Provider

Question 7 *Please rank the three services you believe are most needed to help older adults with* ***substance abuse*** *needs to stay in their current living arrangements.*

All Provider Types	AAA Outreach	AAA Senior Meals	Adult Protective Services	Home Care / Home Health	Hospital Social Worker / Discharge Planner	Legal Services	Local Housing Authority	Long Term Care Ombudsman	RSVP / SEARCH	Senior Housing / Retirement Community	Shelters / Food Kitchens	Services
1st	1st	2nd	1st	1st	1st	1st	1st	1st	1st	1st	1st	a. in-home mental health or substance abuse services
2nd		1st	2nd	2nd		3rd	3rd	3rd		2nd	3rd	b. availability of 24-hour-a-day / 7-day-a-week services
						3rd			2nd			c. family support groups
	2nd			2nd					3rd			d. respite support to families
	3rd	3rd			3rd							e. adult day services
3rd			3rd		2nd	2nd	2nd	1st		3rd	2nd	f. case management
												g. assistance in establishing legal guardianship / payee
								3rd				h. other _____
214	20	14	33	22	24	2	7	4	6	66	16	Number of completed responses

APPENDIX E

Table 1: Study Populations by Setting/Data Source

	Assessment Location			Medicaid Claims			
	NF (MDS)	ResCare	Home Care	All	Services	Diagnoses	Drugs
Total population age 60+	17,668	2,506	5,871				
Sample (any MH,MR,SA, dementia)	11,513	1,915	3,265	28,593	2,474	10,047	14,732
MH diagnosis	4,505	962	1,546	7,892	1,942	7,892	6,249
SA diagnosis	*	89	82	1,312	246	1,312	808
Dementia diagnosis	6,039	1,004	1,075	2,597	380	2,597	1,828
Mental Retardation diagnosis	*	337	41	472	358	472	307
Diagnostic Groups (excl MR):							
Sole Diagnosis:							
Dementia	4,026	642	791	1,103	51	1,103	672
Mental health condition	2,514	558	1,240	5,802	1,289	5,802	4,583
Substance abuse	3	24	36	787	39	787	362
Dual diagnoses:							
MI & dementia	1,715	307	268	1,379	272	1,379	1,067
Substance abuse & dementia	2	19	9	25	1	25	16
MI & substance abuse	5	23	30	424	156	424	366
MI, SA, and dementia	0	19	5	55	31	55	47
Mental Retardation diagnoses:							
MR only	304	77	35	222	151	222	109
MR & dementia	184	11	2	11	7	11	6
MR and MH condition	159	47	2	198	166	198	159
MR and substance abuse	0	1	1	0	0	0	0
MR, MH, & dementia	112	5	0	20	15	20	16
MR, MI, dementia, & SA	0	1	0	2	2	2	2
Diagnostic subgroups:							
Schizophrenia	266	198	30	935	564	935	838
Anxiety disorder	1,179	236	592	1,335	230	1,335	1,183
Depression	3,578	562	1,198	677	463	677	642
Bipolar disease	210	91	52	252	205	252	237
Other affective psychoses [3]	*	*	*	438	314	438	414
Other psychoses [4]	*	*	*	1,091	277	1,091	830
Other organic conditions [6]	*	*	*	1,689	365	1,689	1,275
Stress & adjustment disorders [7]	*	*	*	404	229	404	325
Personality disorders [8]	*	*	*	148	87	148	123
Childhood disorders [9]	*	*	*	352	122	352	305
Other mood disorders/anxiety [10]	*	*	*	3,398	777	3,398	3,040
other mental disorders [11]	*	*	*	421	98	421	289
Substance abuse diagnoses:							
Any diagnosis	*	89	82	1,312			
Alcoholic psychoses [12]	*	*	*	114	35	114	88
Alcohol dependence/abuse [13]	*	*	*	376	108	376	230
Drug psychoses/mood disorders [14]	*	*	*	79	30	79	71
Drug dependence/abuse [15]	*	*	*	44	14	44	37
Other alcohol/drug disorders [16]	*	*	*	125	24	125	80
Other indicators:							
Persons with no MH diagnosis	12,675	1,268	3,236	20,701			
Persons with any indicator	4,419	387	1,442				

Medications:							
Any medication	4,013	154	1,062	8,483			
Anti-depressants	1,686	161	436	4,649			
Anti-psychotics	1,125	146	148	1,797			
Anti-anxiety	1,372	146	588	3,908			
Hypnotics	889	146	60	1,492			
Depression symptoms	764	224	512				
Treatment indicators							
Any treatment indicator	52	57	18	532			
MH	213	82	40				
SA	5	4	*				

Table 1a: Percentage of Total Population Age 60+ by Setting/Data Source

	Assessment Location					
	NF (MDS)	ResCare	Home Care	Medicaid Claims Data		
				All	Services	Diagnoses
Total population age 60+	100.0%	100.0%	100.0%			
Sample (any MH,MR,SA, dementia)	65.2%	76.4%	55.6%	28,593	2,474	10,047
MH diagnosis	25.5%	38.4%	26.3%	7,892	1,942	7,892
SA diagnosis	*	3.6%	1.4%	1,312	246	1,312
Dementia diagnosis	34.2%	40.1%	18.3%	2,597	380	2,597
Mental Retardation diagnosis	*	13.4%	0.7%	472	358	472
Diagnostic Groups (excl MR):						
Sole Diagnosis:						
Dementia	22.8%	25.6%	791	1,103	51	1,103
Mental health condition	14.2%	22.3%	1,240	5,802	1,289	5,802
Substance abuse	0.0%	1.0%	36	787	39	787
Dual diagnoses:						
MI & dementia	1,715	307	268	1,379	272	1,379
Substance abuse & dementia	2	19	9	25	1	25
MI & substance abuse	5	23	30	424	156	424
MI, SA, and dementia	0	19	5	55	31	55
Mental Retardation diagnoses:						
MR only	304	77	35	222	151	222
MR & dementia	184	11	2	11	7	11
MR and MH condition	159	47	2	198	166	198
MR and substance abuse	0	1	1	0	0	0
MR, MH, & dementia	112	5	0	20	15	20
MR, MI, dementia, & SA	0	1	0	2	2	2
Diagnostic subgroups:						
Schizophrenia	266	198	30	935	564	935
Anxiety disorder	1,179	236	592	1,335	230	1,335
Depression	3,578	562	1,198	677	463	677
Bipolar disease	210	91	52	252	205	252
Other affective psychoses [3]	*	*	*	438	314	438
Other psychoses [4]	*	*	*	1,091	277	1,091
Other organic conditions [6]	*	*	*	1,689	365	1,689
Stress & adjustment disorders [7]	*	*	*	404	229	404
Personality disorders [8]	*	*	*	148	87	148
Childhood disorders [9]	*	*	*	352	122	352
Other mood disorders/anxiety [10]	*	*	*	3,398	777	3,398
other mental disorders [11]	*	*	*	421	98	421
Substance abuse diagnoses:						
Any diagnosis	*	89	82	1,312		
Alcoholic psychoses [12]	*	*	*	114	35	114
Alcohol dependence/abuse [13]	*	*	*	376	108	376
Drug psychoses/mood disorders [14]	*	*	*	79	30	79
Drug dependence/abuse [15]	*	*	*	44	14	44
Other alcohol/drug disorders [16]	*	*	*	125	24	125
Other indicators:						
Persons with no MH diagnosis	12,675	1,268	3,236	20,701		
Persons with any indicator	4,419	387	1,442			

Medications:						
Any medication	4,013	154	1,062	8,483		
Anti-depressants	1,686	161	436	4,649		
Anti-psychotics	1,125	146	148	1,797		
Anti-anxiety	1,372	146	588	3,908		
Hypnotics	889	146	60	1,492		
Depression symptoms	764	224	512			
Treatment indicators						
Any treatment indicator	52	57	18	532		
MH	213	82	40			
SA	5	4	*			

Drugs
14,732
6,249
808
1,828
307
672
4,583
362
1,067
16
366
47
109
6
159
0
16
2
838
1,183
642
237
414
830
1,275
325
123
305
3,040
289
88
230
71
37
80

APPENDIX F

Table 2a: Nursing Home Residents	Number	% of Total Residents	Age		Dependence in Daily	
			Mean	Range	Mean	Range
Total in Sub-Groups						
Nursing Home Residents (60+)	**17,668**	100.0%	81	60-107	3.3	0-5
Study population residents	12,029	68.1%	82	60-107	3.6	0-5
All Residents w/ Diagnosed Mental Illness, Substance Abuse or Dementia	9,195	52.0%	82	60-107	3.7	0-5
All Residents with Mental Health Diagnosis (dx.)	4,773	27.0%	80	60-104	3.6	0-5
Indication of Mental Illness from other than diagnosis:						
Any Indication of Mental Illness	4,716	26.7%	81	60-106	3.5	0-5
Anti-depressant Medication	1,801	10.2%	80	60-105	3.5	0-5
Other Mental Health Related Medication	2,481	14.0%	81	60-105	3.5	0-5
Symptoms of Depression	379	2.1%	84	61-106	3.7	0-5
Treatment for Mental Illness	55	0.3%	81	60-98	3.1	0-5
Mutually Exclusive Diagnostic Groups (excluding MR):						
Dementia only	4,422	25.0%	84	60-107	3.9	0-5
MH condition only	2,857	16.2%	79	60-104	3.4	0-5
Substance abuse only	n/a					
MI and dementia	1,916	10.8%	83	60-104	3.9	0-5
Substance abuse & dementia	n/a					
MI and substance abuse	n/a					
MI, SA, and dementia	n/a					

Demographic, Capacity, and Health Characteristics from Assessment and Claims Data

Table 2a: Nursing Home Residents	Number	Diagnoses/Medical Conditions					
		Endocrine	Heart	Musulo-skeletal	Neuro-logical	Pulmonary	Cancer/ Renal
Total in Sub-Groups							
Nursing Home Residents (60+)	**17,668**	5145	11730	6279	9358	3234	2704
Study population residents	12,029	3826	8562	4646	8188	2407	1804
All Residents w/ Diagnosed Mental Illness, Substance Abuse or Dementia	9,195	2920	6513	3607	7382	1686	1210
All Residents with Mental Health Diagnosis (dx.)	4,773	1705	3591	1994	2960	1091	689
Indication of Mental Illness from other than diagnosis:							
Any Indication of Mental Illness	4,716	1462	3388	1788	2814	1010	828
Anti-depressant Medication	1,801	613	1353	685	1045	379	304
Other Mental Health Related Medication	2,481	712	1721	918	1471	555	458
Symptoms of Depression	379	121	276	165	258	59	59
Treatment for Mental Illness	55	16	38	20	40	17	7
Mutually Exclusive Diagnostic Groups (excluding MR):							
Dementia only	4,422	1215	2922	1613	4422	595	521
MH condition only	2,857	1111	2213	1172	1044	769	515
Substance abuse only	n/a						
MI and dementia	1,916	594	1378	822	1916	322	174
Substance abuse & dementia	n/a						
MI and substance abuse	n/a						
MI, SA, and dementia	n/a						

Demographic, Capacity, and Health Characteristics from Assessment and Claims Data

Table 2a: Nursing Home Residents	Number	Male	Married	Medicaid	MH history	No guardian	Short-term memory	Cognitive Skill			
								Independent	Moderately Independent	Moderately Impaired	Severely Impaired
Total in Sub-Groups											
Nursing Home Residents (60+)	17,668	5,488	4,166	6,003	1,833	7733	9443	4834	3293	4994	3001
Study population residents	12,029	3,555	2,949	5,276	1,833	4,703	8117	2577	2181	4320	2829
All Residents w/ Diagnosed Mental Illness, Substance Abuse or Dementia	9,195	2,597	2,192	4,648	1,426	2,878	7143	1241	1507	3767	2663
All Residents with Mental Health Diagnosis (dx.)	4,773	1,308	1,061	2,267	1,145	2,147	2966	1095	1087	1782	801
Indication of Mental Illness from other than diagnosis:											
Any Indication of Mental Illness	4,716	1,519	1,309	1,615	346	2,121	2886	1375	841	1501	994
Anti-depressant Medication	1,801	557	498	606	148	879	1053	560	376	556	309
Other Mental Health Related Medication	2,481	853	729	829	177	1,068	1527	747	384	758	587
Symptoms of Depression	379	87	72	153	17	146	272	54	73	164	88
Treatment for Mental Illness	55	22	10	27	4	28	34	14	8	23	10
Mutually Exclusive Diagnostic Groups (excluding MR):											
Dementia only	4,422	1,289	1,131	2,381	281	731	4177	146	420	1985	1862
MH condition only	2,857	828	683	1,078	728	1,776	1187	1030	902	750	168
Substance abuse only	n/a										
MI and dementia	1,916	480	378	1,189	417	371	1179	65	185	1032	633
Substance abuse & dementia	n/a										
MI and substance abuse	n/a										
MI, SA, and dementia	n/a										

Demographic, Capacity, and Health Characteristics from Assessment and Claims Data

Table 2a: Nursing Home Residents	Number	Cognitive Performance Score		Antipsychotic Meds		Antianxiety Meds		Antidepressant meds		Hypnotic Meds	
		Mean	Range	Mean	Range	Mean	Range	Mean	Range	Mean	Range
Total in Sub-Groups											
Nursing Home Residents (60+)	17,668	2.3	0-6	0.8	0-7	0.9	0-7	1.9	0-7	0.4	0-7
Study population residents	12,029	2.7	0-6	1.1	0-7	1.2	0-7	2.6	0-7	0.6	0-7
All Residents w/ Diagnosed Mental Illness, Substance Abuse or Dementia	9,195	3.1	0-6	1.3	0-7	1.1	0-7	2.7	0-7	0.4	0-7
All Residents with Mental Health Diagnosis (dx.)	4,773	2.4	0-6	1.3	0-7	1.5	0-7	4.2	0-7	0.5	0-7
Indication of Mental Illness from other than diagnosis:											
Any Indication of Mental Illness	4,716	2.4	0-6	1.5	0-7	1.5	0-7	2.3	0-7	0.9	0-7
Anti-depressant Medication	1,801	2.3	0-6	0.9	0-7	1.0	0-7	6.0	1-7	0.5	0-7
Other Mental Health Related Medication	2,481	2.5	0-6	2.3	0-7	2.1	0-7	0.0	0-0	1.4	0-7
Symptoms of Depression	379	2.8	0-6	0.0	0-0	0.0	0-0	0.0	0-0	0.0	0-0
Treatment for Mental Illness	55	2.4	0-6	0.5	0-2	0.0	0-0	0.0	0-0	0.0	0-0
Mutually Exclusive Diagnostic Groups (excluding MR):											
Dementia only	4,422	3.9	0-6	1.4	0-7	0.7	0-7	1.0	0-7	0.2	0-7
MH condition only	2,857	1.6	0-6	0.9	0-7	1.5	0-7	4.3	0-7	0.6	0-7
Substance abuse only	n/a										
MI and dementia	1,916	3.6	0-6	1.9	0-7	1.4	0-7	4.2	0-7	0.3	0-7
Substance abuse & dementia	n/a										
MI and substance abuse	n/a										
MI, SA, and dementia	n/a										

Demographic, Capacity, and Health Characteristics from Assessment and Claims Data

Table 2a: Nursing Home Residents	Number	Days of psych therapy		Easily Distracted	Altered Perception	Disorganized Speech	Restless-ness	Lethargy	Mental Function Varies	Delusions/ Hallucina-tions
		Mean	Range							
Total in Sub-Groups										
Nursing Home Residents (60+)	17,668	0.0	0-7	2097	1681	1763	2291	1692	2766	600
Study population residents	12,029	0.0	0-7	1918	1515	1642	2118	1440	2368	552
All Residents w/ Diagnosed Mental Illness, Substance Abuse or Dementia	9,195	0.0	0-2	1721	1356	1489	1864	1248	2033	485
All Residents with Mental Health Diagnosis (dx.)	4,773	0.0	0-2	684	593	587	812	594	931	280
Indication of Mental Illness from other than diagnosis:										
Any Indication of Mental Illness	4,716	0.0	0-7	800	655	694	979	550	1020	232
Anti-depressant Medication	1,801	0.0	0-7	224	199	197	276	174	334	75
Other Mental Health Related Medicatio	2,481	0.0	0-2	454	354	402	577	296	544	123
Symptoms of Depression	379	0.0	0-1	114	97	86	119	73	133	31
Treatment for Mental Illness	55	0.2	0-2	8	5	9	7	7	9	3
Mutually Exclusive Diagnostic Groups (excluding MR):										
Dementia only	4,422	0.0	0-2	1037	763	902	1052	654	1102	205
MH condition only	2,857	0.0	0-2	243	206	174	287	276	384	125
Substance abuse only	n/a									
MI and dementia	1,916	0.0	0-2	441	387	413	525	318	547	155
Substance abuse & dementia	n/a									
MI and substance abuse	n/a									
MI, SA, and dementia	n/a									

- Getting agencies to help you get help from another agency when you are eligible or the other's services. Not having to find that out by yourself.

- Need a way of finding out about what services there are and how to get help. Senior college. The mental health system is a mystery. Get more information about it out to physicians, like who, where, how, and when to act.

- That fool man (state employee) needs to learn how to listen and maybe even how to speak English.. Actually, if there was one place to go to get information, including everything that is available and how it works.

- If you want to attract retired people you need to give some type of tax credit. Maine one of six states who don't do that.

- Everyone, including seniors with the labels, need to be approached and seen as a "normal" person,
  - Need more self advocacy trainings,
  - Support for individuals and groups.
  - People should not need to move they should be able to age where they want to live

- Training training training,
  - Not enough dental care,
  - Not enough home health,
  - Lack of companionship,
  - More group homes, assisted living,
  - NEED TRAINED STAFF to work with older people.

Do you think you will have the same needs in 5 years?

Dad is physically fine, he has Alzheimer's. He may need to go to the Alzheimer's unit some day.

Don't know how to get groceries and things like that if I'm not able to drive myself.

Not sure.

Do not know, I'm afraid.

Do not have anyone to call if I need help.

Do you think you will have the same needs in 10 years?

He will need the services he is getting and may need to move to the first floor.

Not sure.

Do not know, I'm afraid.

Fortunate to have enough resources to have long term care insurance.

Really haven't given it much thought, I know I should.

Table 2a: Nursing Home Residents	Number	Distress														
		Negative Statements	Repetitive Questions	Repetitive Verabilizat.	Self-deprecation	Unrealistic Fears	Recurrent Statements	Health Complaints	Anxious Complaints	Unpleasant Mood	Insomnia	Facial Expressions	Crying	Repetitive Movement	Withdrawal from Activ.	Reduced Social Interaction
Total in Sub-Groups																
Nursing Home Residents (60+)	17,668	1099	1018	1022	1595	368	769	334	996	1351	1225	1070	2498	1677	2114	1497
Study population residents	12,029	940	945	953	1431	322	709	303	843	1188	1126	910	2145	1490	1981	1291
All Residents w/ Diagnosed Mental Illness, Substance Abuse or Dementia	9,195	808	864	855	1225	283	635	262	665	997	1000	680	1827	1279	1786	1108
All Residents with Mental Health Diagnosis (dx.)	4,773	511	382	409	650	181	352	159	464	603	490	400	1107	767	791	603
Indication of Mental Illness from other than diagnosis:																
Any Indication of Mental Illness	4,716	435	479	487	729	144	362	142	447	611	528	472	994	647	901	535
Anti-depressant Medication	1,801	131	125	132	195	41	75	42	123	144	155	116	282	210	245	174
Other Mental Health Related Medication	2,481	152	209	230	320	48	157	61	148	242	255	277	404	276	503	251
Symptoms of Depression	379	149	141	121	207	54	128	38	175	221	111	77	305	156	145	104
Treatment for Mental Illness	55	3	4	4	7	1	2	1	1	4	5	2	3	5	8	6
Mutually Exclusive Diagnostic Groups (excluding MR):																
Dementia only	4,422	297	482	446	575	102	283	103	201	394	510	208	720	512	995	505
MH condition only	2,857	289	112	150	310	90	146	78	311	343	198	233	537	364	233	309
Substance abuse only	n/a															
MI and dementia	1,916	222	270	259	340	91	206	81	153	260	292	167	570	403	558	294
Substance abuse & dementia	n/a															
MI and substance abuse	n/a															
MI, SA, and dementia	n/a															

Demographic, Capacity, and Health Characteristics from Assessment and Claims Data

Table 2a: Nursing Home Residents	Number	Behaviors					Medications				Alocohol/ Drug Treat.	Alzheimers SCU	Psych. Therapy	Intervention Program
		Wandering	Physically Abusive	Verbally Abusive	Socially Inappropriate	Resists Care	Antipsychotic	Antianxiety	Anti-depressant	Hypnotic				
Total in Sub-Groups														
Nursing Home Residents (60+)	**17,668**	983	656	852	1264	1964	2187	2752	5016	1419	11	1125	108	3591
Study population residents	12,029	958	639	806	1201	1758	2187	2752	5016	1419	11	1125	108	3223
All Residents w/ Diagnosed Mental Illness, Substance Abuse or Dementia	9,195	900	602	729	1098	1568	1956	1896	3900	642	7	1091	80	2865
All Residents with Mental Health Diagnosis (dx.)	4,773	299	229	331	477	677	988	1286	3215	470	5	379	72	1379
Indication of Mental Illness from other than diagnosis:														
Any Indication of Mental Illness	4,716	498	313	407	556	765	1199	1466	1801	949	5	428	36	1215
Anti-depressant Medication	1,801	144	99	120	160	228	266	343	1801	170	.	133	12	388
Other Mental Health Related Medicatio	2,481	309	185	217	330	416	933	1123	.	779	4	233	11	630
Symptoms of Depression	379	38	26	65	60	114	379	.	.	.	.	55	3	147
Treatment for Mental Illness	55	7	3	5	6	7	.	.	.	.	1	7	10	50
Mutually Exclusive Diagnostic Groups (excluding MR):														
Dementia only	4,422	601	373	398	621	891	968	610	685	172	2	712	8	1486
MH condition only	2,857	40	49	119	145	266	403	821	1969	361	5	27	49	571
Substance abuse only	n/a													
MI and dementia	1,916	259	180	212	332	411	585	465	1246	109	.	352	23	808
Substance abuse & dementia	n/a													
MI and substance abuse	n/a													
MI, SA, and dementia	n/a													

Demographic, Capacity, and Health Characteristics from Assessment and Claims Data

Table 2a: Nursing Home Residents	Number	Incontinent	Special Treatment	Rehab/ restorative Care	Rehab. Therapy	Unable to Understand	Not Understood
Total in Sub-Groups							
Nursing Home Residents (60+)	**17,668**	6875	9091	684	8323	766	1020
Study population residents	12,029	5878	6059	495	5159	734	954
All Residents w/ Diagnosed Mental Illness, Substance Abuse or Dementia	9,195	5164	4102	364	3236	705	897
All Residents with Mental Health Diagnosis (dx.)	4,773	2243	2455	192	2012	148	222
Indication of Mental Illness from other than diagnosis:							
Any Indication of Mental Illness	4,716	1979	2721	200	2488	199	244
Anti-depressant Medication	1,801	752	1011	74	964	50	72
Other Mental Health Related Medication	2,481	1018	1474	113	1331	133	149
Symptoms of Depression	379	185	205	12	169	16	21
Treatment for Mental Illness	55	24	31	1	24		2
Mutually Exclusive Diagnostic Groups (excluding MR):							
Dementia only	4,422	2921	1647	172	1224	557	675
MH condition only	2,857	973	1797	115	1583	16	41
Substance abuse only	n/a						
MI and dementia	1,916	1270	658	77	429	132	181
Substance abuse & dementia	n/a						
MI and substance abuse	n/a						
MI, SA, and dementia	n/a						

Demographic, Capacity, and Health Characteristics from Assessment and Claims Data

Table 2b: Residential Care Facility Residents	Number	% of Total Residents /Recipients	Age		Dependence in Daily Activities	
			Mean	Range	Mean	Range
Total in Sub-Groups						
Residential Care Rresidents (60+)	2,505	100.0%	81	60-105	0.5	0-5
Study population residents	1,914	76.4%	80	60-104	0.5	0-5
All Residents with Mental Health Diagnosis (dx.)	1,238	49.4%	78	60-102	0.5	0-5
Indication of Mental Illness from other than diagnosis:						
Any Indication of Mental Illness	387	15.4%	81	60-98	0.7	0-5
Anti-depressant Medication	55	2.2%	80	63-96	0.9	0-5
Other Mental Health Related Medication	99	4.0%	82	63-96	0.7	0-4
Symptoms of Depression	176	7.0%	83	61-98	0.7	0-5
Treatment for Mental Illness	57	2.3%	78	60-93	0.5	0-5
Mutually Exclusive Diagnostic Groups (excluding MR):						
Dementia only	652	26.0%	83	60-104	0.7	0-5
MH condition only	605	24.2%	77	60-102	0.4	0-5
Substance abuse only	25	1.0%	74	62-89	0.0	0-0
MI and dementia	312	12.5%	80	60-101	0.7	0-5
Substance abuse & dementia	19	0.8%	78	60-93	0.4	0-3
MI and substance abuse	25	1.0%	72	60-86	0.1	0-3
MI, SA, and dementia	20	0.8%	72	60-87	0.2	0-2

APPENDIX G

Demographic, Capacity, and Health Characteristics from Assessment and Claims Data

Table 2b: Residential Care Facility Residents	Number	Male	Married	Medicaid	MH history	No guardian	Short-term memory	Cognitive Skill			
								Independent	Moderately Independent	Moderately Impaired	Severely Impaired
Total in Sub-Groups											
Residential Care Rresidents (60+)	2,505	638	266	1,670	501	942		704	781	831	189
Study population residents	1,914	484	201	1,272	501	647		381	581	767	185
All Residents with Mental Health Diagnosis (dx.)	1,238	302	123	856	501	480		311	387	442	98
Indication of Mental Illness from other than diagnosis:											
Any Indication of Mental Illness	387	94	55	234	37	107	267	63	105	169	50
Anti-depressant Medication	55	16	10	30	5	15	36	12	12	22	9
Other Mental Health Related Medication	99	23	20	56	8	24	68	19	20	48	12
Symptoms of Depression	176	34	17	105	11	53	135	20	54	76	26
Treatment for Mental Illness	57	21	8	43	13	15	28	12	19	23	3
Mutually Exclusive Diagnostic Groups (excluding MR):											
Dementia only	652	153	93	372	39	123	583	47	142	359	104
MH condition only	605	136	46	460	294	309	192	224	219	142	20
Substance abuse only	25	18	2	19	5	17	8	12	6	7	.
MI and dementia	312	67	31	190	97	72	253	21	79	167	45
Substance abuse & dementia	19	12	4	12	3	6	16	4	.	12	3
MI and substance abuse	25	10	.	18	17	13	8	10	8	7	.
MI, SA, and dementia	20	7	2	12	13	6	14	.	8	11	1

Demographic, Capacity, and Health Characteristics from Assessment and Claims Data

Table 2b: Residential Care Facility Residents	Number	Cognitive Performance Score		Antipsychotic Meds		Antianxiety Meds		Antidepressant meds		Hypnotic Meds	
		Mean	Range	Mean	Range	Mean	Range	Mean	Range	Mean	Range
Total in Sub-Groups											
Residential Care Rresidents (60+)	2,505	1.9	0-6	1.4	0-7	1.0	0-7	2.2	0-7	0.3	0-7
Study population residents	1,914	2.2	0-6	1.8	0-7	1.1	0-7	2.5	0-7	0.3	0-7
All Residents with Mental Health Diagnosis (dx.)	1,238	2.0	0-6	2.4	0-7	1.5	0-7	3.3	0-7	0.4	0-7
Indication of Mental Illness from other than diagnosis:											
Any Indication of Mental Illness	387	2.5	0-6	1.4	0-7	1.0	0-7	1.6	0-7	0.2	0-7
Anti-depressant Medication	55	2.5	0-6	0.8	0-7	1.4	0-7	4.2	1-7	0.2	0-7
Other Mental Health Related Medication	99	2.5	0-5	2.1	0-7	1.7	0-7	0.0		0.3	0-7
Symptoms of Depression	176	2.7	0-6	0.9	0-7	0.7	0-7	1.7	0-7	0.2	0-7
Treatment for Mental Illness	57	2.0	0-5	2.1	0-7	0.6	0-7	1.4	0-7	0.1	0-7
Mutually Exclusive Diagnostic Groups (excluding MR):											
Dementia only	652	3.0	0-6	1.3	0-7	0.5	0-7	1.2	0-7	0.2	0-7
MH condition only	605	1.4	0-5	2.5	0-7	2.0	0-7	3.9	0-7	0.5	0-7
Substance abuse only	25	1.1	0-4	1.0	0-7	0.3	0-7	1.4	0-7	0.0	
MI and dementia	312	2.8	0-5	2.6	0-7	1.0	0-7	3.8	0-7	0.2	0-7
Substance abuse & dementia	19	2.8	0-5	0.5	0-7	1.1	0-7	0.0		0.0	
MI and substance abuse	25	1.3	0-4	3.5	0-7	2.1	0-7	3.7	0-7	1.2	0-7
MI, SA, and dementia	20	2.5	1-5	3.7	0-7	2.2	0-7	3.5	0-7	0.4	0-7

Demographic, Capacity, and Health
Characteristics from Assessment and Claims Data

Table 2b: Residential Care Facility Residents	Days of psych therapy		Delusions/ Hallucina-tions	Distress														
	Mean	Range		Negative Statements	Repetitive Questions	Repetitive Verablizat.	Self-deprecation	Unrealistic Fears	Recurrent Statements	Health Complaints	Anxious Complaints	Unpleasant Mood	Insomnia	Facial Expressions	Crying	Repetitive Movement	Withdrawal from Activ.	Reduced Social Interaction
Total in Sub-Groups																		
Residential Care Rresidents (60+)	0.0	0-7	378	225	391	140	465	112	207	105	355	491	270	259	609	272	388	327
Study population residents	0.0	0-7	535	204	363	132	420	103	191	95	303	441	241	231	527	233	370	287
All Residents with Mental Health Diagnosis (dx.)	0.1	0-7	267	145	217	99	282	79	152	79	233	324	157	187	385	162	251	209
Indication of Mental Illness from other than diagnosis:																		
Any Indication of Mental Illness	0.1	0-7	103	89	115	54	170	33	78	36	109	156	93	68	191	96	110	74
Anti-depressant Medication	0.0	0-1	14	9	14	10	19	2	9	4	8	12	9	13	25	9	17	12
Other Mental Health Related Medicatio	0.0	0-1	23	10	24	12	29	5	16	7	11	27	16	16	31	11	30	8
Symptoms of Depression	0.1	0-7	56	67	71	31	109	28	51	25	86	111	60	32	130	74	52	44
Treatment for Mental Illness	0.1	0-1	10	3	6	1	13	.	.	.	4	6	6	7	5	2	11	10
Mutually Exclusive Diagnostic Groups (excluding MR):																		
Dementia only	0.0	0-7	117	71	179	51	160	27	61	21	64	136	101	61	168	61	156	92
MH condition only	0.2	0-7	120	65	69	42	126	34	71	47	138	155	67	72	176	74	85	101
Substance abuse only	0.1	0-1	4	2	1	2	5	1	1	.	2	4	4	2	2	1	2	4
MI and dementia	0.1	0-7	72	44	83	28	64	31	45	16	57	91	39	49	113	58	78	59
Substance abuse & dementia	0.0		5	1	5	1	8	.	.	.	2	3	3	1	.	1	3	1
MI and substance abuse	0.3	0-7	4	2	.	.	6	2	2	.	3	2	2	3	9	.	5	5
MI, SA, and dementia	0.4	0-7	6	2	4	1	6	2	1	.	4	8	5	2	6	.	6	3

Demographic, Capacity, and Health Characteristics from Assessment and Claims Data

Table 2b: Residential Care Facility Residents	Behaviors					Medications				Psych. Therapy	Intervention Program
	Wandering	Physically Abusive	Verbally Abusive	Socially Inappropriate	Resists Care	Antipsychotic	Antianxiety	Anti-depressant	Hypnotic		
Total in Sub-Groups											
Residential Care Rresidents (60+)	173	56	203	152	322	526	379	843	120	81	530
Study population residents	172	54	189	144	298	522	345	729	94	81	518
All Residents with Mental Health Diagnosis (dx.)	93	32	131	98	189	443	306	630	77	81	408
Indication of Mental Illness from other than diagnosis:											
Any Indication of Mental Illness	63	25	66	58	84	83	70	107	17	12	103
Anti-depressant Medication	10	3	8	8	12	7	15	55	2	1	11
Other Mental Health Related Medication	20	6	14	14	16	35	33	.	7	2	24
Symptoms of Depression	30	12	38	28	47	23	17	41	7	4	39
Treatment for Mental Illness	3	4	6	8	9	18	5	11	1	5	29
Mutually Exclusive Diagnostic Groups (excluding MR):											
Dementia only	99	30	74	61	133	122	56	121	16	5	150
MH condition only	14	5	55	31	67	226	183	347	48	49	198
Substance abuse only	1	.	4	2	1	4	1	5	.	3	4
MI and dementia	38	11	30	27	58	117	51	177	12	17	111
Substance abuse & dementia	5	1	3	2	5	2	3	.	.	.	4
MI and substance abuse	1	1	3	1	5	13	8	14	4	2	11
MI, SA, and dementia	2	.	4	3	8	10	7	11	1	1	10

Demographic, Capacity, and Health Characteristics from Assessment and Claims Data

Table 2b: Residential Care Facility Residents	Incontinent	Special Treatment	Rehab/ restorative Care	Rehab. Therapy	Unable to Understand	Not Understood
Total in Sub-Groups						
Residential Care Rresidents (60+)	694	798	56	153	26	29
Study population residents	550	703	40	102	25	29
All Residents with Mental Health Diagnosis (dx.)	328	438	30	81	7	12
Indication of Mental Illness from other than diagnosis:						
Any Indication of Mental Illness	127	162	18	24	7	12
Anti-depressant Medication	12	31	3	3	1	2
Other Mental Health Related Medication	32	49	4	10	1	2
Symptoms of Depression	66	55	9	8	3	6
Treatment for Mental Illness	17	27	2	3	2	2
Mutually Exclusive Diagnostic Groups (excluding MR):						
Dementia only	231	298	12	19	20	22
MH condition only	139	173	8	43	1	3
Substance abuse only	1	7	1	4	.	.
MI and dementia	108	128	11	16	2	2
Substance abuse & dementia	3	6	.	1	1	.
MI and substance abuse	2	9	.	3	.	.
MI, SA, and dementia	5	5	1	.	.	.

Demographic, Capacity, and Health Characteristics from Assessment and Claims Data

Table 2b: Residential Care Facility Residents	Behaviors					Medications				Psych. Therapy	Intervention Program
	Wandering	Physically Abusive	Verbally Abusive	Socially Inappropriate	Resists Care	Antipsychotic	Antianxiety	Anti-depressant	Hypnotic		
Total in Sub-Groups											
Residential Care Rresidents (60+)	173	56	203	152	322	526	379	843	120	81	530
Study population residents	172	54	189	144	298	522	345	729	94	81	518
All Residents with Mental Health Diagnosis (dx.)	93	32	131	98	189	443	306	630	77	81	408
Indication of Mental Illness from other than diagnosis:											
Any Indication of Mental Illness	63	25	66	58	84	83	70	107	17	12	103
Anti-depressant Medication	10	3	8	8	12	7	15	55	2	1	11
Other Mental Health Related Medication	20	6	14	14	16	35	33	.	7	2	24
Symptoms of Depression	30	12	38	28	47	23	17	41	7	4	39
Treatment for Mental Illness	3	4	6	8	9	18	5	11	1	5	29
Mutually Exclusive Diagnostic Groups (excluding MR):											
Dementia only	99	30	74	61	133	122	56	121	16	5	150
MH condition only	14	5	55	31	67	226	183	347	48	49	198
Substance abuse only	1	.	4	2	1	4	1	5	.	3	4
MI and dementia	38	11	30	27	58	117	51	177	12	17	111
Substance abuse & dementia	5	1	3	2	5	2	3	.	.	.	4
MI and substance abuse	1	1	3	1	5	13	8	14	4	2	11
MI, SA, and dementia	2	.	4	3	8	10	7	11	1	1	10

Demographic, Capacity, and Health Characteristics from Assessment and Claims Data

Table 2b: Residential Care Facility Residents	Incontinent	Special Treatment	Rehab/ restorative Care	Rehab. Therapy	Unable to Understand	Not Understood
Total in Sub-Groups						
Residential Care Rresidents (60+)	694	798	56	153	26	29
Study population residents	550	703	40	102	25	29
All Residents with Mental Health Diagnosis (dx.)	328	438	30	81	7	12
Indication of Mental Illness from other than diagnosis:						
Any Indication of Mental Illness	127	162	18	24	7	12
Anti-depressant Medication	12	31	3	3	1	2
Other Mental Health Related Medication	32	49	4	10	1	2
Symptoms of Depression	66	55	9	8	3	6
Treatment for Mental Illness	17	27	2	3	2	2
Mutually Exclusive Diagnostic Groups (excluding MR):						
Dementia only	231	298	12	19	20	22
MH condition only	139	173	8	43	1	3
Substance abuse only	1	7	1	4	.	.
MI and dementia	108	128	11	16	2	2
Substance abuse & dementia	3	6	.	1	1	.
MI and substance abuse	2	9	.	3	.	.
MI, SA, and dementia	5	5	1	.	.	.

Demographic, Capacity, and Health Characteristics from Assessment and Claims Data

Table 2b: Residential Care Facility Residents	Diagnoses/Medical Conditions					
	Endocrine	Heart	Musulo-skeletal	Neuro-logical	Pulmonary	Cancer/ Renal
Total in Sub-Groups						
Residential Care Rresidents (60+)	720	1654	764	1335	494	237
Study population residents	543	1194	543	1197	366	163
All Residents with Mental Health Diagnosis (dx.)	379	768	375	627	263	110
Indication of Mental Illness from other than diagnosis:						
Any Indication of Mental Illness	92	249	127	248	66	38
Anti-depressant Medication	10	32	21	41	10	3
Other Mental Health Related Medication	28	68	31	57	18	10
Symptoms of Depression	35	119	62	120	29	19
Treatment for Mental Illness	19	30	13	30	9	6
Mutually Exclusive Diagnostic Groups (excluding MR):						
Dementia only	162	398	165	652	81	50
MH condition only	210	387	196	124	140	52
Substance abuse only	5	17	6	6	10	3
MI and dementia	84	184	94	312	52	32
Substance abuse & dementia	2	5	4	19	5	2
MI and substance abuse	4	15	3	4	13	1
MI, SA, and dementia	5	16	4	20	9	2

Demographic, Capacity, and Health Characteristics from Assessment and Claims Data

Table 2c: Home Care Recipients (Mecare)	Number	% of Total Residents /Recipients	Age		Dependence in Daily Activities	
			Mean	Range	Mean	Range
Total in Sub-Groups						
All Auth. Home Care Recipients (60+)	5,871	100.0%	79	60-106	1.7	0-5
Study population recipients	3,265	55.6%	78	60-102	1.8	0-5
Recipients with Mental Health Diagnosi	2,635	44.9%	77	60-101	1.8	0-5
Indication of Mental Illness from other than diagnosis:						
Any Indication of Mental Illness	1,442	24.6%	78	60-101	1.8	0-5
Anti-depressant Medication	436	7.4%	77	60-98	1.8	0-5
Other Mental Health Related Medication	626	10.7%	78	60-98	1.9	0-5
Symptoms of Depression	362	6.2%	79	60-101	1.8	0-5
Treatment for Mental Illness	18	0.3%	78	62-91	2.1	0-4
Mutually Exclusive Diagnostic Groups (excluding MR):						
Dementia only	793	13.5%	82	60-102	2.2	0-5
MH condition only	1,242	21.2%	76	60-101	1.6	0-5
Substance abuse only	37	0.6%	72	60-93	1.1	0-5
MI and dementia	268	4.6%	80	60-101	2.2	0-5
Substance abuse & dementia	9	0.2%	79	71-91	2.1	0-5
MI and substance abuse	31	0.5%	72	60-85	1.2	0-4
MI, SA, and dementia	5	0.1%	73	63-80	1.4	0-4

Demographic, Capacity, and Health Characteristics from Assessment and Claims Data

Table 2c: Home Care Recipients (Mecare)	Number	Cognitive Performance Score		Male	Married	Medicaid	MH history	No guardian
		Mean	Range					
Total in Sub-Groups								
All Auth. Home Care Recipients (60+)	5,871	1.7	0-6	1,636	1,658	3,320		5,689
Study population recipients	3,265	2.0	0-6	897	999	1,863		3,137
Recipients with Mental Health Diagnosis	2,635	1.7	0-6	703	804	1,548		2,552
Indication of Mental Illness from other than diagnosis:								
Any indication of Mental Illness	1,442	1.8	0-6	402	418	823		1,396
Anti-depressant Medication	436	1.5	0-6	113	126	258		428
Other Mental Health Related Medication	626	1.8	0-6	169	182	369		606
Symptoms of Depression	362	2.1	0-6	112	105	185		345
Treatment for Mental Illness	18	1.9	0-3	8	5	11		17
Mutually Exclusive Diagnostic Groups (excluding MR):								
Dementia only	793	3.4	0-6	218	272	386		735
MH condition only	1,242	1.4	0-5	314	378	757		1,209
Substance abuse only	37	1.7	0-5	26	5	24		36
MI and dementia	268	3.1	0-6	80	106	126		249
Substance abuse & dementia	9	3.3	2-5	6	3	2		7
MI and substance abuse	31	1.4	0-3	13	3	20		29
MI, SA, and dementia	5	3.2	3-4	2	2	2		-

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Demographic, Capacity, and Health Characteristics from Assessment and Claims Data

Table 2c: Home Care Recipients (Mecare)	Number	Short-term memory	Cognitive Skill			
			Independent	Moderately Independent	Moderately Impaired	Severely Impaired
Total in Sub-Groups						
All Auth. Home Care Recipients (60+)	5,871	3102	1729	2530	1330	282
Study population recipients	3,265	2052	729	1272	1012	252
Recipients with Mental Health Diagnosis	2,635	1455	713	1167	639	116
Indication of Mental Illness from other than diagnosis:						
Any Indication of Mental Illness	1,442	809	423	525	407	87
Anti-depressant Medication	436	209	154	177	90	15
Other Mental Health Related Medication	626	343	188	223	163	52
Symptoms of Depression	362	246	78	118	146	20
Treatment for Mental Illness	18	11	3	7	8	0
Mutually Exclusive Diagnostic Groups (excluding MR):						
Dementia only	793	781	10	111	487	185
MH condition only	1,242	606	355	685	190	12
Substance abuse only	37	21	10	17	9	1
MI and dementia	268	261	7	55	169	37
Substance abuse & dementia	9	0	0	1	7	1
MI and substance abuse	31	12	6	18	7	0
MI, SA, and dementia	5	0	0	0	0	0

Demographic, Capacity, and Health Characteristics from Assessment and Claims Data

Table 2c: Home Care Recipients (Resave)	Number	Distress														
		Negative Statements	Repetitive Questions	Repetitive Verbalizat.	Self-deprecation	Unrealistic Fears	Recurrent Statements	Health Complaints	Anxious Complaints	Unpleasant Mood	Insomnia	Facial Expressions	Crying	Repetitive Movement	Withdrawal from Activ.	Reduced Social Interaction
Total in Sub-Groups																
All Auth. Home Care Recipients (65+)	5,971	783	508	461	560	414	224	148	512	883	260	1684	1816	796	350	1293
Study population recipients	3,295	580	429	380	478	313	188	133	385	602	214	770	1139	563	220	933
Recipients with Mental Health Diagnosis	2,835	500	280	251	358	268	135	113	354	603	189	652	974	508	157	747
Indication of Mental Illness from other than diagnosis:																
Any Indication of Mental Illness	1,442	308	190	169	264	146	87	52	200	338	101	346	540	291	98	368
Anti-depressant Medication	436	38	27	18	27	18	8	4	25	43	18	60	97	47	15	83
Other Mental Health Related Medication	626	84	53	48	73	33	20	15	45	84	27	111	138	71	34	113
Symptoms of Depression	982	291	190	165	184	91	58	33	130	212	56	174	300	162	48	215
Treatment for Mental Illness	10	4	0	0	0	2	0	0	0	0	0	1	4	1	0	5
Mutually Exclusive Diagnostic Groups (excluding MR):																
Dementia only	783	104	192	151	159	57	56	28	53	125	57	174	197	107	62	229
MH condition only	1,242	285	84	82	164	156	75	59	226	347	77	348	553	296	82	415
Substance abuse only	37	3	2	3	4	1	0	0	3	8	3	14	11	4	3	11
MI and dementia	288	75	110	84	78	48	48	28	50	108	36	91	152	73	37	119
Substance abuse & dementia	9	4	6	4	3	3	2	1	3	4	2	5	6	2	2	7
MI and substance abuse	31	13	5	6	9	6	2	2	10	15	6	17	20	10	0	21
MI, SA, and dementia	5	1	1	1	2	0	2	1	1	2	1	1	1	1	2	3

Demographic, Capacity, and Health Characteristics from Assessment and Claims Data

Table 2c: Home Care Recipients (Mecare)	Number	Behaviors				
		Wandering	Physically Abusive	Verbally Abusive	Socially Inappropriate	Resists Care
Total In Sub-Groups						
All Auth. Home Care Recipients (60+)	5,871	221	59	210	163	288
Study population recipients	3,265	204	51	179	151	251
Recipients with Mental Health Diagnosis	2,635	113	31	121	84	152
Indication of Mental Illness from other than diagnosis:						
Any Indication of Mental Illness	1,442	87	24	93	68	119
Anti-depressant Medication	436	10	2	11	6	12
Other Mental Health Related Medication	626	38	9	33	23	45
Symptoms of Depression	362	38	13	149	39	61
Treatment for Mental Illness	18	1	0	0	0	1
Mutually Exclusive Diagnostic Groups (excluding MR):						
Dementia only	793	133	29	84	84	136
MH condition only	1,242	10	4	38	15	38
Substance abuse only	37	1	0	2	4	3
MI and dementia	268	50	13	34	38	52
Substance abuse & dementia	9	3	1	1	0	3
MI and substance abuse	31	0	1	2	0	2
MI, SA, and dementia	5	2	0	1	1	1

Demographic, Capacity, and Health Characteristics from Assessment and Claims Data

Table 2c: Home Care Recipients (Mecare)	Number	Incontinent	Special Treatment	Rehab. Therapy	Unable to Understand	Not Understood
Total in Sub-Groups						
All Auth. Home Care Recipients (60+)	5,871	1502	94	754	60	102
Study population recipients	3,265	944	59	420	52	83
Recipients with Mental Health Diagnosis	2,635	691	57	374	22	39
Indication of Mental Illness from other than diagnosis:						
Any Indication of Mental Illness	1,442	373	25	170	22	33
Anti-depressant Medication	436	103	4	48	5	9
Other Mental Health Related Medication	626	169	16	73	11	18
Symptoms of Depression	362	99	5	45	6	6
Treatment for Mental Illness	18	2	0	4	0	0
Mutually Exclusive Diagnostic Groups (excluding MR):						
Dementia only	793	345	1	49	42	64
MH condition only	1,242	311	31	220	1	6
Substance abuse only	37	3	1	5	0	0
MI and dementia	268	99	4	22	5	6
Substance abuse & dementia	9	2	0	2	0	0
MI and substance abuse	31	4	2	5	0	0
MI, SA, and dementia	5	2	0	2	0	3

Demographic, Capacity, and Health Characteristics from Assessment and Claims Data

Table 2c: Home Care Recipients (Ilecare)	Number	Diagnoses/Medical Conditions					
		Endocrine	Heart	Musculo-skeletal	Neuro-logical	Pulmonary	Cancer/ Renal
Total in Sub-Groups							
All Auth. Home Care Recipients (60+)	5,871	1983	4424	3224	2554	1314	837
Study population recipients	3,265	1114	2419	1721	1783	789	496
Recipients with Mental Health Diagnosis	2,635	960	2030	1481	1196	702	440
Indication of Mental Illness from other than diagnosis:							
Any Indication of Mental Illness	1,442	468	1075	734	696	354	232
Anti-depressant Medication	436	183	322	217	203	102	66
Other Mental Health Related Medication	626	172	466	309	294	166	102
Symptoms of Depression	362	108	272	200	190	80	59
Treatment for Mental Illness	18	5	15	8	9	6	5
Mutually Exclusive Diagnostic Groups (excluding MR):							
Dementia only	793	197	500	318	793	99	62
MH condition only	1,242	497	1000	781	401	362	222
Substance abuse only	37	4	21	19	9	17	6
MI and dementia	268	86	196	147	0	47	34
Substance abuse & dementia	9	2	8	5	0	1	2
MI and substance abuse	31	13	21	15	11	16	8
MI, SA, and dementia	5	1	2	1	0	2	1

Table 4: Behavioral Health Service Users and Average Claims per Beneficiary Receiving Services
Among Older Medicaid Beneficiaries with a Diagnosed Mental Illness or Pharmacy Claim for Psychoactive Drugs

Service	*N*	*Average/ Person*	*Minimum*	*Maximum*	*Total Expenditures*
Community/Targeted Case Manage.	1,152	$2,972	$15	$102,682	$3,424,262
Outpatient (Cloz., MH Ctr., Outpt., Psychol.)	1,026	$601	$1	$10,519	$616,118
Inpatient	17	$22,164	$22	$67,240	$376,794
PNMI	68	$37,081	$28	$83,217	$2,521,503
Psychiatrist	640	$177	$6	$2,174	$113,141
Substance Abuse Services	42	$574	$23	$3,240	$24,107
Services to MR	258	$43,227	$8	$150,803	$11,152,544

Executive Summary

Mental Health Status of Older Adults in Maine: A profile of long term care consumers' and older Medicaid beneficiaries' needs and service use.

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Submitted: December 10, 1999

Profile of Long Term Care Consumers' Mental Health Status

This section uses assessment data for residents of nursing facilities and residential care facilities, and consumers of home-based long term care services, to profile the mental health needs of high-risk adults age 60 and older.

1. Diagnosed mental illness was more common among older adults in residential care facilities (38%) than among long term care consumers served in nursing facilities or in their own homes (27% and 26% respectively).

2. Among LTC consumers with a diagnosed mental illness (excludes dementia), the most frequent diagnosis was depression. Between 20% and 22% of consumers of LTC in all three settings had a diagnosis of depression. Twenty-two percent of all nursing facility and residential care facility residents had a diagnosis of depression; among home care consumers 20% had a diagnosis of depression.

3. The second most frequent mental health diagnosis among LTC consumers was anxiety disorder. Among nursing facility residents 7% were diagnosed with an anxiety problem, while 9% of residential care consumers and 10% of home care consumers had diagnosed anxiety disorders.

4. Among consumers in residential care facilities, diagnoses of schizophrenia were nearly as prevalent as diagnosed anxiety disorders, with 8% and 9% diagnosed with schizophrenia and anxiety disorders, respectively.

5. Use of medications (anti-depressants, anti-anxiety, anti-psychotics, or hypnotics) to treat LTC consumers with mental health problems ranged from 18% of consumers receiving home care, to 20% and 24% of residential care and nursing facility residents, respectively.

6. In contrast to the relatively high proportion of LTC consumers receiving medications, fewer than 4% of these consumers received other treatment such as counseling or related services. Those in residential care facilities were most likely to receive treatment other than medications (3%), followed by nursing facility residents and home care consumers (1% of consumers in each setting).

7. Mental health related problems can be defined more broadly by including undiagnosed mental illness. Undiagnosed mental illness may be represented by other indicators such as symptoms of depression, use of psychotropic medications or treatment for mental illness. A broader definition can also include persons with diagnosed dementias, substance abuse or mental retardation. Using this broader definition (including undiagnosed and other diagnosed mental health related problems), the percentage of long term care consumers with problems increases significantly. Using this broader classification over three-quarters of all residential care consumers (76%), nearly seventy percent of nursing facility residents (68%), and more than one-half of long term care consumers served at home (56%) have mental health related problems.

8. Among those included in the more broadly defined group, 24% to 27% of long term care consumers had an indication of mental illness but no diagnosis of mental illness.

9. Much the increase in the proportion of LTC consumers with a mental health related problems can be attributed to the inclusion of diagnosed dementias. Among nursing facility consumers, adding dementia includes an additional 24% of residents in the group defined as having a mental health problem. Among residential care consumers, an additional 26% of residents are included, while an additional 21% of home care consumers are encompassed by the broader definition including dementia.

10. Many older adults receiving long term care services have co-occurring mental health related problems. For example, among nursing facility residents 10%

have both a diagnosed mental illness and diagnosed dementia, and the proportion of residents with these co-occurring problems rises to 12% among residential care facility consumers. Interestingly, diagnosed mental illness and dementia are least frequent among LTC consumers receiving services at home (5%).

11. In contrast to those with co-occurring diagnoses of mental illness and dementia, it is interesting to compare the proportion of LTC consumers in each setting who have only diagnosed mental illness versus only diagnosed dementia. Among nursing facility and residential care facility residents, a sole diagnosis of dementia is more common than a sole diagnosis of mental illness (NF mental illness = 15%: dementia = 24%; residential care mental illness = 22%: dementia = 26%). This pattern, however, is reversed for home care consumers, where 21% have a sole diagnosis of mental illness and 14% have a sole diagnosis of dementia. This pattern is also reflected in the average scores on the Cognitive Performance Scale for consumers in each setting. This scale measures cognitive status, with possible scores from 0 (intact) to 6 (severely cognitively impaired). The average score among home care consumers was 1.7 points, compared with average scores of 2.3 points for nursing home residents and 1.9 points for residential care consumers.

12. Difficult behaviors displayed by LTC consumers in each setting also provide insight into the challenges of providing adequate assistance to older adults with mental health and related problems. In general, a greater percentage of LTC consumers in residential care and nursing facilities had "problem" behaviors.

- Nearly 7% of residential care and 6% of nursing facility residents wandered, compared with 4% of those served at home.

- Verbally abusive behaviors (8%) and resisting care (13%) were most frequently a problem for residential care consumers. Among nursing facility residents, 5% were verbally abusive and 11% resisted care, compared with 4% of home care consumers who were verbally abusive and 5% who resisted care.

- Nursing home residents were most likely to be physically abusive (4%), fewer residential care consumers (2%) and home care consumers (1%) were physically abusive.

- Socially inappropriate behaviors were more prevalent among nursing facility and residential care facility residents (7% and 6% residents, respectively), than among home care consumers (3%).

13. Some of these differences in the prevalence of behavior problems can be attributed to differences across settings in the proportion of residents who have limitations in physical function, since persons with greater physical limitations are less able to move about independently. On a scale of physical function dependence with a range of 0-5 (where "0" represents no limitation and "5" represents total dependence), nursing facility residents were substantially more impaired (average score 3.3 points) than home care (average score 1.7 points) and residential care consumers (average score 0.5 points).

Summary of Mental Health Concerns: Long Term Care Consumers

Mental health related problems are relatively common among long term care consumers assessed and receiving services in all settings. Differences in the diagnosed prevalence of mental illness may be explained, at least in part, by the different frequency which consumers in each setting are seen by their physician, and/or others trained in the symptoms and detection of mental health problems. The higher proportion of consumers in residential care facilities who have diagnosed mental illness and/or behavior problems likely is attributable, to some extent, to the history of deinstitutionalization of persons with chronic mental illness from state operated facilities to residential care facilities. While the majority of such moves occurred several years ago, many of these consumers are now reaching age 60 and older.

One apparent consideration is the relatively high prevalence of diagnosed mental illness, and the large number of consumers with potential mental illness who have symptoms or are receiving medications with out benefit of diagnosis. This group, combined with information on the proportion of consumers with mental health problems for whom medications are the sole source of treatment (and previous findings from other research--Maine Rural Health Research Center 1998), suggest that long term care consumers in all settings do not have adequate access to mental health professionals. For these consumers, an important source of care is primary care providers who may or may not have training in mental health care.

Mental Health Status & Service Use by Medicaid Beneficiaries Age 60 +

This section provides highlights from the analysis of Medicaid Claims data for beneficiaries age 60 and older residing in all settings. These data focus on beneficiaries with a diagnosed mental illness or pharmacy claim for mental health related medications and who had claims for services submitted to Medicaid in 1998, unless otherwise specified.

1. Approximately 23% of the 34,140 Medicaid beneficiaries age 60 and older had a diagnosed mental illness (7,892) in 1998. Of those with such diagnoses 5,999 or 18% had a diagnosis of mental illness with no co-occurring diagnosed dementia or mental retardation. An additional 1,434 or 4% of older beneficiaries had diagnosed mental illness *and* diagnosed dementia, while 228 older beneficiaries (under 1%) had a diagnosed mental illness and diagnosed mental retardation.

2. When other indicators of mental health problems, including use of psychotropic medications and/or behavioral health services are considered, and diagnoses of dementia and substance abuse (excluding abuse of tobacco) are included, an additional 9,632 older beneficiaries (28%) are defined as having a mental health related problem.

3. Among the more broadly defined group of older adults with mental health related problems (a total 17,524[1] beneficiaries), 1,107 or 11% had a diagnosis of dementia with no diagnosed mental illness, and 8,483 or 88% were receiving psychoactive medications and had no diagnosed mental illness on claims submitted during the study year.

[1] 17524 = 7,892 diagnosed with mental illness
+ 9,632 with other indicators of mental health related problems

4. Of the 17,524 older Medicaid beneficiaries identified using the broader definition of mental health related problems (excluding those with mental retardation who have no indication of mental illness):

- 6,954 (40%) received nursing facility services under Medicaid ,
- 1,207 (7%) received home health services funded by Medicaid (excluding those with any nursing facility stay), and
- 2,284 (13%) received Medicaid assistance in paying for residential care facility services (excluding ICF/MR board and care).

5. It is important to note that Medicaid claims for mental health related services to older adults in the categories of services discussed below (and identified as being within the "behavioral health universe") include claims for services submitted by a *variety of providers.* Average annual claims per service recipient and total claims by category of service are included on Table A. The data in this table, described below, include only older adults with a diagnosed mental illness or pharmacy claim for mental health related medications.

6. Claims for behavioral health services to older adults in 1998 totaled approximately $18.228 million. Excluding claims for services to meet the special needs of older adults with mental illness and mental retardation[2], 1998 Medicaid claims for mental health related services to older adults totaled approximately $7 million.

7. The greatest share of claims among the behavioral health services described in Table A, (excluding those for persons with co-occurring mental retardation) were for community support services, at an annual total of $2.547 million for services

[2] Services excluded are: specialized residential care, day habilitation services and transportation to day habilitation, and claims for care provided under the home and community-based waiver for beneficiaries at greatest risk

to 839 individuals. This represents annual average claims per person served of $3,036. [3]

8. The category of services with the highest average annual claims per older person served (excluding mental retardation services) was private non-medical institutions (PNMI or residential care facility services). PNMI services "cost" $37,081 per person for the 68 beneficiaries in PNMI with diagnosed mental illness. Relative to total annual claims, this was the second most expensive category of service ($2.521 million) for the older beneficiary population described here.

9. On a per person served basis, the behavioral health service with the second highest average annual claims total per person served was inpatient mental hospital services at $22,164 per person served, with 17 older beneficiaries receiving this service.

10. Targeted case management at $2,507 per person served, and serving 350 individuals, was the remaining service with average annual per recipient claims in excess of $1,000. Targeted case management includes intake/assessment, plan of care development, coordination/advocacy, monitoring, and evaluation of services for persons in defined target populations[4] (Maine Medical Assistance Manual Chapter II, Section 13.01).

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[3] According the Maine Medical Assistance Manual, Chapter II, Section 17.01-1 "Community support services are rehabilitative services, treatment services and living skills services provide pursuant to an individualized rehabilitation/service plan for a person with severe and disabling mental illness or class member.... Community support services include: case management, individualized rehabilitation/service planning, participation in discharge planning while a persons is in a state psychiatric hospital, medication education and arranging for medication monitoring, participation in assuring the delivery of crisis intervention ad follow-up services, assisting in the exploration of lesser restrictive alternatives to hospitalization, identification and documentation of unmet needs, outreach services, follow along services, contacts with the person's guardian, family, significant other and provider of services or supports, family education and consultation, day treatment, and any other supportive counseling or problem solving activities...to develop and maintain the person's growth and supports necessary to manage his or her illness.

[4] Target populations include persons with mental retardation, HIV or AIDS, adults in need of protective services, adults meeting defined criteria with long term care needs, individuals in substandard housing or who are homeless, individuals diagnosed as having psychoactive substance dependence or receiving treatment or follow-up/aftercare by a Department of Mental Health, Mental Retardation and Substance Abuse Services provider.

11. Mental health clinic services totaling $0.5M served 885 individuals. This was the category of service serving the largest number of older beneficiaries in the group studied.

12. Only 54 older adults received outpatient mental health services[5] billed to Medicaid (at an average annual total of $421 per older person served) and no older adults received home based mental health services[6].

13. Traditional behavioral health services billed to Medicaid for older adults are provided relatively infrequently. For example services provided by psychiatrists (such as counseling and evaluation) were provided to only 8% of older adults beneficiaries who had a diagnosed mental illness. Psychiatrist and psychologist services were received by 640 and 97 older adult beneficiaries, respectively. The average annual total submitted for payment by Medicaid for these services was $177. for psychiatrists and $314. for psychologists.

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[5] Outpatient mental health services are defined in the Medical Assistance Manual as "a planned combination of diagnostic, treatment and rehabilitative services provided to mentally or emotionally disturbed persons who need similar or more active or inclusive treatment than is available through a weekly visit to a mental health center, psychologist pr psychiatrist but who do not need partial hospitalization or full-time hospitalization or institutionalization." (Chapter II, Section 46.01-5).

[6] "Home-based Mental health Services are short-term, crisis-oriented, counseling services provided in the recipient's home or other appropriate setting....Home-Based Mental Health is NOT intended to provide emergency services." Maine Medical Assistance Manual, Chapter II, Section 37.01-1.

Summary Mental Health of Medicaid Beneficiaries Age 60+

Although infrequent use of mental health services paid for by Medicaid may simply reflect providers billing Medicare for these services, reports from providers (see survey findings section) suggest it is more likely that mental health providers simply are not serving older adults with mental health services needs in the same manner they serve younger adults . For example, only about 3% of those receiving outpatient mental health services are age 60 or older. Whether this reflects the lack of expertise in serving older adults with mental illness, deficient supply of mental health professionals, or ageism cannot be ascertained from these data. That service access is limited appears nearly certain given the numbers of older adults with diagnosed mental illness and the absence of claims for services to these individuals.

THE MAINE ELDERLY MENTAL HEALTH NEEDS SURVEY RESULTS

A questionnaire was sent to all 90 DMHMRSAS-contracted Mental Health providers in the state. Forty-five responses were received. Following is the information provided by those 45 respondents. **Note:** this questionnaire was sent out to the Mental Health Providers in August and completed questionnaires were received in DMHMRSAS during the months of September and October 1999.

1. What best describes your type of organization?

   a. 13 Mental Health Center
   b. 26 Mental Health Provider
   c. 6 Other Related Services Provider (please describe)

   Included in Other descriptions are:

   Home Health Agency,
   Skilled Nursing Facility/Geriatric Unit,
   Service Provider for Adults/Children with Mental Retardation/Autism,
   Mental Health Services Group Home,
   Residential Assisted living Group Home,
   Homeless Shelter.

2. Please indicate:
   The services provided by your organization.
   The number of individuals age 60 and over who are currently receiving each service.
   Which services have waiting lists.
   The number of individuals who are on each list.
   (Note: best estimates for numbers of individuals on waiting lists is acceptable.)

(The following list of services is the complete list of mental health services licensed by DMHMRSAS.)

Number of Agencies Providing Services	Numbers of Individuals 60 and Over Receiving Each Service	Numbers of Individuals 60 and Over on Waiting Lists
5 Transportation	**46**	--
24 Individual Therapy	**749**	**56**
12 Group Therapy	**87**	--
0 Sex Offender Treatment	--	--
1 Trauma Recovery Services	**10**	--

No. of Agencies Providing Services	Numbers of Individuals 60 and Over Receiving Each Service	Numbers of Individuals 60 and Over on Waiting Lists
7 Day Treatment Services/ Partial Hospitalization	45	--
3 Family Support Services	25	--
5 Psychiatric Nursing Services	103	--
5 In-Home Supports	88	1
11 Supportive Counseling	209	3
9 Crisis Program	--	--
4 Social Club	56	--
2 Residential-Alcohol & Drug	104	--
1 Residential-Secure Care	16	--
3 Residential-Transitional Mental Health	3	--
0 Residential Trauma	--	--
2 Peer Support	11	3
1 Dual Diagnosis – Non-Residential	25	9
8 Psychological Assessment Services	107	--
18 Case Management/ CSW/ ICM	938	43
5 Employment/ Vocational Services	18	1
6 Independent Living Skills Training	26	3
14 Medication Management Services	1647	43
5 ACT/ Access Team	13	--
2 Outreach Services	38	7
7 Residential Crisis Programs	16	--
2 Telephone Support Services	15	--
14 Residential – Mental Health	77	6
0 Residential Sex Offender Programs	--	--
Mobile Geriatric Mental Health Services	SEE SPECIFIC SECTION	

3. What training has your staff participated in during the past year? Please describe.

Of the 45 agencies that responded 8 agencies listed trainings specific to aging or mental health and aging.

Other trainings listed by both the 8 agencies referred to above and the remaining agencies included, in part: case management, Mandt, CPR, first aid, suicide assessment, court reporting, guardianship, PTSD, ethics, diversity, sexual harassment, sensory integration, consent decree, beyond Prozac, and DBT, with many others.

4. What training is needed by your staff? Please describe.

To this question 15 agencies listed training topics related to various aspects of the aging process. Topics included: death and dying issues, dementia, caring for aging people with mental illness, interface between medical conditions and psychiatric issues, resources available for families re: dementia, medication and elderly, and crisis intervention to/with older persons, among others. The remaining agencies that indicated training needs listed a wide variety of trainings related to mental health issues but non-age specific.

5. Please indicate, by percentage, those individuals 60 and older currently receiving services through your agency

   Who have developed Mental Health concerns later in life (after the age of 45). Versus those individuals who have aged with a mental illness.

This appeared to be a poorly asked question. Most respondents either did not complete this section or their response indicated that they did not understand this question. Therefore, we are not reporting these responses.

6. What gaps do you consider to exist in our mental health and substance abuse service delivery system for this group of people, both in the areas of service and geographic locations?

The following table lists the 10 most identified service gap areas by numbers of agencies indicating the gap in services.

Service Identified as Needed	Number of Agencies Indicating the Need
Mobile Geriatric	**15**
In-Home Support	**12**
Residential-Mental Health	**11**
Residential –Secure	**10**
Residential –Transitional	**10**
Independent Living Skills	**10**

Partial Hospitalization/Day Treatment	**10**
Transportation	**9**
CM/CSW/ICM	**9**
Psychological. Assessment/ Medication Management/ Trauma Services	**8**

7. Comments

Our agency currently provides in-home community support services for people with mental health issues. At this time our clients that we serve are in their fifties.

I think that we are just seeing the tip of the iceberg as the institutionalized mental health clients of the 50-70's age out, and their caretakers pass away we will have substantially more need for specialized services & skilled workers.

Although Franklin County has high suicide rates & many long term facilities there are no crisis stabilization beds within an hour and no access to mobile geriatric services. Older pop. in rural areas are more needful for having services avail in their own communities

Would like to see more support workers available for 1:1 with these clients. We have several residents who would benefit from this, yet due to funding and long waiting lists, they have been unable to access this service.

Due to vast differences in medical/psychosocial needs of consumers over 60 and those 20-60 attempting to coexist on same unit. Since adopting a psychosocial approach to delivering care staff noticed improved resident satisfaction and less aggressive behavior.

# of 60+ in need of services is significantly higher than those currently being served. perhaps by 10 times. Education needed to help individuals/families/gatekeepers to identify Mental Health issues for people.
Make relevant people aware of services available especially primary.

As our identified clients are minors (or youth), it is difficult to assess this need via our services. At LSN meetings it has been stated that this is a great unmet need in the mid-coast area.

In Bath-Brunswick area, mobile geriatric team has significantly increased services to elderly. We have only tapped the # of people who need service. Part time nature of team especially having only 8 hrs psychiatric time has limited number of patients we can serve.

Only one of our residents is over 60 and has an active SA problem. This person participates in SA treatment minimally... The resident is doing what he can. Has not been a problem in providing services

The issues are with skill of service providers & general lack of good fundamental assessment of the individual, their involvement and needed accommodations. After individuals are asked to fit into programs or facilities rather than programs or facilities adjusting themselves to fit the individuals.

Wow! Didn't realize our client population is all younger than I am!

We needed more time to complete this! I apologize for its brief but cannot easily obtain all specific information requested! Call if you need clarification.

When looking at resources, look beyond what is currently provided by public sector to what is in the private sector.

Agency has 5 residential programs: 1 Mental Health program has adequate Mental Health services, 1 Mental Retardation program has adequate Mental Health services, 1 Mental Retardation program does NOT have the necessary Mental Health services, 2 Cross Disability programs do NOT have necessary Mental Health services. More Mental Health services are required for residential programs.

Outreach and making seniors aware of mental health issues & treatment potentials is very much needed. [However, this] would bring out many times [the number of] needs as are seen today with no marketing. Public education available to this population would create a vastly greater demand for services which will be a great burden to our existing services.

Often times even when services exist, it is difficult for many elderly clients to accept services. If there was an individual who could spend an unlimited amount of time at the referring agencies to develop trust perhaps services would be utilized.

APPENDIX L

Substance Abuse Elderly Services Survey.

This survey is part of a study requested of DMHMRSAS and DHS by the Legislature to assess the substance abuse/mental health needs of the elderly. For the purpose of this survey elderly is defined as those persons who are 60 years of age and older. Please take a few moments and complete and return this survey to us to assist in fulfilling the Legislative request.

Name of Individual completing the survey:_____ Tel =_____

Organization Name and Address:_____

1. Which of the following services do you provide to elderly clients?
   a. ( ) Detoxification b. ( ) Inpatient c. ( ) Intensive Outpatient
   d. ( ) Non-intensive outpatient e. ( ) Shelter f. ( ) Other_____

2. Which towns/counties do you serve?_____
   _____

3. What percentage of your current caseload are elderly?
   ( ) 1-10%; ( ) 11-20%; ( ) 21-50%; ( ) 51-75% ( ) 76-100%

4. Do you feel your program is effective in serving the elderly client population?
   Not Very; Somewhat; Moderately; Very; Completely.

5. Do your staff receive/participate in training related to serving the elderly? Yes No
   If yes, describe:_____

6. How familiar are you with programs/counselors who specialize in services for the elderly?
   Not at all; Somewhat; Moderately; Very; Completely;

7. Which of the following best describes the kind of services you provide to the elderly?
   a. Alcohol abuse; b. Alcohol addiction; c. Prescription Drug abuse;
   d. Prescription Drug Addiction; d. Dual diagnosis; e. Other_____

8. Please circle the most prevalent mental health/health problems that require referral to Mental Health and/or Medical services.
   a. Depression; b. Anxiety or severe nervousness; c. Alcohol/Drug abuse;
   d. Types of dementia; e. Unreal fears/beliefs; f. Other_____

9. Are these services available in your community? Yes No

10. Please indicate the three most serious problems, in numeric order of seriousness, from the list below which you see as barriers preventing the elderly from receiving needed substance abuse services.

___ a. Lack of separate, specialized substance abuse services for the elderly.
___ b. Inconvenient locations for services.
___ c. Cost of obtaining services.
___ d. Negative attitudes or reluctance of providers to provide services to the elderly.
___ e. Lack of home-based outreach services.
___ f. Lack of transportation.
___ g. No one to assist the elderly in accessing services.
___ h. Limited insurance coverage for these services.
___ I. Limited Medicaid or Medicare reimbursement to providers.
___ j. Lack of community substance abuse providers who are trained in elderly services.
___ k. Other_____

11. Please indicate the three most serious problems in numeric order from the list below that might prevent the elderly from seeking needed substance abuse services.

___ a. Difficulty getting services due to limited transportation.
___ b. Denial or lack of awareness of having a substance abuse problem.
___ c. Negative attitudes of the elderly toward substance abuse counselors.
___ d. Negative attitudes of family members toward substance abuse services.
___ e. Stigma or fear of being labeled associated with receiving substance abuse services.
___ f. The elderly's lack of awareness of the availability of substance abuse services.
___ g. Unwillingness of the elderly to admit the need for services, or to ask for help.
___ h. Little confidence among elderly that substance abuse services will help them.
___ I. Difficulty getting to services because of limited physical mobility, poor health.
___ j. Other_____

12. Did you feel you had enough knowledge to comfortably answer the above questions?
Not at all; Not very much; Somewhat; Very much; Extremely comfortable.

Thank you for your time and patience in completing and returning this survey form.

Please return survey to: Cherry K. Denno
DMHMRSAS - OSA
State House Station 159
Marquardt Bldg.., AMHI complex
Augusta, ME 04333

SUBSTANCE ABUSE STUDY

How study was conducted

98 questionnaires were sent to licensed substance abuse treatment agencies across the state of Maine. 49 agencies responded providing the following information.

Results of Survey

- 79% of responding agencies indicate the percentage of elderly served by their current caseload is between 1 and 10%. No agency indicate the percentage of elderly served by their caseload is over 20%

- Not one agency reports they consider their services are completely effective for the elderly.
  Of the responding agencies:

55%	**not very or somewhat effective**
35%	**moderately effective**
10%	**very effective**

- 59% of the responding agencies indicate that their staff receive in trainings related to serving the elderly, consisting of seminars, trainings, annual training by geriatric psychiatrist. However, **a need more for trainings** is also indicated by agencies.

- Services offered older persons by the agencies are:

Alcohol Abuse	offered by	**40**	agencies
Alcohol Addiction	offered by	**41**	agencies
Prescription Drug Abuse	offered by	**33**	agencies
Prescription Drug Addiction	offered by	**33**	agencies
Dual Diagnosis	offered by	**4**	agencies

  Other identified
  Case Management & Codependency

- Most prevalent mental health or medical problems that require referral as ranked by agencies:

Depression	36
Alcohol/Drug Abuse	22
Anxiety or severe nervousness	20
Types of dementia	14
Unreal Fears/Beliefs	8

  Others reported
  Medication Detox/Schizophrenia

- 65% of responding agencies indicate they are not familiar or only somewhat familiar with programs/counselors who specialize in providing services for the older person.

- In response to the question "Are these services available in your community?"
  40 agencies said YES **7** said NO
  Comments:
  Not enough, Resources are limited, Long waiting lists, Difficult to find/access

- Listed below are barriers preventing the elderly from receiving needed substance abuse services, in order of seriousness (most serious barriers first):

  1. **No one to assist the elderly in accessing services**
  2. **Limited insurance coverage for these services**
  3. **Lack of home-based outreach services**
     Lack of transportation
  4. Limited Medicaid or Medicare reimbursement to providers
  5. Cost of obtaining services
  6. Lack of community substance abuse providers who are trained in elderly services.
  7. Lack of separate, specialized substance abuse services for the elderly.
  8. Inconvenient locations for services.
  9. Other:
     Stigma, Fear, Denial, Depression,
     Medical community and society's denial of problem,
     Reluctance to call providers,
     Lack of education about substance abuse/addiction in the elderly population
     Lack of acknowledgement of substance abuse in elderly among the providers who have frequent contact with the elderly
     Inconvenient timing for seniors (programs too long and late)

- Listed below are the most serious problems that might prevent the elderly from seeking substance abuse services, as ranked by agencies.

  1. **Denial or lack of awareness of having a substance abuse problem (ranked No. 1 by 25 agencies)**
  2. **Unwillingness of elderly to admit the need for services or to ask for help**
  3. **Stigma or fear of being labeled associated with receiving substance abuse services**
  4. The elderly lack awareness of the availability of substance abuse services
  5. Little confidence among the elderly that substance abuse services will help them
  6. Difficulty getting to services because of limited physical mobility, poor health. And tied as number 6.

Difficulty getting to services due to limited transportation

7. Negative attitude of the elderly towards substance abuse counselors
8. Negative attitude of the family towards substance abuse services

Other:

Why bother – the elderly feel it is too late

Money – How do I pay for this if Medicare doesn't

I don't think the elderly folks in general know how to financially access services

Hopelessness and self medication issues

A Compilation of Public Comments

A statewide toll free phone number was set up for the month of October for anyone to call with concerns or comments to be included in the survey of mental health needs of the elderly.

A total of 23 calls were received, providing the following information:

Are you calling concerned about yourself 12
parent 4
sibling 1

Age of person concerned between 59 to 97

What is reason for calling?

Mental Health	**16**
Mental Retardation	**5**
Substance Abuse	**3**

Have you attempted to get help before? Yes **14** No **5** Not Applicable **4**

If yes, where did you call? Most callers stated they had made many calls

If yes, was it difficult or easy to get the help? **13** Difficult **1** Easy

Reasons for difficulty:

Didn't know where to go	**9**
Sent from one place to another	**7**
Funding	**5**

Where does individual live? Towns: Belfast, Blue Hill, York, York Beach, Bucksport, Cherryfield, Eagle Lake, Rockland, So. Paris, Norway, Brunswick, Readfield, Bowdoinham, Northport, Windham, Union, Bangor.

Live alone? Yes **16** No **7**

If no, they live with spouse, **4** other **3** **(1 assisted living, 2 others in group home type)**

Age of person/s individual lives with from 63 to 69

Type of dwelling? own home **12** apartment/rental **8** other **3**

General Comments/Concerns

- ✓ Want to let people know this is hard to do. Locating all the services and organizing them to work together. They are there, just it is very hard finding them.

- ✓ Brother and Dad were living in Mass. Both needed care. After attempting to be the care provider from a distance it became clear, I could not be the care giver from two states away. I could not organize the services to work together from so far away. I moved both of them to Maine. This took an enormous amount of coordination and help. I found an assisted living placement for my father and called MR in Augusta, they referred me to Bangor and the people there were and continue to be very helpful.

- ✓ Concerned that the Blue Hills Area Community Center needs to expand to include elderly nutrition and other alternative information.

- ✓ Recent widow. Just moved to Maine from New Hampshire. Have been coming here for 25 years. Also lost mother at about the same time as husband. Looking for something to do. Being here year round is not the same as visiting every year.

- ✓ Long term alcoholic. She is no longer interested in doing anything. She gets home from delivering meals on wheels and goes to bed.

- ✓ Need respite for us.

- ✓ Many issues related to medical needs. Many health issues needing medication. No coverage for very costly medicines

- ✓ Health

- ✓ Has been disabled since '86. Long string of medical problems. No health insurance. Medicine costs $711 per month.

- ✓ Wife became ill 20 years ago and went to BMHI. Since then she has been in and out many times. We have had to sell our place and I am living in subsidized housing. She is in a nursing home and things are OK for us. They say she no longer needs a nursing home. I can not take care of her. So, she is going to some home someplace and I will need to drive a long ways to be with her. She doesn't do well with change and she will get sick again and who knows where we will be.

- ✓ Concerned that the medication that I am taking is "making me a little crazy". Currently taking different medication from what the doctor in Caribou gave me. Want to know someone who knows enough to say this medication is OK.

- ✓ Caring for mom with sister. Mom doesn't want to go out anymore – forgetful. Getting some help but respite is undependable.

- ✓ Sad that elderly are not getting the help here that they get in other countries. Worked all their lives and cost of living rises then turn around and charged all of the small amount to pay for what?

- ✓ Very concerned about the costs of medication and cost of insurance. Medication cost has gone from $4.25 to $21.75 in 12 years for the same exact amount.

- ✓ Sober for 20 years, AA, concerned about isolation, cost of medication, getting counseling, lots of penalties for being older.

- ✓ No respect for older people, no need for free things, make it easier to get services, med co-pay has gone from $10 to $20.

- ✓ I was trying to find out if my mother was eligible for the rent credit. That man just was not listening to what I was asking. I told him several times I wanted to know if she was eligible and he kept saying when you get the denial letter. You don't get a denial letter if all you're doing is asking for information and haven't applied yet. What we need is for that man in Augusta to learn English and to listen.

- ✓ The cost of medication. It costs $1500 for medicine not including over the counter or transportation.

- ✓ Concerned about the cost of medicine.

- ✓ Retired early, currently has health coverage - Health Source which will go away when he turns 65.

- ✓ Concerned about self and everyone else who is part of the DMHMRSAS system, being labeled and limited by those labels.

- ✓ Medicaid and Medicare guidelines leave large gaps, housing a major concern, not enough placement available for folks with dementia.

- ✓ I am a mental health provider who goes into nursing homes. My observation and concern is that some individuals need a private room. It helps them and the other residents as well as making it easier for the staff.

- ✓ Volunteering gets me out.

- ✓ I get the services I get because I am persistent and fight for it.

- ✓ Brother in nursing home with MS, only worked 5 years gets $900, I worked for 40 years and only get $500 disability. gender bias.
- ✓ Applied for low cost medicine but waiting, have wait still need to wait.
- ✓ Do not know who to call if in need of any services

What type of assistance would help?

- ➢ Transportation
- ➢ There needs to be a way of letting people know that there are a lot of services for people. It is just hard, very hard to know how to find them. I'm thinking of starting a business using what I've learned getting my father and brother taken care of.
- ➢ Something to keep active, something to do at night.
- ➢ Some way of getting past the denial by the person who needs help. She isn't interested in doing anything at all.
- ➢ Need help paying for medicine. In a good year, without any extra medication needs, it costs $18,000 per year. Husband had kidney transplant 12 years ago. Medicare doesn't pay for medication. Health insurance from work does not cover after you retire.
- ➢ We need more emergency vehicles. I've had enough of lying politicians.
- ➢ He wants some one who is educated to medicines that he can talk to.
- ➢ More eldercare—help with bathing, and housework
    - o need support groups for caregivers,
    - o need training for caregivers,
    - o not aware of all the services available,
    - o day respite,
    - o transportation