Policy Issues in Mental Health Among the Elderly

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• Policy issues • Mental disorders • Elders

Americans are living longer than ever before in history. The Centers for Disease Control and Prevention (CDC)[1] predicts that the number of persons older than 65 years will increase from approximately 35 million in 2000 to an estimated 71 million in 2030, comprising approximately 20% of the US population. The CDC[1] further estimates that the number of persons older than 80 years is expected to increase from 9.3 million in 2000 to 19.5 million in 2030. With age comes an increased risk for chronic mental health disorders. About 1 in 8 baby boomers is expected to be diagnosed with Alzheimer disease, which will amount to some 10 million members of this age cohort.[2] Dementia tends to be the mental disorder most often associated with old age.[3] The debilitating nature of this disease and the intensity of care required guarantee that a particularly heavy demand will be placed on the US health care system. Age is the largest risk factor, with 49% of the population older than 85 years diagnosed with dementia.[2]

The prevalence of mental health disorders among the elderly is often unrecognized. One in four older adults lives with depression, anxiety disorders, or other significant psychiatric disorders.[4] Mental health disorders are frequently comorbid in older adults, occurring with a number of common chronic illnesses such as in diabetes, cardiac disease, and arthritis.[5] Functional declines are more pronounced in comorbid mental and physical disorders, thus threatening the elderly's abilities and capacity for self care. A spiral relationship evolves over time as a mental health disorder (such as depression or anxiety) and increases risk for self-perceived functional and behavioral disabilities. For example, a coexisting cognitive disorder such as Alzheimer disease co-occurring with diabetes threatens the person's ability to understand how to manage blood glucose measurement and readings, thus further eroding self-care management of diabetes.[5] The public is becoming more aware of the aging of the population and the difficulties that are exacerbated by unmet services and limited access to mental health services. This article describes policy issues related to chronic mental health disorders and the older population. Mental health parity, a recent

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policy issue occurring at the national level, is discussed first followed by workforce issues specific to the discipline of nursing.

MENTAL HEALTH PARITY: A NATIONAL POLICY ISSUE

Historically, the perception of the public about mental illness differed from other physical illnesses because of the stigma related to mental illness. The perception held by the public was that society needed protection from people with mental illness by providing care in isolated institutions on the outskirts of town.[6] Mental health care evolved during the years from prisonlike conditions to many forms of treatment financed by state mental health systems. Institutionalization of the most seriously ill propagated the myth that mental illness was "incurable" despite many advances in treatment.[6(p.77)] This negative perception and stigma make mental health parity laws difficult for the public to support. When parity laws are in place, health plans operating in the private health insurance market are required to provide an equivalent level of coverage for the treatment of mental health disorders that is provided for physical disorders. The passage of recent federal mental health parity legislation sent a strong message that mental health disorders are just as treatable as other physical disorders.[7]

Advocacy for Mental Health Parity

At the national level, mental health parity has been proposed since President John F. Kennedy directed the first attempt to regulate insurance coverage for mental health through the US Civil Services, the predecessor agency to the US Office of Personnel Management. Mental health parity was first offered in 2 nationally available Federal Employee Health Benefits (FEHB) Program health plans, Blue Cross Blue Shield and Aetna.[8]

Appeals for parity were framed in many different ways during the political debate. Parity can be framed as a response to market failure, as an antidiscrimination measure, or as a strategy to improve equity and alleviate the financial burden of mental illness.[9] Current success in passage of parity laws resulted primarily because of focus on all 3 arguments.

The debate began historically with the fairness argument that insurance should not discriminate against individuals with mental illness. To investigate this argument, Busch and Barry[10] examined whether state parity laws differentially affected the use of services among people with low income or those with poor mental health. Findings indicated that persons in smaller employee firms were more likely to use services after the implementation of parity and that this effect was concentrated among people with low income. Before the implementation of parity, people with low income were not able to access mental health services. Thus, parity can be viewed as a way to prevent discrimination against people with low income who have a mental disorder.

Another fear about passage of a mental health parity law was that equivalence would dramatically increase costs for employers and drive up premiums for patients or result in claims for frivolous services. These fears have not materialized even with broad parity laws in place.[11] The experience across more than 45 states that have passed parity laws and of the federal government (parity has been provided under the FEHB program since 2001) is that parity does not substantially increase utilization or cost.[7,10] Evidence from the FEHB program, which provided equal coverage for specialty mental health and substance abuse services for 8 million members in 2001, suggested achievement of a real cost saving in the amount of $40 on average annually per treatment user.[12] Even large businesses have recognized the value of