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Mental health care needs of older adults are growing and the system needs to change to meet increasing needs

Emily Muttillo
Applied Research Fellow

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KEY TAKEAWAYS

- As the older adult population increases, so will the number of homebound individuals with mental health needs.
- National and state policies have begun to incorporate mental health into aging network services.
- The aging network is heavily reliant on the mental health network to provide services for older adults.
- The strength of the mental health network is dependent on funding beyond insurance reimbursement.
- Opportunities exist for increased collaboration among aging and mental health providers; additional funding is needed.

Over the past 20 years, the nation's aging services network has been preparing for the demographic shift, known as the Age Wave, which is occurring as the baby-boom generation collectively enters older adulthood. In recent years, there have been discussions at all levels of government, and throughout health and social service delivery networks, on how to redesign systems to accommodate the increasing number of people in their 60s, 70s, 80s, 90s and even 100s who live in the community. When health and social service systems were designed, it was at a time when the older adult population was much smaller and life expectancies were shorter than they are now and are predicted to be in the future. Far fewer older adults expected to live many years beyond retirement and did not require the same level of intervention and support to remain in the community as they aged.

Much attention has been paid to the stress this generation of older adults puts on safety net supports including Social Security, Medicare and Medicaid. There is a lot of debate about how to either tweak or overhaul these programs so that they continue to provide the support that so many Americans depend upon. These programs, along with those provided through the Older Americans Act (OAA), have allowed older adults in this country to access much-needed health and supportive services as well as ensure they have a secure source of income. In the 2006 revision of the OAA, mental health was added for the first time as a type of supportive service available to older adults, alongside existing supports like nutrition, transportation and in-home care. A 2016 revision updated the language from mental health to behavioral health to reflect the addition of substance use disorders into the category. As Ohioans continue to live longer and the largest generation ages into this population, they are more likely to live

in the community, often independently, in their own homes. Many will require home and community-based services to maintain that independence in healthy and safe ways. It is increasingly important to consider whether the current supports and services that are in place best serve individuals in the community, particularly those who have or develop mental health disorders and have limited access to the world outside their home. While the aging network system of supports has worked well for many, it is time to reassess the current needs of older adults and consider additional modes of service delivery.

Older adult and homebound demographics

The U.S. Census Bureau estimates there are 47.7 million individuals over the age of 65 in the nation, 1.8 million of whom live in Ohio. The Scripps Gerontology Center has provided detailed population projections for Ohio and every county within the state[1] which predict higher percentages of older adults across the state than have historically existed. The growth of the older adult population paired with the move toward aging in place has resulted in more people living in their homes longer and requiring higher levels of care within their homes. Also, as the number of community-dwelling older adults has increased, so has the number of homebound older adults. It is estimated that 5.6 percent of the Medicare population (older than age 65 or disabled as determined by Social Security) are considered homebound.[2] Within Ohio that 5.6 percent rate would equate to an estimated 103,300 older adults. Homebound individuals tend to be older, nonwhite and female, and to have less education, less income, and more chronic disease than the general population of older adults. It is likely that communities with higher rates of people of color, people living in poverty and high rates of chronic disease will have higher rates of homebound older adults than the 5.6 percent estimate.

Multiple definitions of the term homebound are used in various settings to describe people who rarely or never leave their homes. To be considered homebound by Medicare, people must need the help of another person or medical equipment such as crutches, a walker, or a wheelchair to leave their homes; their doctor believes that their health or illness could get worse if they leave their homes; and it is difficult for them to leave their homes and they typically cannot do so.[3] For many Medicare services, including home health services, a beneficiary must be determined to be homebound by their physician.

For purposes other than eligibility for Medicare, being homebound can be defined along a continuum in which people may move forward and back depending on their current condition.

Term	Definition
Homebound	Individuals who have never left their homes in the past month.
Mostly Homebound	Rarely (once a week or less) went out in the last month
Semi-homebound	Go out sometimes (twice per week) but never by themselves or need help and have difficulty when they do go out
Non-homebound:	Go out at least twice per week without help or difficulty

[1] https://miamioh.edu/cas/academics/centers/scripps/research/ohio-population/reports/index.html
[2] Epidemiology of the Homebound Population in the United States. JAMA Internal Medicine 2015. Ornstein et al.
[3] https://www.medicareinteractive.org/

As the number of homebound people increases, whether defined by Medicare or somewhere along a spectrum, the scaling up of the services and supports for this population will be necessary to meet community needs. This subpopulation has typically been considered a "hard to reach" population. How information is communicated, services are delivered and social contact is maintained will have a large influence on the health and well-being of the older adult homebound population including on mental health. Relationship development and trust building with providers will be essential to successfully reach and provide services to homebound individuals. Providers with specialized training in the field of geriatrics have the skill set to develop relationships and trust.

Mental health and older adults

Along with a growing homebound population, the number of older adults in need of mental health services has increased as well. The Older Adults Behavioral Health Profile used the Behavioral Risk Factor Surveillance System to examine the current state of mental health, substance use and suicidality among older adults in Ohio.[4] Nearly 7 percent of older adults report experiencing frequent mental distress, with females more likely to report distress than males. More than 50 percent of those who indicated frequent mental distress also reported high rates of poor physical health, with higher rates of stroke, coronary disease, heart attack, diabetes and high blood pressure than their peers who report some or no mental distress. Eleven percent of those older than age 65 reported they rarely or never get social or emotional support.

A study published in *Research on Aging* found that people diagnosed with mental illness are living longer and are more likely to develop dementia than those who have not had mental illness. Increasing numbers of those with serious mental illness rely on long-term care services and supports. The authors of the study explain that people who have both dementia and a mental illness are more likely than the general population to enter a long-term care facility. However, with proper support while they live in the community, they can maintain independence for a longer period of time, which reduces the stress on Medicaid and the long-term care system.[5]

A research study on the prevalence of psychiatric disorders among older adults used a national survey to find the rate at which men and women aged 55 and older experienced mental health disorders. This included mood, anxiety and personality disorders. Within this population, women were more likely to be diagnosed with a mood disorder than men, with the highest rates (12 percent) among women between the ages of 55 and 64. Women were also nearly twice as likely to be diagnosed with an anxiety disorder as men. Women between the ages of 55 and 64 had the highest rate of diagnosis across all groups at 18 percent. Men are more likely than women to be diagnosed with a personality disorder than women. The age group with the highest rate of personality disorder diagnosis is men between the ages of 55 and 64,

[4] Older Adults Behavioral Health Profiles, Region 5, A Behavioral Health Resource SAMHSA's State Technical Assistance Contract August 2016 https://acl.gov/sites/default/files/programs/2017-06/StateTA_OABH_Profiles_Region5.pdf

[5] Estimating the Prevalence of Serious Mental Illness and Dementia Diagnoses Among Medicare Beneficiaries in the Health and Retirement Study, Research on Aging, 2018 Vol. 40(7) 668-686. Maria Teresa Brown, Douglas A. Wolf.

at 20 percent. Rates of mental health disorders decline with age, with those aged 85 and older having the lowest rates of disorder.[6]

Rates of mental health disorder among community-dwelling older adults

Mental Health Disorder	Ages 55+		Ages 55-64	
	Male	Female	Male	Female
Any Mood Disorder	4.49%	8.64%	5.84%	12.00%
Any Anxiety Disorder	7.90%	14.24%	10.76%	18.60%
Any Personality Disorder	16.79%	12.68%	20.26%	16.09%

A data brief produced by the National Center for Health Statistics on Suicide reported that suicide rates have increased for all age groups, including older adults. Suicide rates for females aged 65 to 74 were significantly higher in 2016 than suicide rates in 2000. Suicide rates for men were highest in the 75 and older age group, although the rate for this group fell from 42.4 per 100,000 men in 2000 to 39.2 per 100,000 men in 2016. Among women in this age group, poisoning was the most frequent means of suicide, followed by suicide with a firearm. Among men who committed suicide, 74 percent of those aged 65 to 74 and 81 percent of those 75 and older used a firearm as the means. [7]

When suicidality is suspected, a best practice in suicide prevention is to inquire about whether someone has made a plan and if they have the means to carry out the plan. Identifying these two aspects can allow the practitioner to assess the level of risk and help the person consider eliminating access to the means and developing coping strategies for keeping suicidal thoughts at bay.

Social isolation and loneliness can be contributing factors to mental health disorders. Although loneliness and isolation can be related, they are unique dynamics that can exist independent of each other. Social isolation is an objective measure of the lack of contact between an individual and society. One study found that in 2011, 24 percent of community-dwelling older adults were characterized as socially isolated. Of those, 4 percent were characterized as "severely socially isolated." Having a low income, being unmarried, being male and having low level of educational attainment are all independently associated with social isolation.[8]

In contrast to the objective measure of social isolation, loneliness is a subjective feeling of disconnection from other people and society. Social isolation often results in loneliness, but it is also possible to experience loneliness with frequent social interaction. Both social isolation and loneliness can contribute

[6] Prevalence of psychiatric disorders in U.S. older adults: findings from a nationally representative survey, World Psychiatry, February 2015, Vol. 14 74-81. Kristin Reynolds, Robert H. Pietrzak, Rene El-Gabalawy, Corey S. Mackenzie, Jitender Sareen.

[7] Suicide Rates in the United States Continue to increase. NCHS Data Brief. No. 309 June 2018

[8] The Epidemiology of Social Isolation: National Health & Aging Trends Study Journal of Gerontology Series B Psychological Sciences and Social Sciences. 2018 Mar 26.
Cudjoe TKM, Roth DL, Szanton SL, Wolff JL, Boyd CM, Thorpe RJ Jr.
Center on Aging and Health, Johns Hopkins University, Baltimore, MD.

to, and result from, mental health disorders. Addressing these factors can be an essential part of a mental health treatment plan.

A number of homebound older adults need mental health services, but accessing those services requires understanding how the behavioral health system is designed and knowing how to access the points of entry. Since it is unlikely that a homebound older adult experiencing the extreme sadness or excessive worries associated with mood or anxiety disorders will have the motivation, energy or organized thought process to research mental health systems, community navigators can serve as guides through the system. As with any system that involves multiple access points, modes of service delivery, types of payment, billing codes and tiered professional qualifications, it is complex and can be difficult to navigate alone.

Mental health services

The Administration for Community Living defines behavioral health as "*the promotion of mental health and well-being, the treatment of mental and substance use disorders, and the support of those who experience and/or are in recovery from these conditions.*" Behavioral health services provide assistance to people to address symptoms related to mental health and substance use and may include evaluation, assessment, medication management, counseling or group therapy. These services can be provided in either an inpatient or outpatient setting. The particular setting is often determined by the severity of the disorder. Professionals including psychiatrists, clinical phycologists, advanced practice nurses, mental health counselors, independent social workers and chemical dependency counselors, provide services. Each of these types of clinicians are licensed by their various professional governing bodies and the State of Ohio. Specific types of licensure are required to be able to bill and receive reimbursement from private insurance or public health coverage programs.

Generally speaking, in order for an individual to receive behavioral health services, the service must be delivered by a licensed professional who treats a diagnosed mental disorder. An individual's mental health encompasses how they think, feel and behave. When thoughts, feelings or behaviors interfere with activities of daily living, a person may meet the diagnostic criteria for a mental health disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). The DSM-5 diagnosis include codes for medical billing: the International Statistical Classification of Disease and Related Health Problems Tenth Revision, more commonly known as ICD-10 codes. A diagnosis and subsequent ICD-10 code allow for a mental health provider to bill for, and be reimbursed for, services from private or public health insurance plans. Receiving a diagnosis can open the door to treatment options for all populations, including homebound older adults.

Not unlike children, older adults benefit from working with mental health care professionals who are specifically trained to understand the complexities of the age cohort on which they focus. An aging adult may have symptoms of mental health disorders that manifest differently from the general population. Mental health professionals specializing in working with older adults also benefit from having an understanding of chronic disease, polypharmacy, social isolation, substance abuse, nutrition and grief theory, among other issues which often impact the functioning of older adults. While the mental health field does have a geriatric specialty, there is a shortage of practitioners. The American Association for Geriatric Psychiatry projects that by the year 2030 there will be just one geriatric psychiatrist per 5,862

older adults with a psychiatric condition.[9] As a stop-gap measure, professionals who work in the aging network can share their expertise and work alongside mental health professionals when treating older adults.

Aging policy

Most programming for older adult services delivered through the aging services network comes through the regulations and associated funding of the Older American Act (OAA). The OAA, originally enacted in 1965, was revised in 2006 to include references to the prevention and treatment of mental disorders. The 2016 reauthorization of the OAA changed the language from "mental health" to "behavioral health" to include suicide and substance abuse. Mentioning behavioral health 13 times, the act lays out the pathways for older adults to connect with mental health services through programs funded by the federal government.

The first mention of behavioral health in the OAA occurs in section 102 which states *"For the purposes of this Act—The term ''disease prevention and health promotion services'' means— screening for the prevention of depression, coordination of community mental and behavioral health services, provision of educational activities, and referral to psychiatric and psychological services,"*[10] The OAA indicates behavioral health services can be offered in "multipurpose senior centers" and allows that not caring for one's own mental health can be considered "self-neglect." In addition to defining services, the OAA details how state and area agencies on aging within states should coordinate plans so that mental health services are available to older adults.

The OAA charges individual states with developing state plans and requiring area agencies on aging to develop coordinating plans to carry out the services and supports outlined. In section 306, the act requires that "*the area agency on aging will— in coordination with the State agency and with the State agency responsible for mental and behavioral health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental and behavioral health services (including mental health screenings) provided with funds expended by the area agency on aging with mental and behavioral health services provided by community health centers and by other public agencies and nonprofit private organizations*;"[11]. The OAA designates that area agencies on aging use their funds to coordinate with local mental health agencies to manage mental health services for the older adult population, in accordance with the state plan.

The Ohio Department of Aging's (ODA) current State Plan on Aging covers the years 2019 through 2022 and outlines goals, strategies and objectives during that timeframe. The narrative that describes the state plan's focus areas related to OAA core programs includes a description of mental health among older adults.

> "*Depression, anxiety, addiction and other mental health issues are not a normal part of aging. Left untreated, they can lead to fatigue, illness and even suicide. Older adults with mental disorders are more likely than those without them to be smokers, to eat an unhealthy diet or not exercise regularly. Unfortunately, mental health problems can be under-identified by older adults, their family members and health care professionals. Stigma surrounding mental illness*

[9] https://www.aagponline.org/index.php?src=gendocs&ref=CareersGeriatricPsychiatry&category=Main
[10] The Older Americans Act 102(a)(14)(G).
[11] The Older Americans Act 306(a)(6)(F)

make people reluctant to seek help. According to the Ohio Department of Mental Health and Addiction Services, mental health and addiction disorders are more common than diabetes or heart disease, and they are just as treatable. The Substance Abuse and Mental Health Services Administration found that nearly 460,000 Ohioans suffer from a serious form of mental illness. Stressors, such as reduced mobility, chronic pain, frailty or other health problems, can lead to isolation, loneliness, depression and anxiety. The department and the aging network provide services and supports that can address and alleviate these stressors, offer opportunities to increase older adults' socialization and civic engagement, and provide guidance to available treatment options. The department will increase the aging network's responsiveness to older adults' needs for mental health resources and services, including suicide prevention, through our objective and strategies."

Objectives that specifically address mental health in the ODA State Plan on Aging fall under the population health goal which is to "*educate and empower older adults and adults with disabilities and their caregivers to live active, healthy lives to maintain independence and continue to contribute to society*." One of those objectives, objective 12, addresses the need to increase awareness of mental health resources and services for older adults through partnerships with the area agencies on aging, Ohio Department of Mental Health and Addiction Services, community partners and senior centers. The identified outcome of the mental health objective is that, *"older adults have improved access to the resources and services they need to manage mental health concerns as evidenced by the increased utilization of programs and referrals to appropriate services."*

ODA State Plan Objective 13 focuses on raising awareness of suicide among older adults and encourages the adoption of suicide prevention strategies by agencies that serve older adults. The state plan also assures, in accordance with OAA, that each area agency on aging will develop its own plan to provide "services associated with access to services" including mental and behavioral health services and in-home services.

Both objectives related to mental health in the ODA State Plan on Aging focus on referrals and awareness as opposed to directing professionals within the aging network to provide mental health counseling. The state conveys the role of the area agencies on aging primarily as referral mechanisms as opposed to service providers. The most recent Ohio Department of Aging budget reflects this view as well. The 2019 Legislative Budget Office Analysis of Enacted Budget for the Ohio Department of Aging provides a descriptive narrative for each appropriation line item. The analysis does not include the words "mental health," "behavioral health" or "suicide" within the document. The appropriation line item for Senior Community Services provides funds available to area agencies on aging to match OAA funding. Although it does not specifically mention behavioral health services, this funding could be used by area agencies to provide mental health referral services. While there are clear objectives and strategies to address mental health in the ODA State Plan there is no line item budget in the ODA budget specifically for these services.[12]

As laid out in both the OAA and the ODA State Plans, area agencies on aging are responsible for working with the local agency responsible for mental and behavioral health services to increase awareness, remove barriers to diagnosis and treatment, and coordinate mental health services. The OAA states that the area agencies on aging are to use their funds for this purpose with the services provided by

[12] Greenbook LBO Analysis of Enacted Budget Ohio Department of Aging. Ryan Sherrock. August 2019

community agencies. Community mental health agencies typically receive oversight and in many instances funding from the local Alcohol, Drug Addiction and Mental Health (ADAMH) Board. The State of Ohio currently has 50 ADAMH Boards which go by various names but which together provide coverage of the entire state, a full list of these boards can be accessed through the Ohio Association of County Behavioral Health Authorities.[13]

Ohio has 12 area agencies on aging, with each covering a specific geography comprised of multiple counties. Each area agency on aging is required to develop a plan that details how it will align with the ODA State Plan to meet the five goals listed. Many of the plans use the same language as the State Plan for their objectives related to mental health. Area agencies on aging are also developing a strong referral network administered through their Aging and Disability Resource Networks (ADRN) to respond to requests regarding mental health. Efforts continue to cultivate and strengthen relationships with existing community mental health agencies for referral purposes.

Aging and Disability Resource Centers (ADRC) provide services for older adults and adults with disabilities within the ADRN coordinated by the local area agency on aging. The ADRCs are designed to be a "No Wrong Door System" that provide referrals to community-based services, person-centered counseling and screening for public benefits eligibility. These services are delivered through information and referral, benefits assistance and Options Counseling. According to the National Association of Area Agencies on Aging, ADRCs were developed to serve as a single point of entry for older adults and people with disabilities to access long-term care services and supports. Many area agencies have utilized existing ADRC infrastructure and staffing for long-term care referrals to connect older adults with mental health resources as needed.

While systems are in place to provide referrals to mental health services, needed services may not always be available, particularly for those who are unable to regularly leave their homes. For instance, the Central Ohio Area Agency on Aging (COAA) State Plan included stakeholder feedback that there are "inadequate mental health services with limited in-home assessments, limited local service providers and waiting lists throughout the region." COAA is currently working to add mental health organizations to their Aging and Disability Resource Network (ADRN) as a way to increase access. The Area Office on Aging of Northwestern Ohio also has a specific strategy under its mental health objective to increase awareness for mental health resources by partnering with mental health agencies at the state and local levels as well as developing referrals from Adult Protective Services into its existing in-home care services.

One example of an area agency on aging that provides a connection to mental health services designed specifically for older adults can been seen in the Uplift program in Butler County. The Council on Aging of Southwestern Ohio connects older adults in the Butler County Elderly Services Program who are in need of in home mental health care to Uplift, which is housed in Community Behavioral Health, a mental health organization. This program provides in-home counseling programs for clients of the Butler County Elderly Services Program.[14] Other communities have developed similar relationships between aging network referral partners and mental health providers offering in-home or onsite mental health treatment and services. The need for these types of programs will continue to grow; it is unclear if the

[13] https://oacbha.org/

[14] https://www.help4seniors.org/Find-Resources/More-Information.aspx?ResourceID=f6c405a3-1b35-47d3-a2ea-b6fbfb375856 Accessed 10/14/19

current model of funding mental health services in general, and those for homebound older adults specifically, will allow for the growth of services to occur.

Insurance

Like all providers of health-related services, the network of mental health providers in any community relies heavily reimbursements for provided services. Older adults and adults with disabilities are generally enrolled in Medicare, Medicaid or both, and have mental health benefits as part of their insurance coverage. Multiple coverage options exist within public health insurance and the access to mental health services varies with the type of coverage.

According to the Centers for Medicare and Medicaid (CMS)[15] Medicare will cover specific services for both inpatient and outpatient mental health services. Outpatient services include one depression screening per year, individual and group psychotherapy, testing to determine effectiveness and fit of services, psychiatric evaluation, medication management, some non-self-administered prescription drugs, diagnostic tests and partial hospitalization. The beneficiary of these services must generally cover a co-payment of 20 percent of the Medicare-approved amount for the service. For inpatient services, Medicare covers a stay in a general hospital for mental health services the same way it covers an admission for a stay related to physical health. Medicare will also pay for a stay in a psychiatric hospital but imposes a 190-day lifetime limit on stays at this type of facility.

If a beneficiary chooses to enroll in a Medicare Advantage plan, the cost structure for mental health services varies. Outpatient mental health therapies are considered specialists visits. Low-deductible plans have an associated cost with each mental health visit, with typical co-pays ranging from $25 to $50. High-deductible plans generally have no mental health copays once the plan deductible has been reached. The Medicare.gov “Find a Plan” tool allows an individual to search for additional benefits such as vision, dental, hearing, transportation and fitness. Mental health, however, is not a category for additional benefits, because, by federal law, mental health should have parity with physical health and therefore does not require additional coverage at an additional cost.

Medicaid provides health insurance for many Ohioans through various categories of eligibility including Medicaid for the Aged, Blind and Disabled. It is a needs-based program and beneficiaries must meet financial eligibility requirements. According to the Ohio Department of Medicaid, any Medicaid beneficiary with a medical need for the following services may receive the service; community psychiatric supportive treatment, crisis intervention, individual or group counseling, injections of long-acting antipsychotic medications, mental health assessment, partial hospitalization, pharmacological management, psychiatric diagnostic interview and psychological testing. No co-pay is required for any mental health service covered by Medicaid.

Those who are above the Medicaid-eligibility threshold may still qualify for services under programs designed for those who meet the program specific criteria. Area agencies on aging administer a number of these programs including Specialized Recovery Services (SRS), PASSPORT, Ohio Home Choice, Assisted Living Waiver and MyCare Ohio. Each of these programs include the same mental health benefits as those under ABD eligibility. The SRS is the newest of these waiver programs and allows for an individual

[15] *Medicare & Your Mental Health Benefits*, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Revised August 2017

with severe and persistent mental illness, and those with chronic health conditions who do not otherwise qualify, to become eligible for Medicaid. Once enrolled in the program, older adults work with recovery managers who contact them at least once every 30 days to ensure they follow the guidelines of their mental health or health care provider and maintain eligibility requirements with Job and Family Services. This allows the older adult to receive continuous care and also ensures that his or her provider is able to consistently bill and be reimbursed for services.

In addition to insurance reimbursements, many community mental health agencies that serve homebound older adults rely heavily on outside funding that comes from tax levies, philanthropic funding and private donors. These additional funding sources make up the difference between what a service costs to provide and what insurance companies negotiate as their payment. In a review of best practices of home-based mental health services for older adults, one study found that all 10 programs reviewed were dependent on sources other than insurance reimbursements and most considered themselves to be fiscally challenged and not fully meeting the existing need.[16]

Implications

As the system currently exists, additional funding outside of Medicare, Medicaid and private insurance appears to be necessary to meet the mental health needs of homebound older adults in the State of Ohio. While some counties within the state have senior specific or mental health levies to fund these types of services, not all counties have this resource. Similarly, some communities have strong philanthropic support to bridge the gap between the actual cost of services and the insurance reimbursement rate. Others do not. With both the aging and mental health networks already challenged with growing demand for their services, policymakers should consider how to meet the needs of the growing older adult population. By following the current guidelines of the Older Americans Act, the Ohio Department of Aging and area agencies on aging have incorporated mental health into the services offered to older adults. However, this is mostly limited to being an access point to the mental health network. In the next revisions of the OAA and the state plan, policymakers should consider incorporating geriatric mental health professionals and services into existing older adult serving agencies and providing the funding necessary to support these professionals. This would broaden the mental health options for older adults, provide employment opportunities for those interested in geriatric mental health specializations and create a workforce prepared to serve homebound older adults with conditions like depression, anxiety and personality disorders.

Comments and questions about this edition may be sent to EMuttillo@CommunitySolutions.com
1501 Euclid Ave., Ste. 310, Cleveland, OH 44115
175 S. Third St., Ste. 350, Columbus, OH 43215
P: 216-781-2944 // F: 216-781-2988 // www.CommunitySolutions.com

[16] Home-Based Mental Health Services for Older Adults: A Review of Ten Model Programs. American Journal of Geriatric Psychiatry. 2014 March: 22(3): 241-247 Burton V. Reifler, Martha L. Bruce