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Susan V. Ponchillia, Ed.D., CVRT, *professor, Department of Blindness and Low Vision Studies, Western Michigan University, 1903 West Michigan Avenue, Mail Stop 5218, Kalamazoo, MI 49008; e-mail: <susan.ponchillia@wmich.edu>.*

Adequacy of the Mental Health System in Meeting the Needs of Adults Who Are Visually Impaired

Amy Horowitz and Joann P. Reinhardt

Although depression is not an inevitable consequence of vision impairment, it is a common mental health problem among adults who are visually impaired. A recent study showed that 7% of applicants for vision rehabilitation services who were age 65 and older met the diagnostic criteria for a major depressive disorder, and another 27% had subthreshold depression (Horowitz, Reinhardt, & Kennedy, 2005). These rates are higher than those found among the general population of community-dwelling older adults, and similar to those for older adults who are medically ill. Additional evidence indicates that the prevalence of mental health problems may be even higher in young and middle-aged adults with adventitious vision loss, with 40–45% having clinically significant depressive symptomatology, and 20% exhibiting moderate to severe anxiety symptoms (Brennan & Cardinali, 2000; Cimarolli, in press).

The consequences of depression for adults with visual impairments are far-reaching. Depression, in general, is associated with greater functional disability, morbidity, and mortality among middle-aged and older adults. Furthermore, adults with comorbid vision loss and depression are less likely to seek, be referred to, or use vision rehabilitation services; and those who do seek care tend to receive less service compared to those who are not depressed. Not surprisingly, depression is also associated with poorer rehabilitation outcomes. Given these consequences, access to the services of the mental health system and the integration of mental health services into the vision rehabilitation system clearly represent high priorities in the organization of services for people with vision impairments. Yet, there remain extensive gaps in services and widespread unmet mental health needs among people who are visually impaired.

The mental health service system

The organization, structure, and funding of the mental health service system in the United States is intergovernmental, involving federal, state, and local units. Yet, overall, there is little disagreement that funding is meager and services inadequate to the need. The primary mechanism for funding mental health services is through the federal government's block grants to the individual states for community mental health centers. These centers are mandated to provide comprehensive, community-based mental health services to all residents within specific catchment areas. However, because block grants are based on the assumption that states have unique needs, there is no common set of mandated services; each state ultimately establishes its own approach. Unfortunately, because resources have been so limited, many community mental health centers cannot provide genuinely comprehensive services, and many have targeted available resources to populations of greatest need, such as people with persistent, severe mental illness (Cummings & Cassie, 2006).

Medicare and Medicaid also provide funding for mental health services, with Medicare primarily serving older adults, and Medicaid programs targeted to individuals in financial need. The policies of both programs, however, have consistently restricted coverage for mental health services in comparison to general medical care. Although parity of coverage of these programs—as well as that of private insurance plans (which often follow the policies

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of these federal programs) has been the target of mental health advocates over the past two decades, disparities between coverage for mental health and physical health programs persist. For example, when comparing mental health care to physical health care, there are higher co-payments (50% versus 20%), higher deductibles, restrictions on the number of visits to a therapist and days in a hospital for mental health treatment, and annual caps on benefits. In fact, less than 1% of all Medicare expenditures are for mental health services. Another provider of mental health services is the Department of Veterans Affairs, which supports a network of mental health services for which there is increasing demand from a growing middle-aged and older population.

Given these limited, and often fragmented, service systems and funding streams, it is not surprising that there are large numbers of people who are not treated for mental disorders. For example, it is estimated that only one-third of older Amercians who need mental health services actually receive them. Lack of resources is not the only reason why older people do not receive mental health care. Some individuals are reluctant to make use of mental health services, and this is especially true for the current cohort of older adults, for whom the stigma of mental illness and mental health treatment persists. Thus, as a function of both the limitations of the mental health system and the hesitancy of people to access specialized mental health treatments, most mental health services—including the prescription of psychotropic medications for depression and anxiety disorders and the provision of brief psychotherapeutic interventions and cognitive behavioral therapies—are actually delivered in the primary care system.

However, a major problem remains for people with visual impairments, whether in the primary care or the mental health system. Many mental health and primary care professionals hold stereotypes about vision loss that lead them to assume that a person's psychological problems stem from vision impairment, when that is not necessarily the case. Feeling incapable or unwilling to address mental health issues that may be confounded by the visual disability, they often refer the individuals to the vision rehabilitation system. The latter, however, does not necessarily have the resources or expertise to address clinical depressive syndromes.

Mental health services in the vision rehabilitation system

Many vision rehabilitation agencies, especially those in smaller communities, simply do not have sufficient numbers of trained staff members (for example, licensed clinical social workers, psychologists) to provide the level of mental health care required by individuals in vision rehabilitation programs with comorbid depression and anxiety disorders. These agencies also face the same problems with lack of funds for reimbursement for mental health services that plague the mental health service system.

Philosophical differences may also serve as barriers to the provision of mental health services: Some rehabilitation professionals may adhere to the belief that services that address and reduce the disability associated with an individual's vision loss will ultimately address the mood disorder. Although this may be true in some cases, it will not be a sufficient course of treatment for most others. Depression and anxiety disorders are diseases, and need to be addressed as such. They are also diseases that can be treated successfully, as is suggested by growing evidence of the effectiveness of psychopharmacological and psychotherapeutic interventions.

Vision rehabilitation professionals should be aware of the prevalence and consequences of mental health problems experienced by people with visual impairments. Professionals in this field can play a key role in identifying individuals who require mental health treatment. Screening tools such as the Patient

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Health Questionnaire Nine-Item Depression Module and the Beck Anxiety Inventory (1990) have been shown to be useful for this purpose. Instructions for these tools identify scores that indicate significant symptomatology that can then trigger the need to schedule a follow-up appointment with a mental health specialist for diagnosis and treatment. Establishing linkages with mental health service organizations and professionals, and making timely referrals for mental health services can be critical in ensuring a comprehensive rehabilitation program.

There is also an emerging body of literature that recognizes and addresses depression and its functional consequences in older adults with vision impairments. For example, Brody and colleagues (2002) have conducted a randomized clinical trial to improve mood and function among adults with age-related macular degeneration. Findings showed significant declines in psychological distress, increased self-efficacy and functional ability, and increased use of vision aids. Cognitive behavioral strategies have also been useful in affecting control of blood glucose levels in adults with diabetic retinopathy (Trozzolino, Thompson, Tansman, & Azen, 2003), and in preventing negative affect, reducing depressed mood, and increasing activities of daily living function among adults with age-related eye disease in an ophthalmological practice (Birk et al., 2004). Interestingly, some vision rehabilitation agencies are obtaining licenses as mental health clinics under Medicaid to provide these services and cover them financially. Thus, the importance of treating depression in the vision rehabilitation setting is being recognized. Still, there is a need for more controlled studies of intervention models specific to people with vision impairment and documented depressive and anxiety disorders. It is important, as well, that professionals in the fields of vision rehabilitation and mental health work with each other to provide cross-training that can facilitate more integrated treatment.

In sum, effective means for assessing and treating depression and anxiety disorders are available, yet policy initiatives and funding streams of the mental health and vision rehabilitation systems are needed to ensure access to treatment, provide sufficiently trained professionals, and stimulate further research in this area. There is a shortage of mental health professionals who have training that would sensitize them to the needs of adults who are visually impaired, as well as a shortage of professionals in the vision rehabilitation system with mental health training. Acceptance of mental health treatment as an integral part of a comprehensive rehabilitation service package for adults with vision loss represents the foundation upon which service structures need to be built.

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Amy Horowitz, DSW, Ph.D., *director of research, Jewish Home and Hospital Life Care System, 120 West 106th Street, New York, NY 10025, and Anna A. Greenwall Professor of Geriatrics and Adult Development at Mt. Sinai School of Medicine; e-mail: <ahorowitz@jhha.org>.* ***Joann P. Reinhardt, Ph.D.,*** *associate director of research, Jewish Home and Hospital Life Care System; e-mail: <jreinhardt@jhha.org>.*

The Complexities and Connectedness of the Public Health and Aging Networks

Alberta L. Orr, Priscilla Rogers, and Judy Scott

With the United States on the brink of a longevity revolution, phrases such as “healthy aging” and “successful aging” represent the growing need for greater collaboration between the public health and aging networks. Since both public health and aging have a nationally coordinated state-based structure, it is especially relevant to look for collaboration at the state level. The field of vision rehabilitation must become part of this collaboration, but faces a challenge in this regard because public health has not been among the field’s “natural” partners. This article will touch on both the problems and the opportunities presented by this challenge to the field of vision rehabilitation to interact and join forces with colleagues in public health.

According to a document produced in 2006 by the Administration on Aging of the Department of Health and Human Services, the gain in life expectancy in the United States during the 20th century poses a public health challenge to improve the quality of life for individuals who are living longer lives than ever before. The number of adults aged 65 years and older is expected to increase to over 70 million by 2030, which will place greater demands on the public health system and on medical and social services (Administration on Aging, 2006). Almost one-third of health care expenditures in the United States, or $300 billion each year, is currently spent on adults aged 65 years and older (Administration on Aging, 2006). Without greater emphasis on disease prevention, health care spending is expected to increase 25% by 2030 because of the growing number of older adults in the United States (Administration on Aging, 2006).

Two separate networks—public health and aging services—share similar goals in addressing the health needs of older Americans, but they reach the older population through different mechanisms. The Centers for Disease Control and Prevention has supported state health departments as counterparts to the aging network’s state units on aging, but historically they have rarely collaborated.

The national aging network comprises the Administration on Aging, which supports a comprehensive network of state units and over 650 area agencies on aging at the local level. The area agencies exist in virtually every community in the United States. The state aging network implements health promotion and disease prevention programs and provides a range of nutrition and supportive services for older people—including congregate and home-delivered meals, transportation, counseling, adult day care, elder abuse prevention—that are designed to promote independent living in the community. Many older people

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