White House Conference on Aging
Connecticut Public Forum and Comment Session
Tuesday, May 5, 2015 – 11AM – Legislative Office Building room 2A

Comments from Jennifer Glick, RN, LMSW
CT Department of Mental Health and Addiction Services, Director of Older Adult Services
Co-Chair of the Older Adult Behavioral Health Workgroup, a Member of the National Coalition on Mental Health and Aging

As Director of Older Adult Services at the CT Department of Mental Health and Addiction Services and Co-Chair of the Older Adult Behavioral Health Workgroup, I would like to ***offer comments under the four categories of special interest at the 2015 White House Conference on Aging: <u>Retirement Security, Healthy Aging, Long Term Services and Supports, and Elder Justice</u>.***

Introduction: The Demographic Imperative

America is dramatically aging, and a contributing factor is the cohort of Baby Boomers, those born between 1946 and 1964. Currently, in the U.S., older adults make up 13% of the general population; in CT, 15%. By 2020, on a national basis, older adults are expected to make up 20% of the general population. Overall, the older adult population is becoming more ethnically and racially diverse, is living longer, many with several health conditions, and consequently facing higher health care service needs.

The *1999 Surgeon General's Report on Mental Health* noted that "….Disability due to mental illness in individuals over 65 years old will become a major public health problem in the near future because of demographic changes." ***According to the Institute of Medicine, by 2020, there will be nearly 11 million older adults with one or more mental health and/or substance use disorders.*** (*The CT Department of Public Health 2014 Supplement to the Statewide Healthcare Facilities and Services Plan noted that males age 45-64 had the highest rate of hospitalizations for mental disorders in 2012. This number includes Baby Boomers.*)

Suicide is also a major concern for older adults. This is evidenced by 2010 Centers for Disease Control and Prevention (CDC) data that shows the suicide rate for persons age 65 and older as 14.9 per 100,000 compared to 12.4 per 100,000 for the general population. In certain parts of CT, the suicide rate approaches the national average for older adults. Studies have shown that about ***70% of older adults who die by suicide have visited their PCP within one month of the suicide.***

Given the rapidly changing demographics, the older adult population presents major challenges to the nation's public and private primary care and behavioral health systems.

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Category #1: Retirement Security

Medicare and Medicaid financing mechanisms should be restructured to support integration of older adult behavioral health and primary care and to support interdisciplinary care coordination and treatment teams.

One of the conclusions in the 2012 Institute of Medicine Report: *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* was that ***Medicare and Medicaid coverage polices present a significant barrier for older adults in obtaining care for mental health and substance use disorders.*** The same report noted a ***severe shortage of practitioners in the behavioral health and aging workforce.*** In order to provide integrated behavioral health services with primary care, the workforce must become more broad and inclusive of multiple health care professionals, such as home health aides, personal care attendants, care managers, peer support specialists, housing managers, along with primary care physicians, geriatricians, geriatric psychiatrists, and physician assistants.

Additionally, as a result of the 1999 U.S. Supreme Court Olmstead decision, there is an emphasis on home and community-based services. ***Treatment settings for older adults, especially those with behavioral health needs, have moved from institutions, such as hospitals and nursing homes, to the entire long term care system, including the aging network, the mental health system, private practices, and even a person's own home.*** Medicare and Medicaid policies often limit service accessibility to clinical settings only.

Bottom line: Medicare and Medicaid provide an essential safety net for older adults. Without changes in policies, many will not have the necessary behavioral health services and supports they need.

Category #2: Healthy Aging

a) **Congress should reauthorize the Older Americans Act (OAA) and retain the mental health provisions that were part of the Act's 2006 amendments. Specific funding should be appropriated to assure implementation.**

Mental health and physical health are critical components to optimal functioning. This is particularly true with respect to aging, which can be complicated by changes in physiology, cognition and social functioning. The 2006 OAA amendments added provisions to grant programs for mental health screening and treatment services for older adults. The amendment also addressed programs to increase public awareness and reduce the stigma of mental illness. However, the OAA provides no specific

funding and the provisions have not been implemented. While research has shown the effectiveness of several behavioral health interventions, ***older adults not only represent an underserved population, but also are at increased risk for receiving inadequate and inappropriate care.***

b) Recommendations from the 2012 Institute of Medicine Report must be addressed by federal agencies.

The Institute of Medicine Report documented that the current and future mental health and substance abuse workforce is inadequate in numbers, education and training- particularly to address the behavioral health needs of the rapidly growing number of older Americans. It was recommended that federal agencies establish uniform data reporting categories so that older adult behavioral health programs can be identified and evaluated, and to also encourage interagency coordination and planning. Additionally, with respect to education and training, ***it is important to consider that the geriatric workforce receive cross-training not only in aging but also mental health and addictions. Also, given the diversity of the population, older adult behavioral health services must be linguistically, culturally, ethnically, and age appropriate.***

Category #3: Long Term Services and Supports

a) Re-establish the Substance Abuse Mental Health Services Administration (SAMHSA) Older Americans Behavioral Health Technical Assistance Center and grant programs to support implementation of behavioral health evidenced-based practices.

Despite being determined successful, the Technical Assistance Center and the Older Adult Targeted Capacity Extension Grant program were ended in 2012; neither has been replaced with other initiatives. Again, the *1999 Surgeon General's Report on Mental Health* noted that "….Disability due to mental illness in individuals over 65 years old will become a major public health problem in the near future because of demographic changes." Given this expectation, ***older adults should be identified as a target population for public mental health and substance abuse program funding.*** The SAMHSA National Registry of Evidenced-based Practices and Programs (NREPP) includes several programs specific to older adults for identification, prevention and treatment of mental illnesses and substance abuse disorders. *(Please see page 5 for a list)* Recently the Connecticut State Department on Aging released an RFQ for one of these programs: Healthy IDEAS. However, more can be done with federal support.

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b) Funding should be provided to support research and development of prevention programs that address older adult suicide.

According to the Centers for Disease Control and Prevention (CDC), the suicide rate of adults aged 75 and older is 16.3 per 100,000, more than the national average for all age groups. ***Males over age 75 have the highest rate (36 per 100,000) and often depression and alcohol abuse lead to dying by suicide.*** There has been little research on the prevention of older adult suicide and few programs have been developed and evaluated.

Category #4: Elder Justice

The Elder Justice Act, as well as elder abuse protections included in the Older Americans Act, must be funded by Congress.

The Elder Justice Coalition estimates that one out of every ten persons age 60 and older is a victim of elder abuse annually. ***And the CDC identifies older adults with a diagnosis of mental illness or alcohol abuse as being at increased risk of elder abuse.*** Other risk factors include lack of support for family caregivers and the lack of further research. Less than two per cent of federal funds are expended on addressing this important issue.

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Examples of Evidenced-based Practices in Older Adult Behavioral Health

There is evidence supporting the effectiveness of a variety of mental health interventions. Listed below are **evidenced-based practices** that address the behavioral health needs of older adults:

1. IMPACT: Located in primary care settings; a team-based approach to address depression including psychotherapy and rigorous symptom monitoring via a depression care manager.

2. PROSPECT: Located in a primary care setting with a similar focus as IMPACT. However, physicians are trained to use an algorithm that helps identify suicide risk.

3. Healthy IDEAS: Located in long term community-based care management settings; provides depression screening, education, simple behavioral change activities, and coordination across service systems.

4. PEARLS: Located in community-based case management; provides in-home, team-based program including psychotherapy for varying degrees of depression.

5. SBIRT: Can be provided in any setting; provides substance use screening, education to prevent problem use and abuse, and connection to formalized treatment for individuals using at abuse or dependence levels.

6. PRISMe: A research study that assessed the use of a mental health and substance abuse specialist co-located in a primary care practice to enhance treatment (integrated care model)versus the use of direct referral to specialty care (enhanced referral model) for older adults with depression, anxiety, or alcohol use problems. Conclusion: the integrated model was preferred for many aspects of mental health care.

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