LIVING LONGER, BUT FOR WHAT? LEGAL NEGLECT OF COGNITIVE TREATMENTS

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The richness of later life is threatened by the subtle cognitive defects and more serious mental disorders that can come with age. Nontraditional therapy programs, such as art and music therapies, may have the potential to curb or cure these mental ailments where such programs are available. In this Note, John R. Schleppenbach discusses the effectiveness of such therapies in helping older people maintain or regenerate cognitive ability. Mr. Schleppenbach explores the private availability of such treatments, as well as their potential for coverage under Medicare. Rather than recommend increased coverage of these treatments, he suggests increased education on the issue of cognitive loss among the elderly and continued exploration of music and art therapy. Further, Mr. Schleppenbach encourages all people to take an active role in maintaining their cognitive ability through active pursuit of cognitive exercise.

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I. Introduction

Americans today are living longer than ever before, and the implications are not necessarily as rosy as one might think. For years the trend has been a steady increase in life expectancy,[1] with Americans born in the year 2000 able to anticipate a life span of 76.9 years.[2] The 2000 census showed more Americans over age 100 than ever before,[3] and today those individuals sixty-five or older make up thirteen percent of the U.S. population.[4] These trends are only expected to increase, as medical advances and senior awareness of good health practices continue to grow.[5] However, along with these seemingly positive statistics have come some more disturbing ones that have perhaps been overlooked. Despite medical advances, most elderly Americans suffer from chronic conditions, such as hypertension, heart disease, and arthritis, which do not have effective cures.[6] The number of older Americans with disabilities has actually increased during the 1990s,[7] and most Americans are now dying from age-related diseases such as Alzheimer's, influenza, pneumonia, kidney disease, hypertension, and septicemia.[8] Alzheimer's disease in particular is ballooning at such a rate that doctors fear more than twenty-two million people worldwide will be affected in the next twenty-five years.[9] So the gift of longevity that

1. Sheryl Stolberg, *U.S. Life Expectancy Hits New High,* N.Y. TIMES, Sept. 11, 1997, at A14. Writing with regard to statistics from 1996, Stolberg analyzes many of the factors that have contributed to increasing life expectancy, including improvements in disease detection, treatment, and prevention. *Id.*

2. Marlene Cimons, *Life Expectancy Has Risen in U.S., Health Experts Say*, L.A. TIMES, Oct. 11, 2001, at A30. In contrast, a person born in 1900 could expect a life span of only forty-seven years. *Id.*

3. *ABC News: World News Now* (ABC television broadcast, Oct. 3, 2001). There were some 50,454 Americans over 100 in the last census, up thirty-five percent from 1990. *Id.*

4. Gerda Gallop-Goodman, *The New Way to Age*, 20 FORECAST (2000), 2000 WL 18270428, at *1.

5. *See* Cimons, *supra* note 2; *see also* Gallop-Goodman, *supra* note 4 (predicting that by 2030, those sixty-five or older will make up twenty percent of the population).

6. Gallop-Goodman, *supra* note 4. On a positive note, this study also found that the elderly today are overall "smarter, richer, more diverse, and healthier [presumably speaking in terms of large-scale illness] than ever." *Id.*

7. *Id.*

8. Cimons, *supra* note 2.

9. Associated Press, *Scientists Search for Alzheimer's Earlier Symptoms—There Is Urgency in the Task: Disease Is Becoming Epidemic*, MINNEAPOLIS–ST. PAUL STAR TRIB., July 10, 2000, at A1. Today, about four million Americans and twelve million people worldwide are afflicted with Alzheimer's. *Id.* Often its early stages are

citizens have received is not a gift that comes without price or complication. Our long American lives may end up beset with disease and discomfort.

Beyond these more alarming statistics, however, lies a problem perhaps more subtle if even more pervasive. Deprived of social interaction and freedom of mobility, many senior citizens begin to suffer from declines in cognitive abilities.[10] About fifteen percent suffer from depression.[11] Agitation and behavioral disorders also become greater issues for older people.[12] More than anything, however, aging adults suffer from what we consider to be "ordinary" losses in memory, attention, and spatial skills that impair their abilities to engage in their ordinary, everyday activities.[13] Moreover, these losses are considered so common that most people who suffer from them do not even notice them.[14] The stereotype of the elderly as fragile and idle is well-ingrained in our society, but it is frightening to think that this stereotype may be slowly becoming reality.

Happily, there are many treatments available that specially target these "natural" losses. For years, therapists and researchers have used cognitive therapies to help alleviate losses in mental capacity of the type that often lead to idleness and inactivity in old age.[15] These treatments can be effective for restoring memory, attention, motiva-

indistinguishable from the minor losses of memory we see as a normal part of the aging process. *Id.*

10. Mary N. Haan, *Can Social Engagement Prevent Cognitive Decline in Old Age?*, 131(3) ANNALS INT. MED. 220, 221 (1999). Haan discusses the potential reasons for loss of cognition in the elderly and emphasizes the potential benefit of various forms of stimulus and engagement to preventing these losses. *Id.*

11. Ron Winslow, *Medication and Psychotherapy Help Elderly Fight Depression, Study Says*, WALL ST. J., Jan. 6, 1999, at B4.

12. Alistair Burns et al., *Care of Older People: Mental Health Problems*, 332 BMJ 789, 790 (2001), http://bmj.com/cgi/reprint/322/7289/789.pdf.

13. *See Declining Mental Skills Can Catch You Unaware*, PENN STATE NEWS, Feb. 14, 2001, http://www.psu.edu/ur/2001/clueless.html.

14. *Id.* The study asked older people to estimate how their performance would be on a series of tests, which analyzed their abilities to read maps, copy designs, use tools, and ignore a series of side distractions. *Id.* The subjects performed normally for their age range, but in most cases overestimated their ability to perform the tasks in advance. *Id.*

15. *See generally* Kate Gfeller, *The Status of Music Therapy Research*, *in* MUSIC THERAPY RESEARCH: QUANTITATIVE AND QUALITATIVE PERSPECTIVES 29 (Barbara L. Wheeler ed., 1995) (briefly summarizing topics and methods in music therapy research). Ms. Gfeller is a board-certified registered music therapist (RMT-BC) and holds a Ph.D. Currently, she is an assistant professor of music at the University of Iowa in Iowa City and one of the most recognized theoreticians in the field of music therapy. *Id.*

tion, and perception, among other things.[16] This Note explores these therapies and the various defects in cognition commonly created by the aging process that they seek to cure. After drawing conclusions about the effectiveness of these treatments in Part II, Part III proceeds to analyze their availability to Americans, both in terms of their private availability and their coverage under Medicare. Finally, Part IV analyzes the long-term prospects for the interaction of law and geriatric psychology, making recommendations for adaptations to attitudes, legal and otherwise, toward the provision of these therapies.

II. Turning Back Time: Cognitive Changes Associated with Old Age and Potential Remedies

Although concerns for geriatric mental capacity have not always been at the forefront of psychologists' (or indeed the nation's) concerns, recent shifts in population toward the older segments have created an increase in research and attention for these areas.[17] Thus, both the problems of aging from a cognitive perspective and many of the solutions available for those who suffer from them have been clearly delineated.

A. The Aging Mind

Most people are probably familiar with the most common cognitive defects encountered in aging, if only because they also happen to be common stereotypes.[18] While it is of course true that generalizations about elderly people are just as likely to be inaccurate as those about young people,[19] it is equally true that many times members of a stereotyped class do bear some of the stereotypical characteristics of that class. Indeed, one of the most difficult aspects in diagnosing the elderly is attempting to determine what is the result of injury or illness and what is simply the result of "normal" aging.[20] Some com-

16. Michael H. Thaut, *Neuropsychological Processes in Music Perception and Their Relevance in Music Therapy*, *in* MUSIC THERAPY IN THE TREATMENT OF ADULTS WITH MENTAL DISORDERS 1, 10 (Robert F. Unkefer ed., 1990).

17. *See* MARGUERITE KERMIS, MENTAL HEALTH IN LATE LIFE: THE ADAPTIVE PROCESS 2 (1986).

18. Stanley M. Rest, *Stereotyping the Elderly*, *in* AGING AND MENTAL HEALTH: A COMPREHENSIVE GUIDE TO WORKING WITH THE ELDERLY 1, 1 (Joseph M. Casciani & Stanley M. Rest eds., 1988).

19. *Id.*

20. *Id.* at 4.

mon problems associated with aging, however, include loss of memory, emotional and sensory changes, and setbacks in general life skills.[21]

Memory, although divided in the common parlance into short-term and long-term, may perhaps better be thought of for clinical purposes as involving three separate components.[22] Primary memory is the memory still in the mind or consciousness, where it is being processed.[23] After being rehearsed or learned, information is transferred into secondary memory, which is more of a storage space and relatively permanent.[24] The third category, called tertiary memory, contains information long held in permanent storage but infrequently accessed.[25] For seniors, it is the second category that is the most problematic, with the learning and storage of information taking on a new aspect of difficulty.[26] This leads to a level of "normal" forgetfulness, which includes problems with remembering dates and names, and generally makes learning new things more difficult.[27] This is the sort of problem that older people most often complain of, and that younger people tend to notice in their older associates.

Emotional and personality changes in the elderly are often difficult to gauge. The questions must always be asked: Are these changes the result of age or other factors? Are they manifestations of the resolution of internal conflicts, or simply the fact that "as we grow old, we grow more like ourselves?"[28] Again, however, some patterns emerge. Many people suffer from depression in old age, often remaining undiagnosed due to isolation and inability to recognize symptoms.[29] This may not be particularly surprising, given the number of potential depressive stimuli occurring in an older person's life;

21. Joseph M. Casciani, *Physical Decline and Psychological Functioning in the Elderly*, *in* AGING AND MENTAL HEALTH: A COMPREHENSIVE GUIDE TO WORKING WITH THE ELDERLY 1, *passim* (Joseph M. Casciani & Stanley M. Rest eds., 1998).

22. *See* Joseph M. Casciani, *Intellectual and Personality Changes with Age*, *in* AGING AND MENTAL HEALTH: A COMPREHENSIVE GUIDE TO WORKING WITH THE ELDERLY 1, 4 (Joseph M. Casciani & Stanley M. Rest eds., 1988); Stanley M. Rest, *Emotional Disorders in the Elderly: Signs and Symptoms*, *in* AGING AND MENTAL HEALTH: A COMPREHENSIVE GUIDE TO WORKING WITH THE ELDERLY 1, 1 (Joseph M. Casciani & Stanley M. Rest eds., 1998).

23. Casciani, *supra* note 22, at 4.

24. *Id.*

25. *Id.*

26. *Id.* at 5.

27. *Id.*

28. KERMIS, *supra* note 17, at 9 (quoting Bernice Neugarten).

29. Winslow, *supra* note 11.

loss is an everyday occurrence, from the loss of loved ones and the support they provided to the loss of employment and independence.[30] Depression in the elderly often expresses itself both emotionally and physically, compounding the difficulty of diagnosis.[31] Although certainly not a problem confined to the elderly, depression can be severe and may be a contributing factor to the high suicide rates that plague the elder population.[32]

Neurotic, anxious, or paranoid reactions are also widespread as people age.[33] These, too, may result from losses of loved ones or support sustained in the aging process.[34] Hypochondria is one of the most common forms of anxiety, occurring as the elderly manifest their real social, economic, or environmental concerns (which they view as untreatable) as complaints about their physical well-being.[35] These neurotic and anxious complaints also serve as outlets for the needs for attention and support that are often unmet.[36] The process by which these external causes create changes in behavior and personality is often referred to as psychodynamics, and when stimuli become extreme enough, a person may lose the ability to deal with everyday life and may develop psychosis.[37] Most cases, however, are far more subtle and often go untreated or completely unnoticed.[38] Paranoid reactions generally take the form of denials of reality and can vary greatly in terms of severity:

> Intensity varies from a lifelong pattern of suspiciousness and aloofness to florid delusions and hallucinations. These sometimes arise from the person's denial of failing mental and physical faculties. For example, a patient with failing memory may claim that something has been stolen as a defense against acknowledging that he cannot remember where he placed the missing item. While there are true paranoid disorders that occur for the first time in old age, for the most part the paranoid symptoms we see in the elderly reflect social isolation and misinterpretation of environmental events (illusions) rather than delusions.[39]

30. KERMIS, *supra* note 17, at 9.
31. *Id.*
32. Yeates Conwell, *Suicide in Later Life: A Review and Recommendations for Prevention*, SUICIDE AND LIFE-THREATENING BEHAV., Apr. 1, 2001, at 5, *available at* 2001 WL 21580368.
33. KERMIS, *supra* note 17, at 9.
34. *Id.*
35. *Id.*
36. *Id.*
37. Casciani, *supra* note 22, at 6–7.
38. Burns, *supra* note 12.
39. KERMIS, *supra* note 17, at 10.

Of course, it is important to remember not to attribute everything an older person says to some sort of delusion or disorder. Truth may lie behind seemingly senseless statements. Researcher Stanley Rest conveys the story of a man who in later life began to accuse his wife first of having an affair and then of poisoning his food.[40] Although his stories seemed wild, they proved themselves worthy of attention when he was later found to have stomach cancer—paranoid or not, his food-related complaints could have indicated a real problem to anyone willing to listen carefully.[41] Although distinguishing these problems from ordinary emotions or complaints can be extremely difficult, it is also extremely important that we attempt to do so.

Many changes in cognitive ability due to age take the form of small setbacks in general life skills like intelligence, attention, and orientation. Generally, researchers distinguish between crystallized intelligence, which remains stable as people age, and fluid intelligence, which follows a pattern of decline.[42] Crystallized intelligence includes learned facts, concepts, and vocabulary, in essence a "measure of the extent to which an individual has absorbed the content of his or her culture."[43] Fluid intelligence, in contrast, is the capacity for new problem solving and reasoning.[44] Its decline in later years is largely believed to be related to physiological changes including the loss and rearrangement of nerve cells.[45] Thus, as people age, they may experience more difficulty learning new things, such as rules or directions, or with problem solving and abstract thinking.[46] The elderly also commonly experience organic brain syndromes, which can involve confusion about one's orientation to time, place, and even person.[47] These problems can be caused merely by isolation or may be manifestations of a physical or neurological illness and lead to impaired judgment and emotional instability.[48] In essence, those things

40. Rest, *supra* note 22, at 6.
41. *Id.*
42. Casciani, *supra* note 21, at 1.
43. *Id.*
44. *Id.*
45. *Id.* at 2.
46. *Id.* Casciani carefully lists out factors that may change with age, as well as those that generally do not. *Id.* While things like the ability to define words and remember factual information may remain steady, older adults may find it more difficult to repeat a series of numbers, for instance, or assemble two-colored blocks to make geometric patterns. *Id.*
47. KERMIS, *supra* note 17, at 10.
48. *Id.*

which we most take for granted in younger life and which most help us live life as we choose—intelligence, memory, emotion, judgment, and orientation—are some of the things most commonly endangered by the unavoidable aging process.

The possibility for more serious cognitive and psychological effects of aging should not be ignored. While perhaps no more common in the elderly, maladies like schizophrenia, obsessive-compulsive disorder, and social phobia affect all age groups. In fact, about one in five adults in the United States suffer from a diagnosable mental disorder in any given year.[49] Alzheimer's disease, the most common cause of dementia among people aged sixty-five and older, affects an estimated four million Americans.[50] As serious as these conditions are, and as useful as the therapies discussed herein may be in their treatment, this Note leaves them outside its scope. Instead, the focus here is on therapeutic tools to treat the more common effects of aging, in hopes of ensuring that life is not merely long, but also productive.

B. Therapies to Shield and Restore Mental Acuity

Although the problems of aging are wholly unique and still not fully understood, there are a number of long-existing therapies that appear to be useful in reducing cognitive decline. Perhaps the most obvious of these is traditional psychological therapy. Researchers have noted that problems common among both the young and old, including depression and personality disorders, may be effectively treated with pharmacology and psychotherapy.[51] Although they stress the need for further study and the development of clinical guidelines specifically dealing with the elderly,[52] current practitioners believe that with sufficient modifications, insight-oriented psychotherapy may be "quite beneficial" to older persons.[53] Behavioral treatments and group therapies may also be of use, although, again,

49. NAT'L INST. OF MENTAL HEALTH, THE NUMBERS COUNT: MENTAL DISORDERS IN AMERICA, *at* http://www.nimh.nih.gov/publicat/numbers.pdf (last visited Oct. 4, 2002).

50. *Id*.

51. Burns, *supra* note 12, at 790.

52. *Id*.

53. Iqbal Ahmed & Junji Takeshita, *Late-Life Depression*, GENERATIONS, Winter 1996–97, at 19 (noting that a different pace of treatment and different goals may be necessary for the treatment of elderly persons).

the effects are not fully known.[54] Studies have indicated a growing, if still not impressive, success rate for a combination of outpatient psychiatric care and prescription drug use for seniors with specific and identifiable mental health problems.[55] In short, traditional methods show great promise here.

At the same time, however, traditional psychological therapies do not require lengthy discussion here. To begin with, their effectiveness is greatest where symptoms are specific and maladies distinct,[56] which is seldom the case with the "natural" problems of aging. Secondly, these therapies are, as noted in part III, relatively widely available, if underutilized, and thus less in need of legal advocacy. Finally, traditional psychological therapies are simply better understood than other modes of dealing with geriatric cognitive decline. Therefore, the remainder of this section introduces two lesser-known forms of cognitive therapy: music therapy and art therapy.

1. SWEET MUSIC: THERAPEUTIC USES OF AN ANCIENT ART FORM

Music therapy involves the use of music in research and treatment to attempt to understand "the effects of music on the human organism."[57] It has been defined as "a systematic process of intervention wherein the therapist helps the client to achieve health, using musical experiences and the relationships that develop through them as dynamic forces of change."[58] Musical experiences used in the context of such therapies are of a wide range and can be carried out in a group or as an individual, involving everything from mere passive listening to full-out performance or composition.[59] So long as music is acting upon the client or being used as a medium for self-expression, its pur-

54. *Id.* In fact, Freud "first stated that psychoanalysis was contraindicated after age 40," although this view is no longer widely held. *Id.*

55. Jürgen Unützer et al., *Care for Depression in HMO Patients Aged 65 and Older*, 48 J. AM. GERIATRICS SOC. 871, 877 (2000) (noting the effectiveness, but lack of availability, of treatments for depression in the elderly during a four-year study in the 1990s).

56. *See* Ahmed & Takeshita, *supra* note 53, at 17–21 (stating that "[s]pecific treatment modalities need to be tailored for the individual patient based upon medical evaluation, severity of illness, and consideration of risks and benefits").

57. Gfeller, *supra* note 15, at 37 (quoting Esther Gilliland, the president of the National Association for Music Therapy).

58. Kenneth E. Bruscia, *The Boundaries of Music Therapy Research*, *in* MUSIC THERAPY RESEARCH: QUANTITATIVE AND QUALITATIVE PERSPECTIVES, *supra* note 15, at 17, 17.

59. *See id.*

pose is likely to be fulfilled.[60] Of course, all experiences must be carefully structured and sequenced by the therapist in order to ensure that the proper interventions and changes to the client's psyche are made.[61] This careful tension between the art of music and its scientific use in therapy is perhaps one of the defining characteristics of this field of study.

Music therapy for the elderly is not exactly a new or an old area of practice for the discipline. Although both musicians and scientists have certainly reflected upon and even made use of the evocative functions of music for centuries, its more calculated study is of more recent vintage.[62] Initially, music was used in treatment situations primarily as entertainment or escape, with its therapeutic and rehabilitative properties not particularly recognized until its use in veterans' hospitals following World War II.[63] A survey of research in the field indicates that for the majority of its history, music therapy research has focused on treatment of those without cognitive or psychological impairment, with a secondary emphasis on specific disabilities, such as mental retardation.[64] At the same time, however, interest in the specific treatment of the elderly has been steadily growing, with seven percent of research in the field going toward this specialty in the most recent data.[65] Perhaps more importantly, however, it should be remembered that data gleaned from all forms of research into this therapy can be just as easily applied to elderly persons who share the same qualities as those studied. Therapists must understand that elderly people may sometimes share more in common with those who are not of their age than those who are—"To achieve . . . we must have

60. *See id.*
61. *See id.*
62. Gfeller, *supra* note 15, at 29.
63. Brian L. Wilson, *Music Therapy in Hospital and Community Programs*, *in* MUSIC THERAPY IN THE TREATMENT OF ADULTS WITH MENTAL DISORDERS, *supra* note 16, at 88, 90. Mr. Wilson is an RMT-BC and holds a Masters of Music. Currently, he serves as a professor of music at Western Michigan University in Kalamazoo, Michigan. *Id.* at xi.
64. Gfeller, *supra* note 15, at 32, 34, 36. Gfeller's survey of articles in the *Journal of Music Therapy* indicates a dedication of twenty percent of research to so-called normals from 1964 through 1986 and twenty-four percent from 1981 through 1993. *Id.*
65. *Id.*

a foundation based on the recognition of every elderly person as being a unique individual."[66]

The potential effects of music therapy on the mind are diverse and far-reaching. To begin with, guided music exercises can have the effect of modeling positive emotional resolution patterns in a person (unlike those commonly created by depression or anxiety disorders).[67] Although the theories explaining this phenomena are many and complex, all basically credit this effect to the inherent patterns of tension and release in music, which listeners experience and emulate.[68] Music creates "expectancy patterns," similar to those caused by real life events, with the important difference that expectations created by music are almost always resolved pleasantly and from the same source from which the conflict came.[69] Listeners consciously or unconsciously expect developments in musical style, melody, rhythm, dynamics, or structure to be resolved in a certain way, and they generally are, after a period of uncertainty that creates a biological arousal of the nervous system.[70] It is this "interplay between prediction and sensory confirmation," felicitously resolved, that gives music much of its healing power.[71] Patients are cognitively engaged and then rewarded in a manner that is not always possible in real life.

Because the centers of the brain that are involved in the processing of music stimuli are also those responsible for coordinating the body's limbic system (which in turn controls many aspects of behavior), much can be achieved through careful stimulation of these areas.[72] Through music-induced changes in arousal level, one can create "changes in alertness, level of activation, emotional responses, perception of reward, pleasure, positive feedback, and level of motivation."[73] As discussed in Part II.A above, these are all difficulties to some extent attendant to the normal aging process. Further, it appears that music therapy can also expand general cognitive/intellectual abilities, or at

66. Mike Church, *Issues in Psychological Therapy with Elderly People*, *in* PSYCHOLOGICAL THERAPIES FOR THE ELDERLY 1, 1 (Ian Hanley & Mary Gilhooly eds., 1986).

67. Thaut, *supra* note 16, at 4.

68. *See generally id.* at 4–7 (reviewing several theories that account for music's effect on listeners).

69. *Id.* at 5.

70. *Id.*

71. *Id.*

72. *Id.* at 9.

73. *Id.* Thaut also cites multiple research-based studies that support the notion of music therapy's usefulness for these purposes. *Id*.

the very least, prevent their decline. Kate Gefeller, a leading researcher in the field of music therapy, refers to studies demonstrating that

> the art form provides a favorable context for expanding cognitive orientation and confronting new ideas because of the intermingling of novel stimuli with the familiarity of either referential objects or structural elements. This blending of the unfamiliar (and thus novel source of high arousal) with the familiar (a source of arousal moderation) replaces boredom of habituation with interest, curiosity, and exploration at a level of arousal palatable to the individual.[74]

In other words, by providing the novel and creative structure of music and encouraging a client to compare it to something concrete, a music therapist can foster the sort of analytic problem solving and creative thinking that becomes more difficult with age.

Another music therapy researcher, Brian Wilson, further breaks down the music therapy experience in psychotherapy, stating three positive categories of influence from the therapy: (1) music therapy as an activity therapy; (2) insight music therapy with reeducative goals; and (3) insight music therapy with reconstructive goals.[75] All three work in some way to prepare the patient for positive reintegration into a community.[76] The first category uses the promise of some sort of music activity to reduce the recurrence of inappropriate behaviors, both inside and outside the therapy session.[77] The second category works on the development of methods for expression and awareness of patient feelings, seeking to create healthier and more socially acceptable outlets.[78] The third is more rehabilitative, seeking to restore lost function.[79] Of course, the functioning of the three cannot easily be separated (especially because they are generally provided by the same activities), and ideally all three work together. The mental division is nonetheless useful to understand the many functions of these treatments.

The intricacies of music therapy are best served, however, not by definition, but by example. The theoretical underpinnings of these

74. Kate Gfeller, *The Function of Aesthetic Stimuli in the Therapeutic Process*, *in* MUSIC THERAPY IN THE TREATMENT OF ADULTS WITH MENTAL DISORDERS, *supra* note 16, at 70, 74.
75. Wilson, *supra* note 63, at 91.
76. *Id.*
77. *Id.*
78. *Id.* at 92.
79. *Id.*

treatments are interesting, but hardly demonstrate the results music therapy seeks to achieve and its methods of doing so. Many recent studies exhibit not only the positive potential effects of music therapy, but also its methodologies and approaches.

One recent study observed the use of music therapy for a wide variety of individuals in a psychiatric inpatient setting.[80] Patients of all ages with disorders like depression, bipolar disorder, substance abuse, anxiety, eating disorder, and posttraumatic stress syndrome were involved in the program for periods of one to two weeks.[81] Each day, the patients met in music groups of ten to twelve people for an hour, listening to four selections of music and sharing any elicited emotions with two staff members.[82] The selections were carefully chosen based on their helpful structural and resonant properties (with some advance input from the group members), and activities like journaling, drawing, coloring, guided visualization, progressive muscle relaxation, and sculpting with modeling clay were incorporated into the experience.[83] After the run of the program, the staff of the hospital found the participants far better able to communicate and less likely to suffer from unproductive, emotional episodes.[84] Further, the patients themselves expressed the feeling that the program helped "quite a bit" as a motivator and a way to reduce anxiety and pain.[85] Although the researcher herself stressed her desire to downplay these results as not particularly predictive,[86] clearly, music therapy provided an excellent vehicle for rehabilitation in this context.

Another study dealt with elderly patients suffering from Parkinson's disease, a serious condition affecting the neurological system.[87]

80. Holly Covington, *Therapeutic Music for Patients with Psychiatric Disorders*, 15(2) HOLISTIC NURSING PRAC. 59, 64 (2001).

81. *Id.* at 60.

82. *Id.* at 64.

83. *Id.* at 65. In designing this study, Covington consulted research on music therapy's use as a "treatment modality to strengthen ego, increase socialization, decrease psychotic symptoms, and promote activity." *Id.* at 60. Although interestingly stated, her discussion of the principles of homeodynamics (roughly the healing interaction between a positive environment and an individual) is too complicated to restate here. *Id.* at 61.

84. *Id.*

85. *Id.*

86. *Id.* at 67.

87. *See* Claudio Pacchetti et al., *Active Music Therapy in Parkinson's Disease: An Integrative Method for Motor and Emotional Rehabilitation*, 62(3) PSYCHOSOMATIC MED. 386, 387 (2000). The study was aimed at determining the affects of music therapy and physical therapy in terms of helping elderly Parkinson's patients re-

Two randomized groups of sixteen patients, each with the mean age of sixty-three, were given traditional pharmacological treatments for Parkinson's, but one group received physical therapy while the other group participated in active music therapy.[88] Each set of treatments lasted three months, for about two hours a week.[89] The physical therapy group participated in passive muscle stretching exercises for rigidity and joint mobility, weight and balance training, and movement strategies, while the music therapy group participated in relaxed visualization exercises, choral singing, rhythmic movement, collective invention and improvisation, and free body expression to music.[90] Examinations of the patients were conducted throughout the program.[91] In the end, while the physical therapy patients showed greater improvement in rigidity, the performance of active music therapy was better in all of the other categories tested.[92] Music therapy patients in the sample demonstrated improvements in motor abilities, emotional status, adaptability, and overall quality of life.[93] Not only are these results promising and impressive, but they clearly address positive changes music therapy can make in the lives of all who encounter it, not just those who suffer from debilitating conditions like Parkinson's disease.

While, of course, these two studies are merely intended as examples, and not as utterly conclusive of a rule, ample scientific sup-

cover some of their lost ability to engage in the activities of everyday life. *Id.* at 386.

88. *Id.* at 387. "Active" music therapy can be distinguished from other kinds of music therapy in that it involves the patient or client entirely with the music, requiring playing of instruments, improvisation, or movement, rather than targeted listening and the acquisition of a "state of mental relaxation." *Id*.

89. *Id.*

90. *Id.* at 387–88. Pacchetti describes the activities of each group in far greater detail, including the types of exercises, instruments, and interactions undertaken by both. *Id.* However, it is perhaps more important for purposes of this Note simply to understand that the activities of both groups were fairly typical for their type of therapy and were designed to be of optimal effect. *Id.* The researchers also attempted to control the setting so as to prevent potential outside effects on the patients' conditions. *Id.*

91. *Id.*

92. *Id.* at 388–90. Generally, physical therapy is expected to be one of the more effective treatments for motor difficulties. *Id.*

93. *Id.* The study noted that music therapy had rather broad-based effects, as opposed to physical therapy's purely physical importance. *Id.* After each session, an improvement in emotional function would be noted, which returned to baseline levels after the treatments stopped, which seems to indicate a causal link. *Id.* Further, sizable improvements in the patients' quality of life and ability to engage in the activities of daily living were noted. *Id.*

port exists for the conclusion that music therapy has innumerable benefits not just for those with concrete "conditions," but for the elderly population as a whole.[94]

2. A FINE ART: CREATIVE VISUALIZATION AS A COGNITIVE TOOL

Art therapy shares much in common with both music therapy and traditional psychotherapy. It employs different art media to help patients relate to their therapists and the world, providing a "focus for discussion, analysis and self-evaluation."[95] It also works within the "firm base of psychotherapeutic principles," creating a highly detailed record of a patient's mental and emotional development.[96] Although the discipline has been variously defined as everything from a pure creative process to a specialized form of behavioral science, it most accurately lies somewhere in between, serving as a specialized form of expression and a vehicle for scientific analysis.[97] In short, it combines disciplines in such a way as to augment the effectiveness of both.

On a physiological level, the same type of cognitive engagement and felicitous release discussed in the music therapy section above is also applicable to the use of art therapy. Researchers have noted three "satisfying factors" inherent in viewing a work of art.[98] First, a viewer may take a solely sensuous pleasure from viewing the colors, designs, and ideas inherent in a work of visual art.[99] Secondly, he or she can experience a "relief of tension gained from the solving of a conflict through the interplay of constructive and destructive tendencies."[100] Finally, a person properly guided through an artwork may experience the "eternal" factor, a realization of the triumph of creative forces over destruction.[101] Again, the recognition of conflict and release patterns stimulates patients and allows them to better understand their own conflicts.[102]

94. *See, e.g.*, Suzanne B. Hanser & Larry W. Thompson, *Effects of a Music Therapy Strategy on Depressed Older Adults*, 49 J. GERONTOLOGY 265, 269 (1994).
95. CAROLINE CASE & TESSA DALLEY, THE HANDBOOK OF ART THERAPY 1 (1992).
96. *Id.*
97. *See* Elinor Ulman, *Art Therapy: Problems of Definition*, 40 AM. J. ART THERAPY 16, *passim* (2001).
98. CASE & DALLEY, *supra* note 95, at 131.
99. *Id.*
100. *Id.*
101. *Id.* at 132.
102. *Id.* at 131.

Several forms of self-reflection and analysis are also made possible through the use of art therapy. One effect is that of "the mirror," which allows a patient to create an external record of, or commentary on, internal events he or she might not otherwise be able to confront or grasp.[103] This gives the patient a chance to articulate concepts in a nonjudgmental fashion and make connections between them, while at the same time laying the groundwork for empathy with the therapist.[104] Similarly, the patient undergoes sublimation, which occurs when he or she substitutes a social act for instinctual behavior "in such a manner that this change is experienced as a victory of the ego."[105] In less scientific terms, sublimation allows a patient to transform potentially harmful feelings or impulses into an act of creative beauty rather than one of violence.[106] Finally, a patient may use art therapy to "take inventory," or discuss feelings or expressions thereof in an item-by-item fashion.[107] Because art can be compartmentalized in a way that emotions often cannot, the work may become a tool for sorting out and discussing those single items with "disturbing associations."[108] Thus, the employment of visuals can add great depth and dimension to therapeutic processes of self-discovery.

Some instances of the use of art therapy with elderly persons demonstrate both the methodologies and successes of this form of treatment. For instance, some geriatric rehabilitation researchers created a study in which elderly adults were involved in clay sculpturing activities as part of their therapeutic process.[109] A group of eight patients ranging from seventy to eighty years of age were put through a structured five-week program of sculpting, guided discussion, and group interaction.[110] The researchers noted that work of this type "enables sensimotor therapy for the upper limbs and fosters visuo-motor coordination, spatial perception and construction, and communica-

103. Michael Franklin, *Becoming a Student of Oneself: Activating the Witness in Meditation, Art, and Super-Vision*, 38 AM. J. ART THERAPY 2, 13 (1999).
104. *Id.*
105. Ulman, *supra* note 97, at 21 (quoting EDITH KRAMER, ART THERAPY IN A CHILDREN'S COMMUNITY 6–23 (1958)).
106. See *id.* at 21–23.
107. Selwyn Dewdney et al., *The Art-Oriented Interview as a Tool in Psychotherapy,* 40 AM. J. ART THERAPY 65, 68 (2001).
108. *Id.*
109. Abraham Yaretzky et al., *Clay as a Therapeutic Tool in Group Processing with the Elderly*, 34 AM. J. ART THERAPY 75, 75 (1996).
110. *Id.* at 78.

tion."[111] At the end of the sessions, the patients noted that they felt the sculpting had contributed to their rehabilitation and well-being, with six of the eight patients expressing a desire to continue with such work in the future.[112]

Similarly, a study of the effectiveness of art therapy with seniors suffering from Alzheimer's at an adult day care center found significant advantages to the program. The researcher noted that because these subjects had lost many of their verbal skills to the disease, art provided them with not only a means of self-expression, but also an outlet for tension and frustration.[113] The study was conducted over the course of two years and involved twelve participants in discrete and individually tailored drawing activities that lasted an average of two and a half hours.[114] In a number of cases, the therapy enabled patients to break down the barriers their disease had built for them and communicate their own "rich, fascinating world."[115] Given their circumstances, this would otherwise not have been possible.

Thus, a number of therapies are available to combat the general problems of mental health that accompany aging. Just how available the therapies are, however, remains a question for analysis.

III. Analysis: Access to Therapies for the Preservation of Mental Health

There are two major barriers to the potential availability of these therapies as tools for senior citizens to improve their mental quality of life. First, factors like the number and quality of providers, cost, and public acceptance of these treatments bear on their general availability. Second, government regulation and funding may make an immense difference in their practical availability.

A. Cognitive Treatment in the Private Sector

As a general rule, traditional psychological therapies suffer not from problems of availability, but from problems of adoption. Although the number of therapists nationwide is generally considered

111. *Id.* at 76.
112. *Id.* at 81.
113. Ofra Kamar, *Light and Death: Art Therapy with a Patient with Alzheimer's Disease*, 35 AM. J. ART THERAPY 118, 119 (1997).
114. *Id.*
115. *Id.* at 123.

adequate to the demand,[116] the real problem lies in encouraging those in need of treatment to recognize that need and seek help.[117] Despite the high incidence of mental health symptoms in the elderly, this population makes up only six percent of all mental health patients nationwide.[118] This may be partially due to the differences in symptoms for elderly people and the difficulties of recognizing them in hurried primary-care visits.[119] Psychiatrists have identified a number of "barriers" to the treatment of older adults:

> These include patient barriers such as out-of-pocket costs for medications, patient and provider barriers such as lack of information and stigma, provider barriers such as limited time and limited ability to track chronic conditions such as depression in primary care. Older adults seem significantly less likely than younger adults to seek care . . . and they may also be less likely than younger adults to accept and follow suggested treatments . . . .[120]

Thus, although the potential certainly exists for adequate psychiatric services for the elderly, a number of barriers to implementation will have to be addressed.

For music and art therapies, actual physical availability of the treatments remains an issue.[121] To begin with, these fields are not easy for professionals to enter. Music therapists must complete an undergraduate degree in music at an American Music Therapy Association approved institution, complete a several-month, full-time clinical internship, and pass a national board certification exam to enter the field.[122] Coursework is necessary in five areas: music therapy, music, behavioral/health/natural sciences, general education, and general

116. The American Psychiatric Association boasts 37,000 members. AM. PSYCHIATRIC ASS'N, ABOUT THE APA, *at* http://www.psych.org/aboutapa.cfm (last visited Sept. 29, 2002).

117. *See* Winslow, *supra* note 11.

118. Trisha L. Howard, *Program to Help Elderly Suffering Mental Illnesses*, ST. LOUIS POST-DISPATCH, Nov. 27, 2000, at 1.

119. *See* Bernard J. Carroll, *The Use of Antidepressants in Long-Term Care and the Geriatric Patient: Geriatric Psychiatry Issues,* GERIATRICS 54, 57 (Supp. 1998); Winslow, *supra* note 11.

120. Jürgen Unützer et al., *supra* note 55, at 877.

121. As recently as 1992, the number of professional music therapists certified by the major accrediting organization was only 3,650 nationwide. WILLIAM B. DAVIS ET AL., AN INTRODUCTION TO MUSIC THERAPY: THEORY AND PRACTICE 12 (1992). The American Art Therapy Association has a mere 4,750 members. AM. ART THERAPY ASS'N, AATA FACTS, *at* http://www.arttherapy.org (last updated Oct. 24, 2002).

122. BETSEY BRUNK & KATHLEEN COLEMAN, PRELUDE MUSIC THERAPY, FREQUENTLY ASKED QUESTIONS, *at* http://home.att.net/~preludetherapy/faq.html (last visited Oct. 24, 2002).

electives.[123] A complete comprehension of the principles of music therapy and the psychology of music is necessary, in addition to research and clinical experiences applying these theories to a variety of disability groups.[124] Similarly, art therapists must hold a master's degree in art therapy and have at least a thousand hours of clinical experience in order to be certified.[125] Their coursework involves the disciplines of both art and psychotherapy, and trains them for "personal understanding, aesthetic appreciation, critical awareness and creative problem-solving."[126]

Additionally, a career in one of these therapeutic professions is difficult and demanding to maintain. It is therefore no surprise that music therapy is populated primarily by young rather than veteran professionals, with only fifteen percent of current therapists having more than ten years of experience in the field.[127] After certification, therapists of both types are required to participate in continuing education and recertification programs.[128] Further, a complicated code of ethics and conduct governs all the activities of a therapist, including hours, treatment programs, fees, client acceptance, and information handling.[129] Of course, these therapists, like many of today's health care professionals, are also under the pressure of keeping up with the voluminous rules and regulations promulgated by the federal gov-

123. DAVIS ET AL., *supra* note 121, at 11.
124. *Id.*
125. AM. ART THERAPY ASS'N, *supra* note 121.
126. CASE & DALLEY, *supra* note 95, at 148.
127. DAVIS ET AL., *supra* note 121, at 13. This data additionally indicates that over half the practicing music therapists are under thirty years of age, and almost ninety percent are female. *Id.* This data was gathered during a 1989 survey of 226 Registered Music Therapists taken by B.L. Reuer and Kate Gfeller. *Id.*
128. AM. ART THERAPY ASS'N, *supra* note 121; BRUNK & COLEMAN, *supra* note 122.
129. BETSEY BRUNK & KATHLEEN COLEMAN, PRELUDE MUSIC THERAPY, WHAT TO EXPECT FROM A MUSIC THERAPIST, *at* http://home.att.net/~preludetherapy/mtbc.html (last visited Nov. 21, 2001). Ethical and practical considerations bind music therapists from individual and institutional perspectives. DAVIS ET AL., *supra* note 121, at 355. Providers must deal with their professional organizations' rules and ethical mandates as well as the issues attendant to accreditation of the facilities they may work for. *Id.* Add in the changing nature of the health care field and the American population in general, and the social responsibility demands on music therapists can seem somewhat overwhelming. *Id.* at 358–59. Art therapists share some of these concerns, and have concerns of their own, such as the proper definition of their role and the avoidance of overreaching. Ulman, *supra* note 97, at 25–26.

ernment.[130] More than anything, however, they face long hours and the emotional difficulties of working with patients with mental and emotional disorders. Robert Tusler, a longtime performer, teacher, and researcher, has pointed out that

> [n]ot all musicians . . . are capable of combining their art with that of therapy. . . . [Some] would be neither psychologically apt nor intellectually concerned with the inner workings of humans. . . . [For some] [t]he analytical, historical, or even technical matters relating to their art are rarely of burning import. . . . The following three character traits are always present in those who are successfully involved in music therapy: (1) They have a predilection for music and the other arts. (2) They value and respect life, which is manifested in actual and constructive involvement. (3) The first two are undergirded by curiosity, by a continuing desire to know, to understand, and to experience.[131]

A rare and difficult combination of artistic skill and humanistic concern is required to successfully participate in the creative therapy fields.

Of course, the salary factor cannot be overlooked. Art and music therapists simply do not earn as much as some other professionals of similar training and experience. Although both fields have been characterized as "growing," with ample opportunities for employment

130. DAVIS ET AL., *supra* note 121, at 353. The authors discuss the various changes that the Americans with Disabilities Act, Medicare and Medicaid, and particularly the Education for All Handicapped Children Act of 1975 have had on the profession. *Id.* at 353–54. Although not all of these are within the more contemporary scope of this Note, they all certainly demonstrate the extent to which government regulation, even if seemingly unrelated to the field, can change the ways in which therapists interact with patients.

131. ROBERT L. TUSLER, MUSIC: CATALYST FOR HEALING 21–23 (1st ed. 1991). Tusler also lists many more pragmatic attributes of the successful music therapist. *Id.* at 24–25. These include a strong understanding of the function of rhythm, the ability to play a portable instrument, as well as piano, the ability to sing, a working knowledge of percussion instruments, a knowledge of history and repertoire of both Western and other musical cultures, elementary training in other arts, and experience in ensemble performing. *Id.* On the art therapy side, therapist Bruce Moon has noted that

> there are surely some students who bring to the training experience a certain wholesome, healthy, warmth that is intrinsically charismatic. Their inherent characteristics alone are not enough to produce an arts therapist. Nor is intellectual capacity enough, nor artistic sensibility, nor concern for humankind . . . . The would-be art therapist must bring a passionate discipline that will patiently blend the charisma, warmth, artistic perspective and skill, love for humanity and intellect with a willingness to work.

BRUCE L. MOON, ESSENTIALS OF ART THERAPY TRAINING AND PRACTICE 70 (1992).

available in the field, neither are extremely remunerative.[132] Even upper-level positions do not rise to the same level of prestige and salary as would seem appropriate, given the amount of education and training required.[133] This seems to make music and art therapy careers attract only those whose skill is combined with an extraordinary desire to help people through this type of work.

Adding to the general unavailability of creative therapy treatments for private citizens is the fact that most positions seem to be institutionalized, located in hospitals or homes, with little opportunity for those who are not residents or patients there to seek out help.[134] Of course, this level of job security is probably necessary for most practitioners, but the lack of real "private practice" in the area seems to limit the type of patient who can be helped. Additionally, many positions seem to be located in metropolitan areas.[135] Again, while logically understandable, this factor seems to limit (or indeed entirely foreclose) the types of treatment available to help reverse some of the natural losses of aging. Although generally quite effective, it is unfortunate that these treatments have found little notoriety in the American culture as a whole.

132. Art therapists have a "median income" from $28,000 to $38,000, with the top salary for "administrators" falling at $60,000. AM. ART THERAPY ASS'N, *supra* note 121. The "salary range" for music therapists has been estimated at $25,000 to $60,000 per year. ROBERT GERARDI, OPPORTUNITIES IN MUSIC CAREERS 125 (1997). This source also notes that "even with the economy and budget cuts, the job market seems to be healthy." *Id.*

133. *See id.* (enumerating the levels of education required and ranges of salaries expected). However, these therapists are certainly not the only professionals who seem to make less than their skills, applied to another career, might earn them. DAVIS ET AL., *supra* note 121, at 10. This source notes that music "therapists salaries are comparable to those of other professionals in allied health professions, such as special-education teachers and social workers." *Id.* Therefore, the salary factor is certainly debatable.

134. Brunk & Coleman, *supra* note 122. Survey data also indicate that only roughly eight percent of music therapists work in private practice, with schools and inpatient psychiatric units dominating the care outlets utilizing these professionals. DAVIS ET AL., *supra* note 121, at 10. Other places of employment for music therapists include universities and prisons. *Id.* It is also worthwhile to note that a full four percent of certified music therapists in the country are currently not practicing. *Id.* In the art therapy arena, services were similarly institutionalized, with a full three quarters of all therapists working for health, education, or social service agencies. CASE & DALLEY, *supra* note 95, at 6. Only 2.5% of all art therapists were self-employed. *Id.*

135. *See* DAVIS ET AL., *supra* note 121, at 9. One music therapist has observed that "job opportunities vary depending on geographic location," with the West Coast, Midwest, Southeast, and portions of the East Coast having the highest concentrations of practicing music therapists. *Id.*

B. Government Attitudes Toward Cognitive Therapies

Practitioners of these therapies also face a variety of public sector challenges. To begin with, art and music therapies face the challenge of being virtually unrecognized by the major government instruments addressing health care.[136] Of course, with the passage of the Medicare Act (Act),[137] Congress could not have been expected to foresee every treatment that might be useful or coverable under its auspices, nor even enumerate those covered treatments it did foresee. The language of the Act does provide some rather specific guidelines which serve as a good starting point; however, the messy business of delineating specific treatments covered or not covered is in many cases left to the Code of Federal Regulations (C.F.R. or Regulations)—as overseen by the Department of Health and Human Services—and to the courts.[138] Therefore, a full range of sources will need to be consulted.

For a treatment to be covered by the Act, it must fall under the provisions of either Part A, which provides insurance against the cost of institutional health services, or Part B, which covers only eighty percent of the reasonable charge for a number of supplemental services and functions more like "a private medical insurance program that is subsidized in major part by the Federal Government."[139] The definition of "inpatient hospital services" contained within the Act does not seem to embrace music or art therapy because it very narrowly includes only those services directly associated with a hospital stay for illness or injury.[140] It specifically enumerates its covered services, which include bed and board, diagnostic services, and nursing, medical, drug, and supply treatments "ordinarily furnished" by a hospital.[141] Although in some cases music or art therapy might take place in a hospital or even be a prescribed part of a hospital stay, it seems unlikely that any coverage decision would consider it to be part of the treatments "ordinarily furnished" by a hospital. Useful as they may be, such treatments are far from ordinary.

136. No specific discussion of these services can be found in the Medicare Act, 42 U.S.C. §§ 1395–1397f (2000), or the various reports discussing its passage and amendment.

137. *Id.*

138. *See id.*

139. Friedrich v. Sec'y of Health & Human Servs., 894 F.2d 829, 830 (6th Cir. 1990) (quoting Schweiker v. McClure, 456 U.S. 188, 190 (1982)).

140. 42 U.S.C. § 1395x(b).

141. *Id.* The statute itself does enumerate these treatments somewhat more specifically than has been done here.

Coverage determinations under Part B are far more complicated. The Act spills much ink discussing treatments that are generally covered, and generally not covered, and then proceeds to list a number of particular situations in which coverage decisions are reversed.[142] Neither art nor music therapy is specifically listed as a situation of either general coverage or general exclusion.[143] Indeed, no specific mention of these practices can be found in the Act. Any coverage determination would most likely be made, therefore, as indeed many such determinations are, under the general statement that "no payment may be made under part A or part B of this subchapter for any expenses incurred for items or services . . . which, except for items and services described in a succeeding paragraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."[144]

Does mental illness qualify as an "illness or injury," even if it is the sort of minor cognitive defect that often accompanies aging? Does the mind count as a "malformed body member?" Clearly this is a definition in need of further definition, and the Code of Federal Regulations, as disseminated by the Secretary of Health, is a good place to turn for elucidation. Indeed, the Act itself contains an explicit grant of authority for such rulemaking.[145] Within the C.F.R., one finds a more full discussion of this phrase, with enumerated purposes for which a service may be reasonable and necessary.[146] However, each of these purposes is connected to a specific treatment, none of which is music or art therapy.[147] No other provisions seem to address the issue, either. Therefore, in the absence of any binding legislative or regulatory enactment, the National Coverage Decisions (NCDs) issued by the Health Care Financing Administration (HCFA) (now the Centers for Medicare and Medicaid Services) are specifically identified by the Act and Regulations as an authoritative source.[148] These decisions are very carefully considered and seldom reversed because "[a] court's review of a NCD is limited to whether the record is incomplete or oth-

142. *Id.* § 1395y.
143. *Id.*
144. *Id.*
145. *Id.* § 1395hh.
146. 42 C.F.R. § 411.15 (2001).
147. *Id.* For example, the code states that an acceptable purpose might be "[i]n the case of pneumococcal vaccine for the prevention of illness," or "in the case of hospice services, for the palliation or management of terminal illness." *Id.*
148. *Id.* § 405.860.

erwise lacks adequate information to support the validity of the decision."[149] Therefore, a great deal of weight should be given to such a determination.

Unfortunately, no NCD exists that is exactly on point with the determination of whether music therapy is covered. However, the trend in NCDs generally would suggest that such a treatment would not be covered.[150] Decisions traditionally limit therapies to those necessary for the treatment of a tangible physical malady, and the emphasis is on cure rather than on prevention.[151] Further, in making such determinations, HCFA relies heavily on information from the Public Health Service, an organization that has traditionally shown reluctance to embrace treatments that are considered somewhat "alternative" or experimental.[152] Indeed, in many arenas of law there seems to be some distrust of treatments not approved by the mainstream medical community.[153] Thus, it seems unlikely that HCFA would lend its approval to the coverage of these treatments, especially because it would admittedly take a linguistic stretch to make them "reasonably necessary for the diagnosis or treatment of injury or illness."

Previous statements by HCFA in its Medicare Carriers Manual seem to firmly support the view that music and art therapy are not covered by the Act. The Manual states that in order to be covered by Part B, a therapy service should relate directly and specifically to an active treatment regimen prescribed by a physician for a specific illness or injury, and not just be a service for the general good and wel-

149. *Id.*

150. *Cf.* Requirements for Determining Limitation on Liability of a Medicare Beneficiary, HCFA Ruling 96–3 (1996), *at* 1996 WL 936673 (demonstrating the sort of logic the HCFA uses in making its determinations, as well as some key issues that inform the present consideration).

151. Friedrich v. Sec'y of Health & Human Servs., 894 F.2d at 831 (considering, and ultimately rejecting, the possibility of Medicare coverage of chelation therapy treatments for atherosclerosis).

152. *See, e.g.,* Rubman v. Bd. of Natureopathic Examiners, No. CV 950467235, 1996 WL 434265 (Conn. Super. Ct. July 17, 1996) (dealing with charges against one such nontraditional practitioner); Michael H. Cohen, *Holistic Health Care: Including Alternative and Complementary Medicine in Insurance and Regulatory Schemes*, 38 ARIZ. L. REV. 83 (1996); Danyll Foix, *From Exemptions of Christian Science Sanatoria to Persons Who Engage in Healing by Spiritual Means: Why* Children's Healthcare v. Vladek *Necessitates Amending the Social Security Act*, 15 LAW & INEQ. J. 373 (1997).

153. Cohen, *supra* note 152, at 85.

fare of patients.[154] Although art and music therapy treatments, as discussed in Part II.B above, are useful for treating many specific forms of cognitive and mental defects, they are not palliative of illness or injury in the physical sense that muscular or speech therapy are, and would therefore most likely be denied coverage. Further, the Medicare Carriers Manual has also mandated that, in order to receive coverage, treatments should be:

> (1) considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition; (2) . . . of such a level of complexity and sophistication . . . that the services required can be safely and effectively performed only by a qualified therapist or under a therapist's supervision; (3) . . . provided with the expectation that the patient's condition will improve significantly in a reasonable, and generally predictable, period of time, or . . . necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state; (4) . . . [reasonable in] amount, frequency, and duration.[155]

It seems once again that these requirements would exclude art and music therapy from Medicare's coverage. First, these therapies, like many so-called nontraditional forms of patient care, would probably not fare so well under "accepted standards of medical practice," if taken to mean the mainstream medical community. Second, the "specificity" and "sophistication" of these treatments are likely to be underrated as well—there are still those who view music and art therapies as mere creative exercises or diversions rather than scientifically backed treatments.[156] Finally, as characterized in Part II.B above, these therapy treatments are more likely to work gradually and unob-

154. PHYSICAL OCCUPATIONAL, AND SPEECH THERAPY SERVICES, MEDICARE & MEDICAID GUIDE (CCH) ¶ 3128 (Jan. 26, 1999) (citing *Coverage and Limitations,* MEDICARE CARRIERS MANUAL, HCFA Pub. 14 § 2210.A).

155. *Id.*

156. This statement is further substantiated by an analysis of the Medicare Carriers Manual's choice of therapies for further analysis. The manual discusses in detail standards to be applied to various physical therapy tasks to see if they are covered, including range of motion tests (covered because too technical to be provided by anyone but a qualified therapist, § 2210.3) and heat treatments and baths (generally excluded because they do not require the skill, knowledge, and judgment of a qualified therapist, § 2210.3). *Coverage and Limitations,* MEDICARE CARRIERS MANUAL, HCFA Pub. 14 § 2210.3. Similarly, the general requirements for valid therapy coverage are analyzed and defined specifically for the fields of speech pathology (§ 2216) and occupational therapy (§ 2217). *Id.* No discussion, or even a mention, is given to art or music therapy in the Medicare Carriers Manual. This seems to give credence to a view that the Social Security Act's definition of therapy in terms of physical, occupation, and speech therapy was meant to be an exclusive reading of that term. 42 U.S.C. § 1395x (2001).

trusively to improve overall mental health and functioning than to cause a patient to "improve significantly in a reasonable, and generally predictable, period of time." Therefore, art and music therapy are not services covered under Medicare Part B.[157]

One recent court decision is of note simply because it deals with the interaction of traditional medical standards and Medicare coverage. In the case of *Cedars-Sinai Medical Center v. Shalala*,[158] a California court dealt with an interpretation of the Medicare Act by the Secretary of Health and Human Services that excluded per se all services using medical devices not approved for marketing by the Food and Drug Administration (FDA).[159] Although the court did not pass judgment on the contents of this interpretation, it did state that it went beyond mere interpretation of the Act and was a substantive agency rule.[160] Thus, it should have been subject to public notice and comment rulemaking procedures.[161] The implications of this holding are not exactly grand, but they are nonetheless interesting. The case demonstrates that the state of the medical mainstream art is not necessarily determinative for purposes of Medicare coverage as the Act has traditionally been construed. Organizations other than the FDA should generally be involved in the determination of what treatments are "reasonable and necessary"; unless, of course, the Secretary should follow formal procedure to change the rule. Because the Medicare Act itself mandated only reasonableness and necessity, interpreting it to require FDA approval "withdrew coverage previously provided and thus effect[ed] a change in existing law or policy."[162] Such a change could not be casually allowed.

More mainstream forms of cognitive treatment, namely traditional psychotherapy, fare better under Medicare, but still face some administrative red tape. The Act does allow patients to receive reasonable and necessary "qualified psychologist services,"[163] but sub-

157. Cedars-Sinai Med. Ctr. v. Shalala, [New Developments] Medicare and Medicaid Guide (CCH) ¶ 44,188 (C.D. Cal. 1996).
158. *Id.*
159. *Id.*
160. *Id.*
161. *Id.*
162. *Id.* (quoting Linoz v. Heckler, 800 F.2d 871, 877 (9th Cir. 1986)). The quoted case is a good example of the zealousness with which courts examine administrative changes to existing substantive rights.
163. The Act defines "qualified psychologist services" as "such services and such services and supplies furnished as incident to his service furnished by a clinical psychologist (as defined by the Secretary) which the psychologist is legally au-

jects these services to a number of burdensome technical requirements. For instance, regulations have limited patients to a maximum of ninety days of inpatient psychiatric hospital services per benefit period.[164] In addition, there is a lifetime maximum on inpatient psychiatric care of 190 days.[165] Moreover, private health insurers have followed suit, imposing limits on days of care allowed and dollar amount caps on services, in many cases even denying treatment as not "medically necessary" unless severe symptoms are present.[166] These limitations have been questioned on a number of grounds, with practitioners noting the excellent record of patients in deciding for themselves whether treatment is "necessary" and the tendency toward overdiagnosis these requirements may create.[167] Simply put, these constraints on traditional therapy are unwarranted and potentially hazardous to a great number of seniors.

It should be briefly noted that some major movements are underway to attempt to achieve parity between treatments for mental and physical health.[168] Several states, including California, Missouri, Indiana, Texas, and Minnesota, have enacted legislation requiring that private health plans provide at least some degree of equality between mental health and physical health coverage.[169] Clearly, these are positive steps for protecting an individual's mental health from severe disability, but they probably will still not embrace the sort of treatments for general cognitive health discussed here.[170] Thus, there is

thorized to perform under State law. . . as would otherwise be covered if furnished by a physician or as incident to a physician's services." 42 U.S.C. § 1395x(ii) (2002).

164. 42 C.F.R § 409.61 (West 2002).

165. *Id.* § 409.62.

166. Robin F. Goodman, *Prescriptions for the Future: Managed Care*, 36 AM. J. ART THERAPY 35, 37 (1997). Goodman sums up these treatment requirements succinctly: "[s]uicidal behavior is an obvious symptom, feeling unhappy is not." *Id.*

167. *See id.* at 37–38. Goodman notes that the vast majority of patients, regardless of their insurance, enter psychotherapy only briefly and with specific and solvable problems. *Id.* The median length of treatment is only six to ten sessions. *Id.* at 38.

168. *See* AARP RESEARCH CTR., MENTAL HEALTH PARITY: AN OVERVIEW OF RECENT LEGISLATION, AARP RESEARCH CTR., *at* http://research.aarp.org/health/fs69_mental.html (last visited Oct. 30, 2001).

169. *Id.*

170. *Id.* Many of these legislative acts are focused merely on serious mental illnesses, and most seem to be targeted at psychotherapy or pharmacology rather than so-called nontraditional treatments. *Id.* For instance, the federal Mental Health Parity Act merely required employers offering mental health care to equalize their annual and lifetime spending limits for mental and physical illnesses. *Id.* It did not address the common limitations plans had placed on the number of inpatient days and outpatient visits patients could receive for their mental illnesses.

still much progress that must be made to protect the quality of mental health and life in general that Americans are able to enjoy as seniors.

IV. Recommendations

The obvious and common solution to any apparent gap of coverage in a statute is simply to suggest that the statute be amended to clearly cover the current problem. However, in this case it is equally clear that Medicare simply cannot be expanded to embrace every single treatment that might be useful to patients. The statute is already broad and covers many necessities for seniors at an enormous national expense.[171] It seems likely that these seniors who depend on Medicare would rather endure the inconvenience of a few missing services than risk bankrupting the system. Further, precisely because these therapies are so useful at addressing a broad base of small problems, they could be greatly sought after and result in a great additional expense for the nation. Line drawing problems would abound in deciding which patients most deserve or require mental health therapies to combat their "normal" aging difficulties. Even when using the therapies to combat more serious illnesses, it would be difficult for the system to decide which conditions most merit therapeutic attention. Putting the legislative headaches of revising a statute aside, the administrative problems still outweigh the potential benefits of a Medicare system that includes the possibility for art and music therapy.

Of course, another possibility is simply for HCFA and courts to interpret the statute as allowing this type of coverage. As demonstrated by Part IV.B above, the statement in the statute that covers treatments "reasonable and necessary" for illness or injury is somewhat ambiguous, and HCFA has been given latitude for interpretation. Therefore, HCFA (perhaps after lobbying from various industry associations) could simply issue a National Coverage Determination announcing that such therapies will be covered. However, at the

Id. State laws have targeted these remaining restrictions, and other restrictions on care, including differences in deductibles, coinsurance, and copayments between mental and physical health care plans. *Id.* So if anything, these movements show the growing recognition of the importance of mental health, if not its many subtleties.

171. In 1998, Medicaid provided benefits to over thirty-seven million individuals at a combined federal and state cost of over $160 billion. LAWRENCE A. FROLIK & RICHARD L. KAPLAN, ELDER LAW IN A NUTSHELL 102 (2d ed. 1999).

same time, the same cost and consistency issues described above in conjunction with a change in the statute would remain a problem. Therefore, this sort of legal change is perhaps not the most effective solution to the problem.

An obvious component to any attempt to solve this problem is an increased public awareness of the difficulties of aging and the potential solutions offered by mental health therapies. Perhaps one of the reasons for the lack of availability of these treatments is simply a lack of demand from an uneducated public. Here, the government can play a large role by underlining the success and importance of these programs, even if not directly subsidizing them. Any number of government health education programs already exist, and there is no reason that therapies for the aging should be treated differently. Similarly, practitioners, both medical and legal, can be involved in the process of informing clients about the "normal" losses of aging and services to combat them. Although such advice would be awkward to give (and practitioners should avoid unethical overreaching), it can also be extremely effective, and the universality of certain cognitive losses associated with old age should ease the awkwardness somewhat. Further, involvement in care management for older patients is becoming more and more not just the province of the patient, but also his or her multiple advisors.[172] Awareness is truly key.

To that end, even this Note may in some way be a positive step toward reducing the losses aging naturally brings us. For even if no formal steps are taken to increase access to therapies for gerontological mental health, more informal awareness of the problems of aging can be a big step toward reducing the problems of aging themselves. Many of the capacities reduced in the aging process seem to do so due to atrophy,[173] and many of the benefits of music therapy can be achieved in some regard through more informal approaches. Although the careful selection and monitoring of activities involved in music and art therapy are vital components of their success, there seems to be some benefit to be achieved simply from the activity of listening to music or creating art. Even in informal musical sessions, the same physiological processes of expectation building, suspense, and felicitous resolution can be experienced. And regardless of their

172. *See id*. (noting the involvement of attorneys in planning patient care for their clients through devices such as advanced medical directives).

173. *See generally* AGING AND HUMAN PERFORMANCE (Neil Charness ed., 1985).

physiological effects, it cannot be forgotten that music and the arts are enjoyable and enriching experiences. Seniors can use them not just to build their minds, but to build relationships, build memories, and build active lives.

Thus, these recommendations end in a most unscholarly fashion, with a call not for change of law but change of lives. Seniors, and all of us, must not simply wish to remain sharp as we age; we must resolve ourselves to remain so. Cognitive exercise is the key to cognitive health. Do a crossword, stitch a needlepoint pattern, or take up an instrument. Make a long life an active one as well.

V. Conclusion

The fullness of Americans' long lives is increasingly threatened by natural cognitive defects and more serious mental disorders that can occur with age. These problems can be serious or barely noticeable, and include losses in fluid intelligence, emotional stability, and memory. A wide array of therapy programs work to combat these problems, including creating helpful cognitive stimuli and modeling positive emotional resolution for patients. Clinical studies have demonstrated these to be extremely effective. However, due to various factors such as education, salary, and the structure of the medical community, these therapies are not as widely available as they could be. Medicare and other government instruments targeting public health also do little to accommodate, much less promote, their regular use as part of treating the elderly. Therefore, to encourage seniors to maintain their minds, efforts must be made to increase the public awareness through dissemination of information both about mental health and about the therapies themselves. Government, legal and medical practitioners, and private citizens can all play a role in increasing the use of these therapies with the potential to make our lives not only long, but also productive and fulfilling.