

Insuring that individuals with Alzheimer's disease & other dementias who have co-occurring mental health needs receive appropriate mental health care

By Janet Yang

Many persons have both Alzheimer's disease AND mental illness (e.g., Depression, Anxiety, PTSD, Psychosis, Schizophrenia, Behavioral problems, Bipolar Disorder). While mental health insurance benefits do not reimburse for treating Alzheimer's disease itself, which is considered a medical illness according to Medicare and Medi Cal, mental health providers can get reimbursed for treating mental illness in a person with Alzheimer's disease (and other dementias). Given that insurances do not reimburse mental health providers for treating the Alzheimer's disease directly, mental health providers have historically determined that they cannot get paid when they are treating persons with Alzheimer's disease.

Providing mental health services (including individual psychotherapy, family therapy, group therapy, psychotropic medications, mental health case management, psychiatric emergency response & hospitalization) to persons with dementia can help treat and/or decrease the symptoms of the mental illness (such as depression, anxiety, agitation, psychosis, aggression) and also reduce the behavioral problems which are associated with the mental health symptoms.

California State Bill 639 (2001) called for a report to be researched & written to document how to "Improve access to mental health services for persons with Alzheimer's disease and related disorders." The report, issued in 2003, ([https://www.aging.ca.gov/AboutCDA/Publications/Docs/SB639\\_final.pdf](https://www.aging.ca.gov/AboutCDA/Publications/Docs/SB639_final.pdf)) stated that "An individual with dementia would not be excluded from receiving mental health services as long as he or she also meet medical necessity criteria for medically necessary mental health services." Meeting medical necessity includes meeting criteria of a reimbursable mental illness and treatment being expected to significantly diminish the impairment or prevent significant deterioration in an important area of life functioning.

Confusion often exists about the term "primary diagnosis" and "principal diagnosis." In order to be reimbursed for mental health services, the patient must have a principal diagnosis of mental illness, other than the dementia. However, many mental health professionals believe that the patient must have a non-dementia diagnosis as the "primary" diagnosis, which they often understand to be the disease which is the primary cause of the behavior. However, the term "principal diagnosis" actually means the condition being treated at that visit, not the primary cause of the symptoms.

Historically, the mental health field has hesitated or outright refused to treat persons with Alzheimer's disease and other dementias. This may be related to

- funding divisions between the medical health field and the mental health field
- a belief amongst mental health providers that Medi Cal & Medicare won't reimburse on mental health claims if the patient has dementia
- budget short falls leading to reducing funding for caring for persons with dementia

- lack of training in how to help a person with dementia and mental health needs
- stigma
- an erroneous belief that mental health interventions can't be effective in people with dementia

This leads to a number of problems:

1. Persons with AD & other dementias do not receive the medication, psychotherapy, mental health case management, psychiatric hospitalization, and emergency response they could benefit from. This contributes to excess human suffering, including depression, anxiety, agitation, psychosis, etc., in both the dementia patient and their caregivers.
2. Persons with dementia's functioning declines due to exacerbation of their mental illness leading to decline in functioning, increase in behavioral disturbances, quickened caregiver burn-out, increase in use of hospitalization, emergency room use, paramedics and skilled nursing facility placement. This in turn leads to increased expense for the larger institutional systems.
3. No publically funded help being made available to low income persons with dementia, thus leaving many people in the community without help.

Problematic issues which could be addressed:

- Education of mental health professionals as to the rights of persons with dementia to receive mental health services, and the meaning of the term "principal diagnosis"
- Training of mental health professionals on how to provide effective mental health treatment for persons with dementia and co-occurring mental illness.
- Addressing the separation of streams of funding between Alzheimer's disease within the medical health field versus mental health issues within the mental health field.
- Improving financing of services for persons with co-occurring dementia and mental illness – in both streams of services which lead to punting to the other side whenever possible.
- Funding stream issues related to crisis services for persons with dementia – how to find intervention for the Alzheimer's patient in a psychotic crisis.
- Legal issues related to conservatorship, including Probate versus LPS conservatorship, and Public Guardian.

Persons to consider inviting to a committee meeting:

- Someone from California Mental Health Directors Association (CMHDA)
- Dr. Rod Shaner, Medical Director at Los Angeles Dept. of Mental Health
- Cordula Dick Muehlke, Ph.D. Clinical Psychologist and Dementia Care expert
- Laura Trejo, MSG, Gerontologist
- Someone from UCSD Dept. of psychiatry
- Someone from CCCMHA (California Council of Community Mental Health Agencies)

- Karen Baylor