CLINICAL GEROPSYCHOLOGY NEWS

APA DIV. 12 SECTION II

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President's Comments

At the Millennium: Personal and Professional Reflections

Gregory A. Hinrichsen, Ph.D.

In 1975, a few years out of college, I joined a community group in the Fenway neighborhood of Boston that was concerned with the impact of urban renewal on the neighborhood elderly. With some federal funding the group launched a social service outreach program to all older residents of the neighborhood. As part of this effort, two other outreach workers and I (one of them a hearty, charming older man of 64) went door to door and talked with our older neighbors. I learned some very important lessons from a year's worth of conversations with older people in their homes. First, most older people coped quite well with life's many demands. Second, for elderly people with mental health problems there were few resources. Third, I found my contact with older adults intellectually challenging and personally satisfying. I began to wonder, was there such a thing as a "geriatric psychologist?" There were no psychology role models I knew to whom I could turn. A geriatric social worker friend said that while social workers had provided services to the elderly for many years, on the whole, psychology didn't seem to be doing much in geriatric mental health. She said, however, that I could be assured that a career in mental health and aging had a bright future. "The demographics are on your side." Twenty-five years later I realize what a stroke of good fortune that this early introduction to gerontology was since it laid the foundation for a career in geropsychology.

As I anticipated applying to graduate schools I began to investigate whether there were indeed "geriatric psychologists." I discovered several geropsychologists. Robert Kastenbaum was in the Boston area and I learned that he began to write about clinical geropsychology in the 1960's. Robert Kahn was at the University of Chicago. He and a few graduate students (including George Niederehe and Steven Zarit) had begun to map out some important geropsychology issues. Northwestern University and the University of Southern California were places where psychologists with clinical interests could get some training. Martha Storandt, Boaz Kahana, Powell Lawton, David Gutman, Margy Gatz were names that came onto my gero-radar screen. Clinical geropsychologists (I'm not even sure such a name existed then) gathered informally within APA's Division 20 and the Gerontological Society. There was also a cadre of committed geriatric psychiatrists including psychiatrist/psychologist Carl Eisdorfer.

At year 2000, I think that clinical geropsychologists can look back and take considerable satisfaction about how far this new field has come. There have been two major conferences on clinical geropsychology training, a good number of psychology internships in which students can glean substantive geropsychology training, post-doctoral fellowships in clinical geropsychology, a growing library of books on clinical geropsychology, a solid foundation of research on which geropsychological practice rests, and much greater attention to aging issues within APA including a Committee on Aging and recognition of geropsychology as a proficiency. For me, the two most influential events in the last twenty-five years have been recognition of psychologists as Medicare providers and the establishment of Division 12, Section II. (continued on p.2)

President's Comments (continued from p.1)

Until the late 1980's, reimbursement of psychologists' service under Medicare was so severely limited as to effectively disenfranchise most older adults from psychological services. Since psychologists (finally) got paid to do clinical work with the aged, the ranks of geropsychologists have grown from a rather small group of individuals, many of whom had academic ties, to a much larger number of psychologists including those in independent practice who may or may not have had formal geropsychology training. Significant progress has been made toward the goal of providing older adults with easier and more affordable access to psychological services. The creation of Section II signaled that the number of psychologists with substantive interest in geropsychology had grown to a critical mass and that we had began to wield influence within applied psychology and more broadly within APA.

With satisfaction in our successes, we now grapple with a new set of issues in the coming years. 1. We are only partly enfranchised as Medicare providers since psychological services require a higher co-pay from older clients than medical and some psychiatric services. The many Medicare "carriers" throughout the country differ in their interpretation of what constitutes necessary services and some psychologists find it increasingly difficult to provide services to nursing home patients. Providing psychological services in nursing homes often requires doing staff education and systems-level intervention which are not reimbursable. 2. As we welcome psychology colleagues without geropsychology training into our ranks, we must develop affordable and accessible training so that they have the required professional knowledge with which to deliver high quality and ethically sound psychological services to the elderly. 3. We need to develop coalitions within APA and between our division and other geriatric disciplines to advance the mental health agenda for older Americans. At a time of increasing fractious relations within APA and between APA and the other APA, the need for drawing together is ever more important. 4. Training future generations of geropsychologists is critical to our growth. Many applied graduate psychology programs still provide little if any training in geropsychology or gerontology. Gero-education will not only better prepare all psychologists for practice with the growing population of older adults, but further seed interest in geropsychology as a specialization. More funding is needed for geropsychology training. It is an irony that graduate medical education is funded through Medicare (which primarily reimburses services for the elderly) yet those who provide doctoral and post-doctoral psychology training have no access to these training monies. 5. More research is needed to undergird our clinical practice. Increasing numbers of geriatric clinical research scientists are needed to do studies that document that psychological assessment and interventions lead to tangible improvement in the psychological and functional health of older people with mental health problems. Research alliances need to be forged with social and community psychologists to develop prevention programs and systems level interventions with older people.

I find geropsychology to be as interesting and promising a field as I did twenty-five years ago. The one reward from a career in geropsychology I could not fully see twenty-five years ago was the rich personal and professional relationships that would develop with other persons who shared a common vision of professional service to the elderly. Clinical geropsychologists are a wonderful group of human beings and professional colleagues -- and I am honored to be President of Section II.

Update on the American Psychological Association's Task Force on End of Life Decision Making and Assisted Suicide:

Dolores Gallagher-Thompson, Ph.D., ABPP

Dolores Gallagher-Thompson is the representative of 12/II to this group, which has been meeting for over 2 years to develop a position statement that can be endorsed by the APA Board of Directors on these issues. The task force's work is in its final stages: there will be 2 documents that should be available later in the year. The first is a report to the Board of Directors in response to their charge to examine these issues and make recommendations for the membership. The second is called a Resource Guide and it is a monograph going into much greater detail on all of the major points covered in the Board report.. including detailed discussion of the pros and cons of psychologists playing a role in patients' requests for assistance in dying. The Resource Guide is likely to be published by APA when final revisions are completed, although that is not definite at this point in time. The Board Report and Resource Guide are potentially of great value to clinical geropsychologists whose work increasingly calls upon them to assist dying patients and their family members.

Regarding the New 12/II and AAGP Task Force: New collaboration formed between 12/II and AAGP (American Assoc. of Geriatric Psychiatry).

Dolores Gallagher-Thompson, Ph.D., ABPP

Under the leadership of our Section chair, Toni Zeiss, and Soo Borson, M.D., who is chair of the Geriatric Psychiatry Assn, a new task force was established recently to promote professional collaboration between these two groups who have much to gain from the development of a closer working relationship. At the last Board meeting held in Nov at GSA, both Dolores Gallagher-Thompson (new chair of this task force) and Dr. Borson attended and each spoke briefly about the various specific ways in which they see this collaboration progressing over time. For example, joint educational programs could be conducted (e.g., we could propose a pre-conference workshop for next year's GSA on such topics as the roles of psychologists and psychiatrists in competency assessment; how to do mental health consultations in primary care settings; integrative treatments for late-life depression, and so on). For a joint educational program to be successful, we would have to target meetings attended by both groups of professionals so there was some further discussion about what meetings (besides GSA) might be appropriate. A second area of focus that was discussed was the need to jointly lobby for better MEDICARE benefits for mental health. Working together in the public policy arena would seem likely to be of great benefit eventually to both constituencies. The third, and most heavily endorsed by the BOARD, area of focus was the idea of publishing a monograph or actual book on empirically supported therapies for older adults' mental health problems. "Mental Health Treatments that Work for Older Adults" could be our title! Springer Pub. Co. was mentioned as a possible publisher for this work though no one was identified to follow up at this time.

The remaining discussion involved the logistics of how we would begin to work together. Dr. Borson volunteered to set up a conference call involving all task force members sometime in January. She also noted that the annual convention of the AAGP is in Miami in March, and suggested that a meeting be arranged for as many members of the task force as can attend - however, it is not likely that any of the psychologists on this task force will actually be at that convention, so the proposed meeting is not likely to occur. Dolores suggested that an email group be formed, to encourage timely discussion among task force members and to enable other members of 12/II than the ones officially on the task force to have input if they wanted to. Toni indicated that she would assist in this process, which will move forward in February.

Task force members are:

From AAGP: Hugh Hendry, M.D., Indiana Univ. and Barry Myers, M.D., from Cornell Univ. (in addition to Soo)

From 12/II: Sara Qualls and Bill Haley.

Editor's Comments

Suzanne Norman, Ph.D.

Greetings! Once again the newsletter reflects a sampling of what's going on in clinical geropsychology. Thanks to all who have contributed during the past year; I appreciate your willingness to write articles that keep us up to date. This will be my last year as editor of the newsletter and we are soliciting nominees for my replacement. The editorship is a three year term with three editions per year (February, May & October). Knowledge of WordPerfect and access to an assistant (secretarial support or student help) during the production periods is preferable. Ideally, I would like to find someone who could work with me on my final edition of the newsletter in October, 2000 to learn the ropes before taking over in 2001. This is a great opportunity to get involved in our section, to meet the officers, and learn more about the growing field of clinical geropsychology. Self nominations are welcome! If you are interested, please contact Greg Hinrichsen at hinrichs@lij.edu or by phone: 718-470-8184. If you have questions or would like more information, feel free to e-mail me at: normans@xavier.xu.edu.

Clinical Geropsychology Exchange- Geropsychological Aspects of Mental Health Disaster Relief

Victor Molinari, Director; Geropsychology HVAMC

In October of this year, the Director of the Houston VAMC granted a two-week administrative leave to myself and five other staff members to fly to North Carolina and assist Red Cross with the provision of mental health services to the "victims" of Hurricane Floyd (the word "victims" is in quotes because Red Cross prefers the term "clients", since "victims" has unfortunate passivity connotations). I must say that it was a wonderful experience being associated with the Red Cross. It has a well-deserved reputation as the most beloved organization in the world, with the bulk of the work done by hard-working volunteers with a true sense of mission to selflessly help others.

As a first time disaster relief volunteer, I was thrust into an operation which offers exciting opportunities for geropsychologists. Mental health services have been formally implemented by the Red Cross for only about six years, and it became apparent that the lack of role definition offered distinct possibilities for innovative service delivery, particularly for those with a geriatric background.

There are three basic settings at which Red Cross offers assistance: shelters, kitchens, and service centers. The shelters provide relief for homelessness caused by disasters until clients can find a place to stay; kitchens prepare the food which is then transported to clients via emergency transport vehicles (ERV's); and service centers link clients with support vouchers for such things as food or rent. Although I worked only in a kitchen and service center, I believe geropsychologists can ply their trade in all three of these venues.

Red Cross is staffed mostly by volunteers, and 65% of them are reported to be over 55 years of age. Indeed I think this a conservative estimate, and I suspect that close to 100% of the volunteers from the Baptist Relief mission that prepared the food at the kitchen where I served were over the age of 65 years. These older volunteers clearly found their work meaningful and most were fully invested in it. Geropsychologists can be of benefit in consulting with them regarding their volunteer activities and keeping them motivated when their help may not seem appreciated by some over-stressed clients. Much of the volunteers' work involves interacting with overwhelmed individuals, and geropsychologists can teach them state-of-the-art ways (geared to the unique learning needs of older adults) of sensitively addressing their clients' emotional needs and identifying those who require mental health consultation.

I was fortunate to have an ERV driver in his late 60's who knew well the people he was serving food to and was able to drop me off to talk with some of them while the rest of the food was delivered. Most of these townsfolk were geriatric and had to deal with the grief of re-building their lives from scratch after the loss of their homes and possessions. They were buoyed by the support of churches and their neighbors, but I was struck most by their own indomitable spirit. One man in his 70's without insurance lost his home, another building he rented, and the only restaurant in the small town which had been he and his wife's life dream. When I visited him, his wife and family members were already in the process of removing the flooded furniture and re-modeling. However, although my ERV driver did great with the clients, he was gruff and frequently confronted other volunteers regarding not doing their jobs right. I did some counseling with him as we rode on the truck together that I think was helpful. It turns out that he had recently sustained the deaths of two close family members, and appeared to turn his grief into angry diatribes.

In the service center where I worked for the last few days of my volunteer stint, the prime duty of the mental health professional was to reduce the tension on the clients caused by the long waits. For older adults, waiting on line can exacerbate painful medical conditions and increase already high states of frustration caused by relatively less education and savvy in negotiating bureaucratic systems. Since older adults in particular dislike asking for what they believe to be "welfare", it is of considerable benefit to them to be educated that they deserve the services offered by such organizations as Red Cross and FEMA because of their voluntary contributions and tax dollars. As we all know, older adults in particular underutilize psychological services, so the professional must be very savvy in how to proffer mental health interventions so that the client will not be "turned off" by perceived pejorative connotations. A typical modus operandi is to note their strengths at the outset and get them to discuss prior ways of how they managed traumatic situations. Viewing themselves as "survivors" can enhance a sense of self-esteem and encourage them not to give up.

Although I did not have the chance to work in a shelter, I suspect that there are three areas in shelters where the geropsychologist can be of great help. One, to identify and assist those older adults (particularly those with cognitive impairment) who are having difficulty in negotiating the loud and over-stimulating shelter environment, and who may need special assistance in taking medications or filling prescriptions. (continued on p. 5)

Clinical Geropsychology Exchange (continued from p. 4)
Two, to address the re-location trauma that the person may be experiencing currently in the shelter and possibly in the future if the elder needs to permanently move from a former abode.
Some of the towns in North Carolina that I visited were so devastated by the flood that it was still unclear whether they would be re-building or if everyone would be bought out by the government and have to move. Such uncertainty obviously makes it difficult to plan and de-rails the grief process. And three, perhaps more so than with the other sites, it is of great help to debrief these volunteers (who are frequently the first to arrive on a disaster scene) about their feelings regarding the trauma they have witnessed.

Another unique way that geropsychologists can be utilized is for program evaluations which assess the efficacy of mental health interventions for older adults. I was surprised to find that there is an inchoate literature on disaster mental health issues with older adults. At this time research offers no clear answer to the question whether older adults handle such stressors better or worse than younger adults, but it appears that the type and amount of the tragedy combines with the individual resources of the older adult (e.g., community vs. institutional living) to determine outcome.

Overall, my Red Cross volunteer experience was something personally valuable. Learning about the high percentage of Red Cross funds earmarked for non-administrative direct relief efforts to such deserving causes will certainly inform my charity donations. But this work is not for everyone. Since many Red Cross staff did not fully understand what mental health professionals did, we were constantly in the process of educating them. To gain the trust of the volunteers, we had to "become one of the boys" and engage in some heavy physical labor. Interventions in staff-client conflicts is a natural role for mental health professionals, but is made difficult by a complicated system that one is not very familiar with and does not know all the rules. And finally, our framework was a non-traditional community outreach model which my social worker colleagues seemed more comfortable with. However, the negatives were far out weighed by the positives of learning a new "curbside" approach to assessment and intervention where one was forced to think on one's feet. Perhaps most importantly, I was privy to the wisdom of experience that was exhibited by many of the older volunteers whom we quickly formed close bonds with and from whom I learned so much about successful aging.

For those interested in this developing field, there is an excellent new resource guide published by SAMHSA called "Psychosocial issues for older adults in disasters" from which I liberally drew for this piece. It can be ordered for free by calling toll free 800-789-2647 (invoice #SAA99-3323).

APA 1999 Student Award Winner: Can Cognitive Effects of Stroke Be Detected Within Dementia: A Mimic Model

Benjamin T. Mast, MA, Susan E. MacNeill, Ph.D., ABPP, Peter A. Lichtenberg, PhD., ABPP

In this study we incorporated MIMIC model techniques to examine cognitive deficits associated with stroke and dementia (i.e., vascular dementia). The vascular dementia construct has been the subject of controversy almost since its introduction as multiple infarct dementia (MID) by Hachinski in 1974. This controversy has intensified recently with the release of two separate neurology studies (Hulette et al, 1997; Nolan et al, 1998) which sought to examine the autopsy findings of individuals who were clinically diagnosed with vascular dementia. Both of these studies found that what was clinically diagnosed as vascular dementia was in fact better accounted for by Alzheimer's disease (AD) or mixed dementia upon autopsy. That is, these autopsy studies demonstrated that pure vascular neuropathology without coexisting AD pathology is extremely rare and thereby call into question the validity of the vascular dementia construct. The purpose of the current study was to provide a neuropsychological parallel to these autopsy studies by examining cognitive evidence for the construct validity of vascular dementia. By incorporating a structural equation modeling framework we sought to determine whether stroke has unique effects upon cognitive abilities within dementia after controlling for global cognitive impairment.

METHODS

Procedures. Figure 1 contains a graphical representation of the MIMIC model incorporated in this paper. A MIMIC model (Muthen, 1989) is a specific type of latent variable model which can simultaneously (1) test the factor structure of a group of tests, while (2) examining the influence of observed exogenous variables (e.g., stroke, age, depression) upon the latent factors (e.g., dimensions of global impairment) and (3) examine the effects of these exogenous variables upon the individual tests in the battery after controlling for group differences in global impairment. (continued on p.6)

Student Award (continued from p. 5)

The analyses in this paper occurred in two steps. First, the direct effects of stroke upon the dimensions of global cognitive impairment represented by the latent factors were estimated.

Second, group differences on individual tests were estimated after controlling for group differences in global cognitive impairment via the latent factors. Paths a, b, and c represent latent mean differences on organizational memory, attention/mental flexibility, and logical/contextual memory between two groups of dementia patients (i.e., those with clinical evidence of cerebrovascular pathology and those without clinical evidence of cerebrovascular pathology; referred to as "stroke" or "no stroke") . Path d represents the effect of stroke upon individual tests (e.g., Fuld retrieval scores in this figure) after controlling for global cognitive impairment (via the three latent factors). Path e controls for any effect of global cognitive impairment upon Fuld retrieval scores before an examination of group differences on that specific test. In this study, all tests were examined for differences between the stroke and stroke groups, after controlling for the latent variables associated with them, thereby obtaining a multidimensional control for global cognitive impairment.

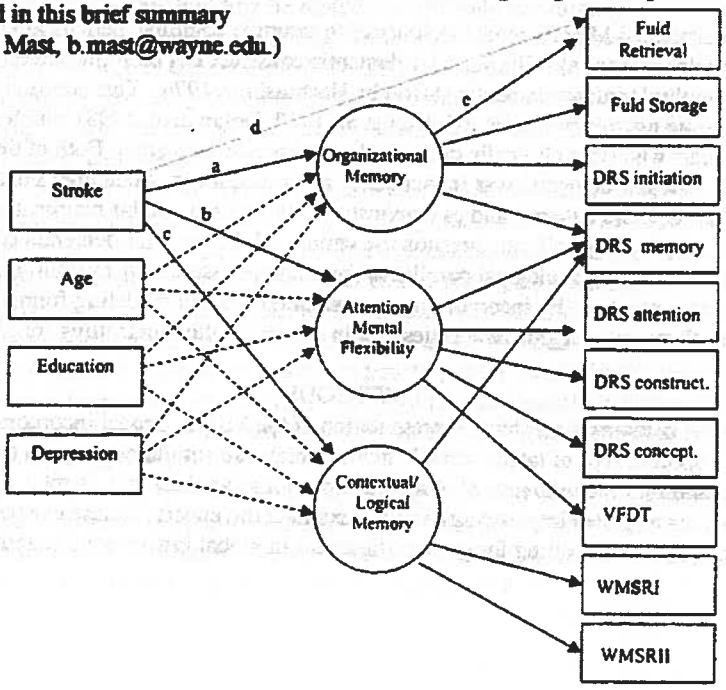
Participants: A total of 217 geriatric patients from a large urban rehabilitation hospital were included in this study. All patients met DSM-IV criteria for dementia. The mean age for the stroke (n=65) and no stroke (n=152) groups were 78.4 and 79.9 years respectively ($t = 1.31$ (214), $p = .193$). There were no significant differences in the level of formal education between the two groups (8.6 years in stroke groups vs. 9.2 years in no stroke groups; $t = 1.01$ (215), $p = .314$). In addition, there were no differences by race (chi-square = 1.21 (1), $p = .270$), or gender (chi-square = 3.50 (1), $p = .06$).

Measures: The assessment instruments used were cognitive measures from the Normative Studies Research Project (NSRP) test battery (Lichtenberg, Ross, Vangel, & Youngblade, 1998; Lichtenberg, 1998). They included the Fuld Object Memory Evaluation (Fuld, 1977), the Mattis Dementia Rating Scale (Mattis, 1988), the Visual Form Discrimination Task (Benton et al, 1983), and the Logical Memory subtests (immediate and delayed) of the Wechsler Memory Scale – Revised (Wechsler, 1987).

RESULTS / DISCUSSION

In this study, stroke was not significantly associated with any of the latent factors pictured in Figure 1 (i.e., attention/mental flexibility, organizational memory, or contextual/logical memory). In addition, stroke was not significantly associated with nine of ten individual tests. Only the DRS memory subscale showed a small, yet significant relationship with stroke. The goal of this study was to provide a psychometric parallel to the neurology studies investigating evidence for vascular dementia. The neurology studies described above (Hulette et al, 1997; Nolan et al, 1998) found that little evidence for pure vascular dementia existed upon autopsy. The findings of the current study are largely consistent with the findings in the neurology literature, but are unique in that psychometric data were used. The current study suggests that for the most part unique, independent effects of stroke upon cognitive abilities could not be detected in dementia syndrome. Therefore, from a neuropsychological perspective, these data do not provide support for the construct validity of vascular dementia.

In addition, this study demonstrates a flexible methodology which can be incorporated into geropsychological assessment research or other areas of assessment research in which controlling for global impairment or functioning is warranted. (References listed in this brief summary are available from Benjamin Mast, b.mast@wayne.edu.)



National Coalition for Mental Health and Aging Conference November 15, 1999

Jiska Cohen-Mansfield, Ph.D.

The National Coalition on Mental Health and Aging Special Conference was devoted to identifying existing and emerging challenges to the delivery of quality mental health care for elder persons, and to formulate recommendations and develop innovative ways to meet these challenges in the new millennium. The Coalition considered the 1995 White House Conference on Aging resolution on mental health and aging in light of current issues and best practices.

Review of the Relevant Recommendations of the 1995 White House Conference on Aging Conference, Margaret Gatz, Ph.D. University of Southern California, Dept. of Psychology.

· Themes which were important in the mini-conference but did not receive as much attention as they should include the following: consumer involvement, outreach, ethnicity and culture, and prevention.

· There is a need for public education regarding suicide in old age, because this is where suicide is most prevalent. Dorfman - outreach for depression can be effective.

· People's life conceptions reflect their life experiences. Rates of mental disorders may be higher in those born after WWII. It is not clear if this is true for late-life disorders. People have become more accustomed to seeing mental health specialists.

· Future issues include: diversity, evidence based practice, genetics, health and behavior - exercise, pain management, sleep hygiene, and proliferation of guidelines and consensus statements.

Presentations on the Issues Addressed in the Recommendations

Interventions to Improve Access to Mental Health Care, Laura Trejo, MSG, MPA Coordinator, Countywide Older Adult Services, Los Angeles County Department of Mental Health.

There is a need for affordability to consumers and to the system, along with comprehensiveness of services. Frail and isolated older adults are usually inappropriately served, getting only one piece of the services they require. Many practice guidelines have not reached the practitioners in the field. These have to be presented in a short format with applicable language in order to be accessible to the practitioners. Basic issues, such as checking for sensory loss are missing and cause misdiagnosis and treatment. A geriatric screening protocol was developed and is used universally before any advise is provided. Professionals are extremely ignorant in working with the elderly and resistant to learning new materials. We need to share the vision of why this is important. We need to educate the public about the wisdom of investing in services for the elderly.

The Hartford Model of Professional Training, Christopher Langston, Ph.D., Program Officer, John A. Hartford Foundation.

Mandate: increase access to cars for the elderly. Need to consider the whole person. Fragmentation is a major problem. Most of the past work of the Hartford foundation was in training of geriatric physicians. There is a shortage of geriatrically competent faculty. The Hartford Foundation helped in providing faculty with mid-career retraining. However, the pool of such competent persons was exhausted rather quickly. Another project supported persons such as residents, junior faculty and fellows in working in geriatrics. Given the current realities of the number of available geriatric specialists, it seems that these specialists will not provide all the needed services, but will lead and train others who will actually provide the services. New geriatric training programs include CD ROM's with basic information on curricula and best practices. The Foundation is working on geriatric retreats for physicians from internal medicine together with psychiatrists and geriatric interdisciplinary teams training in various universities and medical centers. Small groups and interactive learning is the most effective method for teaching for these faculty members. The Hartford Foundation has also funded geriatric nursing studies. Most recently they have started working with social work. They awarded a grant to the council on social work education, as well as grants to promote social work specialists and promote geriatric/social field work. They have funded five sites of project "Impact" for treating depression. The basic underlying idea is that of integrating the continuum of care between the home, office, hospital/emergency room, and nursing home. (Continues on p. 8)

Conference (Continued from p.7)

Involving Consumers, Caregivers and Families in Planning for Services, Lissa Abrams, Assistant Director, Adult Services Division, Maryland Mental Hygiene Administration.

Components of services developed: Network development, payment authorization and service utilization, data collection, evaluation of the public mental health system (including consumer satisfaction), developing incentives to those who provide services to the elderly, discharge of elderly patients from state mental health hospitals to nursing homes with the aid of a geriatric mental health constant, elder options - community mental health program, rehabilitation, residential, treatment, medical day care, for individuals with severe mental illness in their homes (Many were able to return to live in their community.), senior mental health counseling program where managers are placed in senior housing buildings (When people are identified, they are able to direct them to services.), aging caregivers: planning for the future of caregivers who are aging.

From Research to Practice, Barry D. Lebowitz, Ph.D., Chief, Adult and Geriatric Treatment and Preventive Intervention Research Branch, National Institute of Mental Health.

During the past 10 years, the people in the aging field moved from being the consumers of knowledge to being the produces of knowledge, from importers to exporters of concepts, theories and methods, and from peripheral to central roles in science, policy, practice. Issues such as comorbidity are now accepted in other fields. Research centers are proliferating. Emerging issues include: Genetic medicine, biology of brain diseases, new approaches to pathogenesis, advanced instrumentation and computers, new strategies for prevention, and new avenues for development of therapeutics. Emphases for FY 2000: exploiting genomic discoveries, interdisciplinary research, reinvigoration of clinical research, and elimination of health disparities. Challenges for the future: Eroding academic research infrastructure, distorted research career pipeline, growing public ambivalence, and over-reliance on public funding sources.

Substance Abuse and Mental Health, Jennifer Fiedelholtz, Public Health Analyst, Older Adult Issues Coordinator, Office of Policy and Program Coordination, Substance Abuse and Mental Health Services Administration.

An estimated 2.5 million older adults have alcohol related problems (Schoenfield et al., 1995). Whereas there is some acknowledgment of the relationship between substance abuse and mental health problems, most projects deal with one or another. Substance abuse interacts with the multiple medications taken in late life, and with the problems related to declining health and limited resources. Policy issues related to substance abuse tend to get attention only when directed towards young adults. We need to use the available systems of medical care and aging services and increase sensitivity, screening and detection of problems related to substance abuse in the elderly, and then develop the services and interventions to handle the identified problems.

Alice P. McNeill, Assistant Vice President, National Council on the Aging.

NCOA is trying to build a Vital Aging Network, which will connect senior centers, adult day care centers and other community based organizations around the country to exchange information and program ideas electronically. The network will be used to promote awareness of issues and building services to address them.

Integrating Primary Care with Behavioral Health Care, Christopher Colenda, M.D., Chair, Department of Psychiatry, Michigan State University and Chair, American Psychiatric Association's Council on Aging.

Primary care is where most of the mental health problems are seen in the elderly. Linkages between mental health and medical delivery models, inter-related health problems, need to increase detection, need to increase prevention, and need to decrease stigma. In a study by Morgan (1999), of the 56% recommended for psychiatric treatment, 61% dropped out of treatment and did not find treatment helpful. 53% of primary care physicians were confident they could evaluate depression and close to all could prescribe an antidepressive. About half felt that a psychiatric consultation was helpful, but only 11% routinely referred to a psychiatric consultation. Primary care physicians under treat depression.

Aging, Mental Health/Substance Abuse and Primary Care: The Collaborative Study of SAMHSA, VA, HRSA & HCFA. Overview: Paul Wohlford, Ph.D., Program Director for Aging/PC, Center for Mental Health Services (CMHS) SAMHSA

Most mental health services for older adults occur in primary care settings rather than in specialized mental health settings. (Continues on p. 9)

Conference (continued from p. 8)

This was the basis for the study undertaken by the Center for Mental Health Services (CMHS) in SAMHSA to compare the carve in (integrated model) and the carve out (referral) methods of providing mental health services. It is a cooperative agreement. CMHS has also been instrumental in developing a consumers organization for elderly persons who suffer from mental health problems.

Jeanette Takamura, Ph.D., Assistant Secretary for Administration on Aging, Department of Health and Human Services

A major issue is where service providers will be found for the growing older population. A larger proportion of older adults will be minorities with special needs, such as language barriers. There are issues regarding reimbursement and access to services. Frequently it is not only the older person who is suffering, but his/her whole family. Even though older adults see physicians more often than any other segment of the population, depression frequently goes undetected. Suicide rates are also highest in this population. There is a need to plan for a life-course, including appropriate housing, community involvement, access to services, activities in retirement, etc.

Development of Action Items, Nancy Coleman, MSW, Director, Commission on Legal Problems of the Elderly, American Bar Association - Facilitator

Topics for action plans included the following: research, prevention, PR, financing and reimbursement, coalition building, strategy on looking at the surgeon general report, multi-disciplinary work, and consumers and families. Educate to change attitudes and behaviors: use social marketing/pr., focus groups, use older adult celebrity as spokesperson, establish common lexicon, state value of older person, educate older adults about what to expect from mental health service providers, normal aging vs. mental illness, use elderly as consumer advocates, grassroots education, and technology. Prevention: We need to develop and test models of primary, secondary, and tertiary prevention using a variety of approaches which recognize that different strategies will work with different sub-populations (i.e., ethnicity, culture, language, gender, disability, rural/urban, sexual orientation, caregivers, etc.) We must develop funding mechanisms for these prevention programs. Education: PACE as an educational model, CE requirements for those getting Medicare reimbursement, aging/MH curriculum requirement for all professional students, need for interdisciplinary competencies, use needs assessment in designing continuing education programs, identify good models for education, how to use consumers in education, develop fundable strategies for aging/MH in education, and how to reach to groups and professionals for education. Surgeon General's report: Review report, find out who has reviewed; coalition to review for integration of older adults issues throughout report; assess action steps, if any and develop additional steps, and capitalize on it. Send letter to Secretary on Health. Funding: better blending of Medicare and Medicaid, major federal initiative to meet the needs of older adults based on best practices, prescription benefits, benefits need to go beyond current care, need cost analysis, and greater accountability to HCFA of carriers. Research: promote research agenda concerned with clinical intervention and services (research that takes a public health approach), promote a research agenda to examine health behaviors related to mental health issues, develop a cadre of well trained researchers to meet the current and future needs of an aging population, and a coalition to take shared leadership in disseminating mental health research findings. Coalitions: Continue to build coalitions by training and expanding to additional states and local communities. Study impact of coalitions. Disseminate information through net, conferences, and meetings. Support older adult mental health consumer self advocacy. Link national, state, and local coalitions.

Notes for the conference - Jiska Cohen-Mansfield, based on comments by: Brian Carpenter, Deb Frazer, Margie Norris, Mick Smyer, and Nicholas C. Stilwell

Problems in delivery of mental health services to older persons

· 50% copay for outpatient mental health services effectively makes mental health services unavailable to many older adults who are on a limited fixed income.

· Many Medicare carriers do not pay for any psychological services if a person has a diagnosis of dementia, an overly restrictive and inappropriate limitation. Many reimbursement agencies balk at the idea that a "talk therapy" can be useful for someone with dementia. Certainly in cases of mild impairment, and even in cases of moderate impairment, I have seen clear benefits for patients who receive psychotherapy, even if it is brief. Even given limitations in memory, patients can obtain lasting benefit at an emotional, perhaps mostly implicit level. (continues on p. 10)

Conference (continued from p. 9)

Having a trained professional who is knowledgeable about dementia and emotional disorders work with an older adult can bring improvements in emotional and behavioral stability.

· Poor reimbursement policies for work that mental health professionals do that is not directly face-to-face with patients. Consulting with institutional staff and family members, providing training, establishing and monitoring behavioral interventions, reviewing charts, preparing environmental aids -- these are tasks we cannot bill for because they are often not done in the presence of the patient, even though the aim of these tasks is to benefit the patient. With patients who have significant cognitive impairment, some of the most effective mental health interventions focus on the environment and people around them, yet those interventions are different from traditional, face-to-face psychotherapy.

· The low level of training and expertise of people who make reimbursement decisions. Often the decision about whether to pay for a service is made by someone with little training in psychotherapy and perhaps little awareness of the research and clinical literature in geriatrics and gerontology. Providers should feel confident that the people who make decisions about what to pay for are knowledgeable.

· Lack of services for mentally ill nursing home residents, where there are large behavioral health needs. This is related to the next point:

· Managed mental health care is a disaster in nursing homes - the big companies (Magellan, etc.) are not prepared to do on-site service, and the local facilities often contract with providers who are not on, and cannot get on, the HMO panels. The "Evercare" type model tends to deny access to psychological services. Behavioral management is a huge one in these facilities, and the MH providers are not reimbursed for it. Also, Managed care companies or the mental health carve out agencies are making it increasingly difficult to provide mental health services to Medicare patients. In long-term care in our area the carve out is an organization that does not provide services in facilities and does not have geropsychologists on panel. When a patient in a facility is referred the carve out will not provide out of network coverage and they may be able to send in a psychiatrist on panel to do an evaluation but they will not pay for therapy services in the nursing home provided by geropsychologists. Many panels are closed and do not have persons trained in geropsychology. The carve out is shortchanging patients in order to save immediate costs, though long term costs may be increased because of excess disability associated with lack of treatment.

· Managed care Medicare (Senior Blue BC-BS) does not pay for neuropsychological evaluation, which can be critical for determination of appropriate level of care. CT scans do not show a high correlation with cognitive impairment across the range of dementias yet they cost more and would most likely be reimbursed by the insurance company.

· There is no system providing appropriate services to the elderly chronically mentally ill. Many are finding their way into dementia special care units, where the staff are totally unprepared for them. They are often denied access, because staff are afraid of taking them on, without appropriate staff training, ratios, and MH professional team leadership or even back-up. These are the people who used to live out their lives in state hospitals, but have been de-institutionalized into the community, and are now becoming elderly.

· Lack of information about less-regulated settings (e.g., assisted living settings and low income housing projects) where the mental health needs may be substantial.

Other changes in mental health and aging:

· Growing importance of decision-making capacity assessment and interventions at the intersection of clinical practice and legal jurisdiction

· Increased intervention research in dementia and in the nursing home. However, most of this research is still preliminary, and is not translatable to practice, because of the complexity of this population and its caregivers. We still do not know how to address seemingly simple issues in the frail elderly. There is need for much knowledge on the individual, group, and system levels.

· Insufficient work on mental health prevention work in the elderly.

Postdoctoral Training In Clinical Geropsychology in the VA System

Antonette Zeiss, Ph.D., VA Palo Alto Health Care System

The Department of Veterans Affairs has been an important source of post-doctoral training in Clinical Geropsychology. Last year, all existing sites had to re-apply in order to remain training sites; successful sites were awarded two postdoctoral slots. Previously, there were ten sites, each with one Clinical Geropsychology Postdoctoral slot. In the latest VA application process, sites were free to designate whatever training emphasis they chose. The table below shows the current situation for Clinical Geropsychology post-doctoral training; sites that list more than one emphasis generally have one slot for each of the emphases. Thus, there now are six sites with at least one clearly designated Geropsychology Postdoctoral position, with a total of eight slots. Other VAs (not shown in the table) were awarded postdoctoral positions, but the table shows only VAs with Geropsychology slots. Some of the other VAs do offer related training, such as in Health Psychology or Neuropsychology. The stipend for the postdocs at VA sites is now set at $37,000 per year.

It is not clear why the number of slots dedicated to Clinical Geropsychology decreased. There was no decision to reduce support for Geropsychology at the national level; in fact, geriatric care remains a national priority for VA health service delivery and for training. Some sites that previously had Geropsychology postdocs did not submit applications this time around; others may not have successfully competed.

All VAs that were awarded postdocs must obtain APA accreditation for the postdocs within two years. If any do not make it through the accreditation process, there probably will be another round of applications invited in order to redistribute the slots from those sites. Also, if additional training money becomes available for other reasons, those funds might be used to generate more postdoctoral slots rather than internship slots.

As this process proceeds, I encourage any of you who work in VAs or who work with nearby VA sites to consider opportunities you could provide for Clinical Geropsychology Post-doctoral training. When and if another round of invitations to submit proposals is sent out, it would be nice to see some additional strong Geropsychology proposals. There generally is not a lot of time to develop a proposal after the Request for Submissions goes out from VA headquarters, so it's nice to have done some planning ahead of time. I would be happy to work with anyone who wants to lay the groundwork for submitting a proposal, and I'm sure that others on the list of Training Directors in the table below also would be glad to provide advice and guidance.

Table 1 Current VA sites offering Postdoctoral training in Clinical Geropsychology

Location	Director of Training	E-mail Address of Director of Training	Area(s) of Emphasis
Brockton, MA	Michele Karel, Ph.D.	Karel@Boston.va.gov	Geropsychology
Houston, TX	Victor Molinari, Ph.D.	Molinari.Victor@Houston.va.gov	Geropsychology, Substance Abuse/Dual Diagnosis
Milwaukee, WI	James Hart, Ph.D.	Hart.James_D@Milwaukee.va.gov	Geropsychology, Rehabilitation of Seriously Mentally Ill
Palo Alto, CA	Antonette Zeiss, Ph.D.	Antonette.Zeiss@med.va.gov	Geropsychology, Health Psychology
Pittsburgh, PA *	Bernadette Lauber, Ph.D.	Bernadette.Lauber@med.va.gov	Geropsychology
San Antonio, TX	Stephen Holliday, Ph.D., ABPP	Stephen.Holliday@med.va.gov	Geropsychology, Health Psychology, Neuropsychology in collaboration with university

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** Technically the chair of the Program Committee is linked to Board Offices that change on Jan 1. Practice has been for the Program Committee chair to serve from annual meeting to annual meeting of APA.

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- Stay connected with your colleagues in clinical geropsychology by joining our **e-mail network**. Simply send an e-mail to Barry Edelstein at u21b4@wvnet.edu (Be sure to include your name, e-mail address, and express your interest in joining the 12/2 e-mail network).
- Division 12, Section 2 has a **web-site**. Check it out at http://bama.ua.edu/~appgero/apadiv12.htm.
- Encourage your colleagues and students to **join Division 12, Section 2**. Contact Michele J. Karel, Ph.D., Psychology Service, 3-5-C, Brockton VAMC, 940 Belmont Street, Brockton, MA 02301; e-mail: Michele.Karel@med.va.gov; or phone: (508) 583-4500, ext. 3725 regarding membership.

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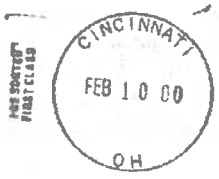

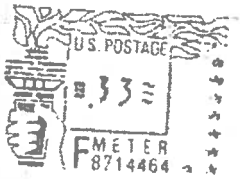

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