Aging and Disability Resource Center Older Adult Behavioral Health Asset Mapping Study

Final Report

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Introduction and Background

In 2012, representatives from the Connecticut (CT) Department of Mental Health and Addiction Services (DMHAS), the Department of Social Services (DSS), and the State Department on Aging (SDA) attended the Older Americans Behavioral Health Technical Assistance Center Policy Academy Regional Meeting at the Substance Abuse Mental Health Services Administration (SAMHSA) headquarters in Rockville, MD. The purpose of that meeting was to explore the increasing challenges and costs of promoting behavioral health care for older adults, and focused on anxiety, depression, prescription medication and alcohol abuse/misuse, and suicide prevention. Acknowledging that behavioral health issues other than those connected with dementia were rarely discussed, the CT state team attending the Policy Academy established the Older Adult Behavioral Health Workgroup (the "Workgroup") with the mission of improving access and delivery of behavioral health services to the older adult population in CT. "Older adult" is defined for these purposes as persons age 55 and above.

Currently under the leadership of DMHAS, the Workgroup is comprised of representatives from DMHAS, other state agencies and private, non-profit organizations. As indicated in its mission statement and goals (Appendix B), the Workgroup focuses on increased communication, collaboration, and problem solving among providers who work or have contact with older adults in a broad range of settings. Through ongoing monthly meetings and other activities, the Workgroup continues to focus on improving the quality of life for older adults needing behavioral health services and their family members, and improving the currently inadequate behavioral health care system serving older adults that is unprepared to meet the upcoming crisis in geriatric behavioral health.

A number of factors contribute to the crisis in unmet behavioral health needs of older adults both nationally and in CT. These factors contribute to decreased quality of life, increased utilization of health care services and costs, including higher mortality rates, and in some situations may result in unnecessary institutionalization.

Factor 1. Unprecedented Growth in the Older Adult Population

Well over a decade ago, the Surgeon General stated that, "Disability due to mental illness in individuals over age 65 will become a major public health problem in the near future because of demographic changes" (U.S. Department of Health and Human Services, 1999). Clearly, the population in America is aging rapidly (Bartels, Pepin, & Gill, 2014). Currently in the United States, older adults make up 13 percent of the general population; by 2030 that figure is projected to grow to 20 percent (Ortman, Velkoff, & Hogan, 2014). By 2025, older adults will make up at least 20 percent of the population of almost every CT town (U.S. Census Bureau, 2014), up from 15 percent of the general population today (U.S. Census Bureau, 2015). It is projected that between 2012 and 2030, CT's population age 60 and older will increase 30 percent (U.S. Administration on Aging, 2012).

Of particular concern is the unprecedented growth in the older adult population in CT because this population experiences increased health risks and related hospitalizations (Connecticut Department of Public Health, 2014). Population growth underscores the urgency, and current data indicate how great the need is. For example, in CT between fiscal year (FY) 2013 and 2015, internal data on DMHAS clients age 55 and older show a 13 percent increase in the number of clients receiving mental health and substance abuse services across all regions (20,521 and 23,463, respectively) (J. Glick, personal

communication, October 16, 2015). Not surprisingly, the majority of increase occurs in the group representing Baby Boomers. The same data show opioid dependence, major depressive order, alcohol use disorder, and posttraumatic stress disorder among the top ten primary diagnoses for CT adults age 55 and older (J. Glick, personal communication, October 16, 2015). The consequences of non-treatment for these behavioral health conditions are devastating and include homelessness, incarceration, episodes of violence, victimization, suicide, and fiscal costs (Treatment Advocacy Center, 2015).

Factor 2. Diversity

The older adult population is becoming more diverse with regard to "generational cohorts, gender, minority status, income, living arrangements, and physical and behavioral health" (U.S. Department of Health and Human Services: Administration on Aging, 2001, p. ix). An estimated one-fifth of older adults are currently members of racial or ethnic minority groups (U.S. Administration on Aging, 2013). In a 2012 profile of CT, of those age 55 and older, 89 percent were White, 7 percent were Black, 2 percent were Asian; 2 percent were other; 3 percent were Hispanic (U.S. Administration on Aging, 2012). These percentages are similar to national figures released in 2014 in which non-Hispanic Whites made up 85 percent of the population 65 and older; 9 percent were non-Hispanic Black; 3 percent were Hispanic; 2 percent were Asian, and 1 percent were other (U.S. Census Bureau, 2014). Percentages, however, are projected to change at the national and state levels with the fastest growth occurring in the older Hispanic population, from 2 million in 2000 to more than 13 million in 2050 (Cohen & Eisdorfer, 2011). By 2050, 42 percent of the older adult population will be members of racial or ethnic minority groups, and over the next four decades there will be a 21 percent increase of racial and ethnic minority groups (U.S. Administration on Aging, 2013).

The prevalence of behavioral health conditions vary across and within racial and ethnic older adult groups and may be influenced by immigration status, gender, education, income levels, life events, and region (U.S. Administration on Aging, 2013). For example, historically older adults living in rural areas have higher rates of behavioral health disorders (e.g., depression, substance misuse, suicide) than other older adult populations because of the difficulties of providing services in more remote areas (Chalifoux, Neese, Buckwalter, Litwak, & Abraham, 1996).

The health care needs of older adults are also diverse. Older adults are living longer, many with comorbidities, and as a result facing greater health care service needs, including those related to behavioral health (Ortman et al., 2014). As many as one-fifth or an estimated six to eight million older adults experience one or more behavioral health or substance use conditions (Institute of Medicine, 2012). Older women, for example, are more likely to have a behavioral health disorder and older men are more likely to have a substance misuse or abuse disorder (Institute of Medicine, 2012). Among minorities, the onset of chronic illness is typically earlier than in Whites and minorities tend to have a higher incidence of obesity and late onset diabetes (American Psychological Association, 1998).

In spite of the need for behavioral health services, fewer African American and Hispanic older adults seek such services than their non-Hispanic White counterparts, and studies show that these disparities exist after adjusting for behavioral and physical conditions, demographic characteristics (e.g., socio-economic status, education level), and type of insurance coverage (U.S. Administration on Aging, 2013). A better understanding of the

health and socioeconomic needs older culturally diverse populations experience is needed so that increased services and supports can be offered to this growing group of people and their families.

Factor 3. Behavioral Health Disorders

Anxiety, depression, and suicide

While the majority of older adults enjoy good behavioral health, about 20 percent of those 55 and older experience behavioral health disorders (e.g., anxiety, depression) that are not a normal part of aging (The John A. Hartford Foundation, 2011; U.S. Department of Health and Human Services: Administration on Aging, 2001). If that percentage holds true for CT, that would translate into approximately 184,000 adults age 55+ with a behavioral health disorder. It is expected that the number of older adults with behavioral health disorders will increase to 15 million by 2030 (Jeste et al., 1999; National Council on Aging, 2014). In addition, nearly two-thirds of nursing home residents demonstrate behavioral health conditions (The American Psychological Association, 2015), and in a 2011 and 2012 study, outcomes show that nearly half of nursing home residents had depression (Harris-Kojetan, Sengupta, Park-Lee, & Valverde, 2013).

Of the seven million older Americans affected by depression, many do not receive treatment (National Council on Aging, 2014). Symptoms of depression and anxiety are frequently overlooked and untreated in older adults because they coincide with other late life occurrences including: retirement, health-related events, loss of loved ones, and other losses (American Psychological Association Office on Aging, 2005; U.S. Department of Health and Human Services: Administration on Aging, 2001). The incidence of depression can increase significantly in specific subpopulations of at-risk older adults because they typically do not recognize depression as a clinically distinct condition, as they would other medical conditions (Charney et al., 2003). Evidence-based disease self-management for depression, such as Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors), uses practical interventions with clients in their home setting, such as 1) screening for symptoms of depression and assessing severity, 2) educating older adults and caregivers about depression, 3) linking older adults to primary care and mental health providers, and 4) empowering older adults to manage their depression through a behavioral activation approach that encourages involvement in meaningful activities (Centers for Disease Control and Prevention and National Association of Chronic Disease Directors, 2009). The intervention which underscores an exemplary partnership between State Units of Aging (SUA) and State Mental Health Authorities (SMHA) incorporates case management during home visits and phone calls, and is also adaptable to culturally diverse populations with varying education levels (Centers for Disease Control and Prevention and National Association of Chronic Disease Directors, 2009).

There is a strong association between behavioral health problems, particularly depression symptoms, and disability related to medical illness. For over a decade, it has been known that older adults with depression seek care more often, use more medication, receive higher outpatient charges, and have longer hospital stays than their counterparts without depression (U.S. Department of Health and Human Services, 1999). In a more recent study comparing older adults with chronic illnesses (i.e., diabetes, congestive heart failure) results demonstrated that the group with chronic illnesses and depression had nearly twice the health care costs of those with the same medical illnesses but no depression (Unützer et al.,

2009). According to the Director of the Hartford Center for Excellence in Geriatric Psychiatry, University of Pittsburgh Medical Center, 6 to 10 percent of older adults receiving health care in primary care practice settings are diagnosed with clinical depression but this percentage increases to 20 to 30 percent among older adults being treated in acute inpatient facilities, skilled nursing facilities, chronic illness clinics, and other long-term care settings (The John A. Hartford Foundation, 2011).

Depression is a significant predictor of suicide (The John A. Hartford Foundation, 2011; National Institute of Mental Health, 2001). Although older adults comprise 13 percent of the population, they account for 20 percent of those who commit suicide and have the highest suicide rate of any age group (National Institute of Mental Health, 2001). Forty percent of older adults saw a physician within a week of committing suicide and three-fourths saw a physician within a month of committing suicide (Conwell & Pearson, 2002).

Substance use and abuse

Alcohol abuse and dependency is a major problem for older Americans and leads to malnutrition, other physical conditions, and a decline in cognitive functioning (U.S. Department of Health and Human Services: Administration on Aging, 2001; Zanjani et al., 2012). An estimated 17 percent of older adults misuse and abuse alcohol and medications and while most older adults (87%) visit a physician regularly, approximately 40 percent of those do not seek behavioral health services and are therefore unlikely to be treated for behavioral health disorders (American Psychological Association, 2015). The number of older adults with substance misuse and abuse problems is projected to double to five million by 2020 and will add to existing challenges in providing behavioral health services for older adults (National Council on Aging, 2014). Once the underlying causes of substance abuse are identified, clinicians can provide evidence-based treatments to older adults that trigger destructive behaviors and enable them to effectively address and avoid high-risk situations (Gfroerer, Penne, Pemberton, & Folsom, 2003).

Factor 4. Higher Incidence of Chronic Illnesses

Eighty-five percent of older adults experience at least one chronic health condition and an estimated 60-65 percent have two or more conditions (Vogelli, Shields, Lee, Gibson, Marder, et al., 2007). Approximately 50 percent of older adults have arthritis, 40 percent have hypertension, 30 percent have heart disease, 12 percent have diabetes, 30 percent have hearing loss, and 15 percent have cataracts (Speer & Schneider, 2003). Poor nutrition, inactivity, alcohol misuse and abuse, and smoking are negative but modifiable behaviors that may contribute to the commencement of or worsen chronic disease (U.S. Department of Health and Human Services, 2000). Behavioral interventions suggested by psychologists and consumer compliance to prescribed treatment are usually effective in successfully helping older adults manage multiple chronic illnesses (American Psychological Association, 2005).

Factor 5. Underutilization of Behavioral Health Services

Twenty percent of people age 55 and older and two-thirds of nursing home residents demonstrate behavioral health disorders, but less than three percent of older adults in the United States report seeking help from outpatient behavioral health clinics, psychiatric hospitals, and Veterans Affairs (VA) medical centers (The American Psychological

Association, 2015). In the community, only about one-third who need behavioral health and substance use treatment actually receive them (Cohen & Eisdorfer, 2011; National Council on Aging, 2014). Older adults represent an underserved population and are at increased risk for receiving inadequate and inappropriate care (Bartels, 2003; Bartels, et al., 2014). As a result, innovative strategies are needed to better understand behavioral health disorders in older adults and to address a health delivery system that has historically been fragmented and underfunded (Bartels & Smyer, 2002; Jeste et al., 1999).

Primary care network

A major factor in the underutilization of behavioral health services is that older adults with coexisting physical conditions who also need behavioral health services seek help in primary health care settings and are therefore much less likely to receive behavioral health services from a behavioral health specialist (Karel, Gatz, & Smyer, 2012). Primary care physicians (PCPs) who may not have adequate training in geriatric behavioral health are unlikely to identify or appropriately treat psychiatric illnesses (Cohen & Eisdorfer, 2011; The John A. Hartford Foundation, 2011). As a result, behavioral health problems in as many as 50 to 80 percent of older adults are unidentified and untreated, and others receive prescriptions that are inappropriate and ineffective (Cohen & Eisdorfer, 2011). The consequences of inadequate treatment are costly to the health care system and include a decline in physical health, increased disability, cognitive impairment; impaired functional effectiveness, compromised independent living and quality of life, and possibly greater caregiver stress (Cohen & Eisdorfer, 2011). Without adequate and appropriate treatment, older adults with behavioral health problems are more likely to have increased health care utilization, greater potential for disability, limited quality of life, and increased mortality (Bartels, 2003).

Shortage of geriatric behavioral health providers

Part of the reason people needing behavioral health treatment seek care from primary care physicians may be the critical shortage of geriatric behavioral health providers. Four disciplines share responsibility for managing behavioral health (i.e., psychiatry, psychology, social work, and nursing) and within these there are not enough geriatric specialists to meet the increasing need (The John A. Hartford Foundation, 2011). Of the 39,000 psychiatrists practicing in the United States, less than 2,000 are certified in geriatrics; by 2020, the projected need will be at least 6,000 geriatric psychiatrists (The John A. Hartford Foundation, 2011). In the United States, there are only 10-15 programs offering a geropsychology track (Institute of Medicine, 2012). Although only 4 percent of practicing psychologists identify geriatric psychology as their main area of focus, 39 percent of all psychologists indicate they provide services to adults over the age of 65 (American Psychological Association, 2009).

Geriatric psychiatric advanced practice nurses (APRNs) provide a large share of behavioral health services to older adults, but few graduate programs are available to train APRNs, leading to a shortage. Social workers also provide behavioral health services and although many work with older adults, they report they have not been specifically trained in geriatrics (The John A. Hartford Foundation, 2011).

There are numerous causes for the shortage in geriatric behavioral health providers including limited funding during the past decade and reduced importance of geriatric specialties in academic institutions. As a result, there are few opportunities for formal

training in geriatric specialties including a system of faculty mentors, peer networks, and research assistant positions to effectively support careers in aging (The John A. Hartford Foundation, 2011). Funding to expand the geriatric health care workforce is needed to meet provider shortages and ensure adequate care for a growing population of people needing behavioral health services.

Ageism and stigma

Other issues contributing to the underutilization of behavioral health services include ageism and stigma. Ageism, or prejudice towards older individuals and the aging process, is a discriminatory practice that has the potential to impact older adults in areas of employment and in other social roles. In one survey, nearly 80 percent of respondents reported experiencing ageism, such as people assuming they had memory problems due to age or being ignored and not valued because of their age; 58 percent in the same survey reported the most frequent type of ageism was being told a joke that makes fun of older adults (Cohen, 2001). Negative stereotypes are not only hurtful but may contribute to increased illness and shorten lives (Levy, Slade, Kunkel, & Kasl, 2002). One study noted the typical dismissals of physical complaints by older adults and the questions and comments by providers related to assumed age-related declines and problems (e.g., vision, hearing, memory, balance, incontinence) (Cohen, 2001). In addition, institutional policies and procedures that perpetuate stereotypic beliefs about older adults also have the potential to diminish their opportunities for a satisfactory life and undermine their sense of personal dignity and self-esteem (Nolan, 2011).

Stigma, a process in which certain people are excluded and discriminated against, is in part perpetuated by media portrayals of older adults with behavioral health problems, ignorance, and disrespect (Graham et al., 2003). The double stigma of older age and behavioral health disorder is one of the greatest barriers to ensuring access to behavioral health care, creates challenges in finding affordable and adequate housing, and isolates older adults with behavioral health disorders from other people in the community, thus eroding their sense of well-being and dignity (Graham et al., 2003; Sartorius, 2003). The Surgeon General's Report (U.S. Department of Health and Human Services, 1999, p. 6) described the powerful impact of stigma as follows:

> *Stigma erodes confidence that mental disorders are valid, treatable health conditions. It leads people to avoid socializing, employing, or working with, or renting to or living near persons who have a mental disorder. Stigma deters the public from waiting to pay for care and, thus, reduces consumers' access to resources and opportunities for treatment and social services. A consequent inability or failure to obtain treatment reinforces destructive patterns of low self-esteem, isolation, and hopelessness. Stigma tragically derives people of their dignity and interferes with their full participation in society.*

Factor 6. Lack of State-Specific Data for Older Adults Needing Behavioral Health Services

There is little data on CT older adults with behavioral health disorders, but what is known demonstrates a need for action. The dearth of data in CT specific to those age 55 and older with behavioral health disorders was a strong factor in implementing the Older Adult Behavioral Health Asset Mapping Project.

CT-specific data on adults experiencing behavioral health disorders

Most data are available only for adults ages 18 and older, with no further breakdown by age. Between 2009 and 2013, approximately 82,000 adults (3% of all adults) in the State reported serious mental illness (SMI) within a year prior to being surveyed by the Substance Abuse and Mental Health Services Administration (SAMHSA) (Substance Abuse and Mental Health Services Administration, 2015). Between 2009 and 2013, of an estimated 200,000 adults in CT with any mental illness (AMI), 55 percent reported not receiving any health treatment or counseling in the past year (Substance Abuse and Mental Health Services Administration, 2015).

Between 2009 and 2013, about 93,000 of CT adults (3.5%) had serious thoughts of suicide within the prior year (Substance Abuse and Mental Health Services Administration, 2015). While substance misuse and abuse are closely intertwined with behavioral health, specific data about substance abuse among older adults in CT is largely unavailable. CT-specific data available from the Behavioral Risk Factor Surveillance System (BRFSS), however, show that among older adults in CT during 2010 and 2011, 16 percent of men and 11.5 percent of women ages 50 and older reported 30-day binge drinking with an overall rate of 13 percent (U.S. Administration on Aging, 2012). Binge drinking is a serious problem in older adults who typically have less tolerance for alcohol as they age, and it can cause serious problems such as stroke, cardiovascular and liver disease, neurological damage, and complications for those with diabetes. Data from 6,580 admissions during 2010 to publically-financed substance abuse treatment show that alcohol was the primary substance of abuse in approximately 73 percent of admissions among individuals 50 and older (U.S. Administration on Aging, 2012).

Data on illicit drug use is also largely unavailable for older adults in CT, but it is startling that nationally since 2002 illicit drug use has more than doubled among those age 50-59 (U.S. Administration on Aging, 2012). According to the U.S. Administration on Aging (2012), this trend is in large part due to the aging of Baby Boomers whose rates of illicit drug use have been higher than those of earlier cohorts. Data from the Treatment Episode Data Set (TEDS) suggest a strong relationship between substance use and behavioral health disorders and show that slightly more than 2 percent of individuals being served by the CT behavioral health system were ages 65 and older; this represents about 1,800 individuals whose data were captured at the time of admissions and reported to TEDS (U.S. Administration on Aging, 2012).

BRFSS data provides a small snapshot of behavioral health data on older adults in CT showing that in 2011 adults in the 50-64 age group were more likely than those in the 65 and older age group (9% vs. 7%) to report frequent mental distress (FMD) (U.S. Administration on Aging, 2012).

Additional data captured by BRFSS measures of behavioral health show risk factors for both behavioral and physical illness and include: Social support, life satisfaction, current depression, lifetime diagnosis of depression, and lifetime diagnosis of anxiety disorder (U.S. Administration on Aging, 2012). Results on these indicators show that nine percent of older adults age 55 and older rarely or never get social or emotional support; five percent are very dissatisfied or dissatisfied with life; nine percent have a diagnosis of current depression; 14 percent have a lifetime diagnosis of depression; 10 percent have a lifetime diagnosis of anxiety disorder (U.S. Administration on Aging, 2012).

As noted in the *Statewide Survey Results* report, while primary care physicians were a targeted group for the statewide survey due to the valuable perspective they have to offer, physicians completed very few surveys and attempts to send email survey invitations through several physician organizations were declined. Recent results of a survey assessing CT physician perspectives on care delivery reform were, however, published in February 2015, and provide some useful data regarding the attitudes of primary care physicians in CT. In response to a main goal of the CT State Innovation Model (SIM) and to provide a baseline assessment of CT's physician workforce, UConn Health and Yale School of Public Health partnered to conduct a statewide survey of primary care physicians to assess physician perspectives on care delivery reform and readiness for change (Aseltine et al., 2015). Consistent with SIM goals, CT aims to support the advanced medical home (AMH) and care coordination, one of its primary components. Although they are not limited to older adults, results disseminated by Aseltine et al. (2015) are informative, especially as they pertain to behavioral health challenges. Outcomes from the physician survey show that half of physicians (50%) reported that recognizing behavioral health problems in their patients was "somewhat" or "very challenging." Nearly half of physicians (47%) reported referring patients for behavioral health treatment was "very challenging," and overall 80 percent of physicians reported finding appropriate treatment for their patients needing behavioral health services was "somewhat" or "very challenging" (Aseltine et al., 2015).

The SIM physician survey also captured data on cultural competency showing that physicians reported "very little" or "some" (42% and 48%, respectively) formal training in ways to improve communication with ethnically and culturally diverse patients. Seventy-three percent of physicians reported enlisting help from their patient's family or friend to assist in interpreting "sometimes," "usually," or "always." In addition, two-thirds of physicians reported that using Information Technology (IT) and Electronic Health Records (EHR) was "somewhat" or "very challenging." Although physicians agreed IT and EHRs contribute to improved quality of patient care and improved care coordination, many believe these systems negatively impact the effectiveness of providing care (Aseltine et al., 2015).

Connecticut Asset Mapping Project

Led by a partnership between the CT DMHAS and the State Department on Aging (SDA), and funded in part through the Enhanced Aging and Disability Resource Center (ADRC) Options Counseling Grant from the Administration for Community Living, the Workgroup engaged UConn Health, Center on Aging (UConn COA) to assist with an asset mapping project. The project's goals were to: 1) review and map community assets that benefit older adults with behavioral health needs, 2) review resource issues, such as overlaps, gaps, and hidden resources and barriers that can impact the implementation of programs/services, 3) identify potential areas where coordination and collaboration could benefit older adults with behavioral health needs, and 4) make recommendations for future action steps the Workgroup and the State of CT can take to improve the behavioral health service delivery system for older adults.

The year-long asset mapping process began in the summer of 2014, focused on identifying strengths and needs by region, and consisted of four phases. In the first phase of the process, the UConn COA led 10 focus groups across the state from July to September of 2014 (two per region as defined by ADRC catchment areas) with behavioral health professionals and other professionals who refer older adults to behavioral health services. Because providers as a group were the least likely to attend a focus group due to their tightly scheduled days, their views were under-represented in the focus groups. In order to supplement the focus group findings and

explore provider views in more depth, in Phase 2 UConn COA conducted ten provider interviews, two in each of the five regions, between October and December 2014. The last two phases of the mapping process included five community forums (one per region, conducted in April and May of 2015), and a statewide electronic survey fielded from mid-February to mid-May of 2015.

This report integrates findings from all four phases of the asset mapping project and presents conclusions and recommendations for the consideration of the Workgroup to inform future direction and action steps to improve the behavioral health services delivery system for older adults.

Detailed results, methodology, and analyses of the four individual phases of the project are described in detail in separate reports: *Regional Focus Group Results, Provider Key Informant Results, Community Forum Results,* and *Statewide Survey Results*. Reports are available on the following websites: CT State Department on Aging at **http://www.ct.gov/agingservices** and UConn Health, Center on Aging at **http://www.uconn-aging.uchc.edu/older-adults-behavioral-health-asset-mapping-study.html**

Study Conclusions

For the most part, data gathered through focus groups, provider interviews, community forums and the 858 respondents to the statewide survey were fairly consistent in identifying certain "community assets" as the backbone and sources of strength of the existing behavioral health system for older adults. There was also considerable overlap among the groups in the much longer and more comprehensive recitation of "resource issues," the gaps and barriers that need to be overcome to create a more robust and effective system. Gaps and barriers identified by CT informants in all four project phases are similar to those named in the overall national data summarized in this report's introduction, but with additional local flavor and specificity that should prove useful to the Workgroup. Finally, informants identified potential areas of coordination and collaboration that may, if achieved, lead to improvements in the older adult behavioral health delivery system.

This section summarizes in turn the data gathered over the course of this project regarding community assets, resource issues, and potential areas of coordination and collaboration.

Community Assets

Community assets are strengths and resources that improve the quality of community life. These assets can include a person (e.g., librarian, police officer, counselor, health worker), a physical structure (e.g., library, hospital, church, university), community service (e.g., public transportation, senior center program), and businesses that provide jobs and support the local economy. Everyone in a community or region is a potential community asset. For example, some individuals have knowledge, skills (e.g., leadership) and/or vision they can share while others may be able to contribute money or time to a project. Potentially, nearly everyone in a community or region of the state can be a force for community or system improvement.

Respondent information from the four phases of this project demonstrates that CT has many resources including a full spectrum of behavioral health services. It should be noted that these assets are not always available throughout the state for everyone needing them, at a cost they can afford, for a variety of reasons that are addressed under the "Resource Issues" section.

Respondents reported the benefits of specific programs in particular settings (e.g., hospitals, behavioral health centers), group therapy, counseling, care/case management, and integration of services between some primary care physicians and behavioral health professionals. They mentioned the value of teamwork referrals, implementing team meetings between collaborators, combating stigma related to behavioral health, integrating primary and behavioral health to increase referrals, and educating providers about the best time to refer. Those involved in staff training or aware of it in their organization remarked on the benefit of that practice as well as those involved in promoting awareness, recognition, and education related to behavioral health. Some key informant providers and statewide survey respondents remarked on the importance of contributions made by medical schools and academic institutions.

Tables 1 and 2 provide examples of the broad range of resources that were reported as community assets by individuals participating in the project. More detailed information can be referenced in the reports. Unfortunately, the community assets data provided by informants is for the most part generic, and does not give a clear picture of how widespread the assets are, how many persons they currently serve, whether they have the capacity to serve additional persons, or whether they are targeted appropriately to older adults. All asset types were reported as available in every region of the state, but it was noted by many that availability of most services in rural areas, regardless of region, is difficult.

Nevertheless, the community asset types identified provide a positive starting point for the state, regions and individual communities to develop a more detailed inventory of behavioral health and ancillary services for older adults needing behavioral health services. While community assets for education and screening were mentioned less frequently by respondents, they also provide a beginning point on which to expand education opportunities and the use of screening tools related to behavioral health services for older adults.

While these services form a continuum, for the purposes of this report, they are separated into “traditional” behavioral health services, education, screening, and ancillary services.

Table 1. Community assets for behavioral health

"Traditional" behavioral health services	Education	Screening
Inpatient/outpatient facilities	Public dissemination of pamphlets, brochures (e.g., Safer Drinking Guidelines)	SBIRT
Emergency room and crisis services	Group setting education (e.g., senior centers)	CAGE
Providers (e.g., geriatric psychiatrists and psychologists, PCPs, LCSWs, APRNs, other mental health counselors)	Websites (e.g., My Place CT (www.myplacect.org)	Folstein/MMSE
REACH Program	Medical schools and academic institutions	MoCA
Group therapy/counseling		PHQ-9
Therapeutic practices (e.g., CBT, TREM, DBT, IMPACT, SBIRT, Motivational Interviewing, PEARLS, Reminiscence Therapy)		Bereavement Screening
Specific organizations that model best practices for older adult behavioral health (e.g., Bridgeport Hospital, CT Geriatric Society, DMHAS, Greenwich Hospital's Center for Healthy Aging, Gatekeeper Program)		Geriatric Depression Scale
		AUDIT
		PGDRS

Table 2. Community assets for behavioral health: Ancillary services

Ancillary services	
Health, Fire, and Police departments	WISE
Care or case management; CCCI	Nursing home diversion programs
Outreach programs involving municipal agents, senior centers, faith–based organizations, other agency workers and/or volunteers	DSS – Protective Services for the Elderly, Infoline (2-1-1)
CommPass[2C]	Referral Program
Support groups (e.g., Clubhouses)	CARE program
Peer support (e.g., Warmlines)	Town social services - food pantry/fuel assistance
Socialization in a variety of settings to decrease loneliness and promote recovery	Husky Logisticare, Dial-A-Ride, ADA transportation
Smoking cessation programs	Meals on Wheels
CHCPE	Adult day programs

Resource Issues

Discussions in all focus groups, provider interviews, and community forums, as well as open-ended survey comments, focused heavily on the resource issues that are frustrating them. Similar comments from different perspectives were heard from behavioral health providers, other service providers, referral sources, older adults themselves, and family members. Respondents from all phases of the project had extensive and sometimes detailed comments and personal stories on what they perceive as the gaps and barriers in service provision for older adults with behavioral health needs. Although there is some overlap between them, resource issues can usefully be analyzed in the following categories:

- Barriers Contributing to Underservice
- Barriers Contributing to Uneven Quality of Care
- Barriers to Integrating Behavioral Health, Physical Health, and Aging Services
- Barriers to Developing an Adequate Workforce
- Barriers to Remaining in or Returning to the Community
- Other Systems Barriers
- Financial Barriers

Barriers Contributing to Underservice

Data collected from focus group participants, providers, in community forums and from the statewide survey overwhelmingly underscore resource issues facing the state in serving older adults in need of behavioral health services. Many reasons for underservice were suggested and include access barriers, individual and family barriers, and language or cultural barriers.

Access barriers

Multiple access barriers were mentioned by respondents including:

- Shortage of geriatric behavioral health services
- Shortage of community-based behavioral health services
- Shortage of in-home services
- Lack of services in certain regions
- Inadequate transportation
- Affordability of behavioral health costs
- Lack of cultural competence

Shortage of geriatric behavioral health services

A shortage of geriatric behavioral health services was one of the most frequently mentioned barriers to accessing older adult behavioral health care across the various methods of collecting data. While respondents noted the quality of existing geriatric behavioral health services throughout the state, they underscored that there are not enough providers with the

skills to identify and effectively manage behavioral health problems in older adults. Southwestern community forum participants expressed extreme frustration regarding the lack of geriatric providers in their region. Forum participants and key informant providers in particular raised the concern that people needing behavioral health services often seek help from a primary care physician because of the shortage of geriatric providers and that these physicians may lack understanding regarding pharmacology and awareness of other unique needs of older adults. Numerous respondents across focus groups, forums, interviews, and the statewide survey reported long wait lists for behavioral health appointments and difficulty in getting wraparound services.

Few options were noted for geriatric substance abuse services. Participants in focus groups, forums, and key informant providers stressed the lack of age-specific services and emphasized the importance of older adults being able to experience recovery in a setting with their peers.

Shortage of community-based behavioral health services

Respondents across data collection groups frequently noted shortages in community-based behavioral health services, however, those in rural regions were more likely to report this access barrier. Community forum participants remarked on frequently missing services in all regions, particularly behavioral health outpatient services. Participants noted that outpatient services and programs in community settings (e.g., senior centers, social clubs, churches) are important and provide opportunities for behavioral health screening, assessment, and treatment. Shortages of these services in community settings were noted as due most frequently to financial and regulatory barriers.

Shortage of in-home services

Numerous respondents reported that a significant number of older adults are homebound and providing them with services requires that in-home services be offered. Key informant providers in particular expressed their frustration at limited in-home services for older adults needing behavioral health services, often because providers are not reimbursed for those services. Key informant providers also noted that shortages of in-home services reflect the basic expectation that patients will go to offices for treatment, but also mentioned this is a problem for those who are homebound, for those who are sensitive to stigma and do not want to be associated with a place labeled as a behavioral health center.

Lack of services in certain regions

Participants in regional focus groups and key informant providers located in more rural areas of the state were more likely to note the lack of services than those in urban areas. For example, a Willimantic/Putnam focus group participant described the struggle they have with so few clinicians and the difficulty trying to meet the needs of so many older adults seeking behavioral health services. Similarly, focus group participants in the Watertown and Torrington areas expressed frustration with lack of services in their rural areas. One participant praised the Gatekeeper model, but said it is not available in the Northwestern part of the state and is therefore useless for those in that region.

Inadequate transportation

Inadequate transportation was reported as one of the most significant barriers in accessing behavioral health services by statewide survey respondents and was also mentioned by participants in other groups and provider interviews. While lack of transportation is obviously more problematic in rural areas, it also impacts the ability of people in urban areas to get to an appointment for treatment. One North Central key informant provider mentioned the difficulty patients have in getting to appointments because they no longer drive and have family members who are unable to take time off from work to help them. In some cases people needing treatment have no family members or friends who are willing to provide transportation.

Affordability of behavioral health costs

Respondents across data collection groups expressed concern about health care insurance limits including behavioral health therapy for older adults and the inability to afford fees associated with this service. Psychiatrists are more likely than any other type of provider to opt-out of Medicare, and for many older adults, out-of-pocket costs associated with outpatient behavioral health services are unaffordable. Statewide survey respondents indicated Medicaid is the most commonly used payment method. Medicaid, the source of half of all payments for public behavioral health care, is, however, still threatened and gaps in care may remain significant and increase for those eligible for Medicaid.

Lack of cultural competence

Participants in focus groups and community forums were more likely than statewide survey respondents and key informant providers to be concerned about language barriers and cultural competence. Problems include not speaking an individual's primary language, lack of competent interpreters, and lack of understanding cultural expectations regarding behavior. Lack of cultural competence has the potential to lead to stigma and discrimination. It may also contribute to poor engagement, inaccurate diagnoses, and inappropriate and/or ineffective treatment.

Individual and family barriers

Another reason for underservice of older adults with behavioral health needs is that they do not typically seek services from behavioral health professionals even when they are available. This indicates a:

- Preference for primary care practitioners
- Focus on ageism and stigma
- Lack of knowledge about behavioral health disorders, treatment and resources

These barriers are briefly discussed below.

Preference for primary care practitioners

As mentioned under the section on "Access Barriers," participants reported that older adults typically seek professional treatment for behavioral health problems from a primary care physician. Forum participants and key informant providers in particular had more to say about the preference older adults have for primary care physicians and the obstacles that emerge when practitioners who have not been trained to identify and treat behavioral health disorders attempt to do so.

Focus on ageism and stigma

Ageism (e.g., negative attitudes toward older adults) and stigma (e.g., feeling shame associated with behavioral health disorders) are barriers contributing to underservice. Forum participants in particular noted a focus on ageism and stigma stating that older adults often have trouble working in therapy groups with younger participants, and have difficulty relating to their comments and interests. Key informant providers also reported ageism and stigma as barriers to care and underscored that people needing care often fall victim to assumptions that it's "normal" for older adults to feel depressed when in fact this is not the case.

Lack of knowledge about behavioral health disorders, treatment, and resources

The majority of participants across all data collection groups suggested that lack of knowledge regarding behavioral health disorders, treatment, and resources is paramount in older adults and their families not knowing about disorders and not realizing how to access affordable, effective treatment.

Language or cultural barriers

In the statewide survey, North Central selected language or cultural differences as a major barrier to accessing services while other regions selected this much less frequently. However, many participants in the focus groups underscored differences in language or culture as problematic for older adults. Spanish-speaking populations were mentioned most frequently but other groups (e.g., Albanian, Asian, Laotian, Liberian, Portuguese, Russian, and Vietnamese) were noted as well. It was suggested that many older adults from different cultures do not seek behavioral health services because they are unfamiliar to their cultures and have concepts of behavioral health that are different from American culture. Preference for nontraditional forms of help was also mentioned.

- Varying cultural concepts of behavioral health
- Preference for nontraditional forms of help

Varying cultural concepts of behavioral health

People who acculturate slowly are more likely to speak in their primary language, hold onto their cultural concepts of behavioral health, and be slow to embrace American concepts of behavioral health. Focus group participants shared frustrations at not having access to

providers that can communicate with people speaking different languages. Participants report that in rural areas there are many migrant workers who need help, but there are no culturally competent providers available with whom they can communicate. In addition to the language barrier, there are cultural barriers that discourage certain groups from talking freely about behavioral health problems. For example, one participant noted that it's not part of some Spanish cultures to discuss family problems with strangers.

Preference for nontraditional forms of help

People from different cultures may rely on family, friends, faith healers, herbalists, and spiritual leaders rather than seeking treatment from professionals trained in psychiatry and psychology. Providers gave examples of older adults who have recently come to CT and appear to not have received any traditional behavioral health services prior to settling here. A combination of lack of traditional care, minimal education, and inability to speak English, is challenging for providers.

Barriers Contributing to Uneven Quality of Care

There is widespread agreement throughout the state that treatment and ancillary services for older adults with behavioral health issues are uneven. Participants were positive about many existing providers, particularly those that specialize in geriatrics; however, they also noted that older adults do not receive adequate clinical or culturally competent service. Reasons for this include:

- Reliance on inadequately trained primary care physicians and other providers
- Lack of knowledge about behavioral health among health providers and aging services
- Failure to use evidence-based practices
- Inadequate recognition of substance abuse/misuse issues
- Lack of integrated treatment for individuals with co-occurring disorders

Reliance on inadequately trained primary care physicians and other providers

As noted previously, participants stressed that older adults typically depend on primary care physicians for behavioral health problems. One key informant provider referred to primary care physicians as "true heroes" because they more often than not are the professionals who interact with older adults seeking help with behavioral health problems. While many may lack training that could improve their treatment of older adults, nevertheless, they have opportunities to care for older adults and are deserving of adequate recognition and the support necessary to improve their ability to provide care and/or to enhance their ability to make referrals when a case is beyond their level of expertise.

On the other hand, some key informant providers also underscored the reliance of older adults on inadequately trained primary care physicians and their lack of training in pharmacology as related to older adults. Providers mentioned that primary care physicians may assume that depression is normal as people age and because of that they do not refer enough in this age group to geriatric psychiatrists who can provide adequate treatment. Alternatively, primary care physicians often dismiss behavioral symptoms in older adults as arising from dementia and may not recognize other potential causes. Providers underscored that primary care physicians are

not trained to do assessments and therapy with older adults or to understand the effects of comorbidities; at best it is often challenging for providers who trained in geriatrics. In addition, the economics of primary care can discourage primary care physicians from spending the time necessary to better diagnose behavioral health problems. Informants suggested that other providers, such as behavioral health counselors, also do not have the training and skills needed to diagnose and treat the unique needs of older adults effectively.

Unevenness of care was also referred to by providers when discussing the paucity of regional services to meet the needs of geriatric patients. For example, providers in the North Central region reported receiving referrals from patients who live in rural areas because there are no providers in their locations to provide the services needed.

Lack of knowledge about behavioral health among health providers and aging services

Services and supports are provided to older adults from a wide range of providers including primary care physicians and their staff, home health workers, residential program staff, senior center staff, case managers, adult protective workers, and nursing home staff. Respondents across all data collection groups underscored the lack of knowledge about behavioral health among many types of community service providers and aging services. Many comments focused on the need for specially trained workers to address the unique needs of older adults with behavioral health disorders.

Failure to use evidence-based practices

Respondents reported a broad range of evidence-based practices (EBP) that are effective in promoting recovery. However, while the infrastructure to develop EBP is growing, there remains a basic misunderstanding among behavioral health professionals of what EBP actually is and confusion as to what standards are more valuable. Some focus group participants mentioned a huge gap in certain practices for education. Others indicated that they do not use EBP because of staffing issues, lack of funding, and competing priorities, such as emergency treatment for behavioral health and/or physical crises.

Inadequate recognition of substance abuse/misuse issues

Substance abuse/misuse is a growing national problem particularly for adults age 50 and older who take prescription or illegal drugs for the experience or feeling it causes (abuse) and/or improperly use medications for therapeutic purposes (misuse) (Substance Abuse and Mental Health Administration, 2015). Misperceptions about drug safety, an increase in availability, and numerous motivations for their use contribute to this growing problem and may have negative outcomes in older adults, such as falls and fractures, overdose and death (Substance Abuse and Mental Health Administration, 2015).

Substance abuse/misuse was more often discussed in the focus groups and forums than by key informant providers and statewide survey respondents. There was agreement among focus group and forum participants that while there is an inadequate recognition of substance abuse/misuse issues, it is a growing problem among older adults and they comprise an underserved subgroup. Some participants noted that many in this subgroup are homeless and hard to reach, but it was also noted that there are not enough professionals specifically trained to provide outreach to people in this group needing behavioral health services. The problem of age-related services was raised once again when discussing this subgroup. While there are

outpatient substance abuse/misuse programs for the younger population, it is difficult to find similar programs designed for older adults.

Lack of integrated treatment for individuals with co-occurring disorders

In this report, the term “co-occurring disorders” refers to the combination of physical and mental health conditions and not to simultaneous substance use and mental health conditions. Individuals with co-occurring physical and mental health conditions represent a significant portion of the population in the United States and are the rule rather than the exception; in fact, more than 68 percent of adults with a mental health disorder had at least one medical condition leading to greater symptom burden, functional impairment and associated costs and decreased length and quality of life (Druss & Walker, 2011). Integration of services, while not widely used, has been shown to provide the most effective treatment for individuals with mental health and comorbid physical conditions (Druss & Walker, 2011).

While integration of services was noted as a best practice, and there is widespread agreement that it is necessary to successfully treat people with co-occurring physical and mental health disorders, respondents across all data collection groups indicated the lack of or limited availability of integrated treatment. Respondents suggested that this reflects a complex combination of factors associated with treatment ideology including a fragmentation of service systems in general and a silo mentality among providers. They also suggested that limited integration of care management results because providers are pressed for time and patients tend to visit numerous doctors without providing the information needed to any of their providers so that a potential for integrated care management can occur.

Barriers to Integrating Behavioral Health, Physical Health, and Aging Services

Survey respondents and participants in groups conducted during the project noted that older adults with behavioral health issues are likely to have chronic physical conditions and as a result are at greater risk for anxiety and depression disorders. While it is therefore crucial to integrate behavioral health, physical health, and aging services, there are barriers to successfully accomplishing this. General barriers to integration include inadequate knowledge of cross-systems and of working networks.

- Inadequate knowledge of cross-systems
- Inadequate knowledge of working networks

Inadequate knowledge of cross-systems

Although survey respondents reported some inadequate knowledge of cross-systems, this was strikingly noted in the focus groups and community forums. During group discussions and community forums, participants acknowledged that while they were aware of services within their own organizations, they were surprised to learn about other services in their regions that they were unaware of before. This inadequate knowledge of cross-systems makes it difficult for providers and consumers to find the services they need.

Inadequate knowledge of working networks

Similarly, the paucity of knowledge regarding working networks exists because there are few existing behavioral health, physical health, and aging service providers in communities where services are available. Respondents and participants noted the inadequacy of both formal and informal networking that has the potential to enable referrals and coordinate service plans. Data collected from focus group participants show that although the state's network of senior centers, municipal agents, resident service coordinators, and other social service agencies have broad coverage, there are capacity restraints and many of these agencies struggle to locate the right person or place to make referrals. Some participants added that in some regions, there is very little to choose from and there exists a general lack of availability of services and therefore very little opportunity for networks to exist.

Some respondents and participants across data collection groups highlighted models for integrating these services, such as co-locating behavioral health and physical health providers and implementing integrated treatment teams. There are, however, barriers to accomplishing this integration including:

- Inadequate knowledge about models of integration
- Private practice and the challenges of collaboration
- Limited funding and/or funding restrictions

Inadequate knowledge about models of integration

Respondents and participants had shared limited knowledge regarding models of integration and in so doing gave evidence that there is a general lack of awareness about different models of integration that are possible between behavioral health and physical health services.

Private practice and the challenges of collaboration

As aforementioned, older adults tend to seek behavioral health services from primary care providers and as noted by participants, private practice providers typically do not schedule the time needed to spend with a patient that may have behavioral health needs. If time is not available for assessment or screening to determine a behavioral health need, it is unlikely private practice providers see the necessity for collaboration with more specialized practitioners.

Limited funding and/or funding restrictions

Statewide data show that one of the top five challenges faced by agencies in making referrals is limited funding and/or funding restrictions. Some models of collaboration, particularly the use of integrated teams or care managers, may not be covered and make it more difficult to integrate behavioral health and health services.

There are also barriers in integrating behavioral health and aging services. Models for integrating behavioral health and aging services were infrequently mentioned but include: cross-system training, collaborative efforts, and on-site services in senior centers and other community settings. Data across groups in this project show that barriers to integrating behavioral health and aging services include:

- Limited training opportunities
- Overloaded providers
- Inadequate funding to support behavioral health services in community settings

Limited training opportunities

Respondents and participants reported few linkages between existing behavioral health and aging services and indicated that there are limited training opportunities. While some mentioned training would be useful, finding the time to do so would be challenging for both behavioral health and aging services providers.

Overloaded providers

Behavioral health and aging services providers noted they are overloaded with patients and cases that make it difficult for them to even think about integrating their services. Providers are often poorly equipped to address patient issues, such as co-occurring conditions. Provider issues include lack of knowledge and/or time to screen for behavioral health conditions and provide non-pharmacological interventions. In addition, system issues (e.g., insufficient time to screen, diagnose, and treat both behavioral health and physical health problems) preclude providers from cross-training in order to better identify behavioral health or aging issues. While a worthy goal, it is not considered practical in terms of the responsibilities and time providers have.

Inadequate funding to support behavioral health services in community settings

Few statewide respondents or other participants noted the availability of funds to support behavioral health in community settings. It was more likely that comments regarding budget restrictions and limited funds related to their own programs.

Barriers to Developing an Adequate Workforce

The critical shortage of competent behavioral health service providers is a major barrier to developing an adequate workforce to meet the needs of older adults. Other health and aging providers are also disadvantaged in being able to identify and respond appropriately to older adults with behavioral health needs. In addition, language and cultural barriers also interfere with the development of an adequate workforce that includes culturally competent providers and interpreters.

Respondents and participants noted a number of barriers to addressing workforce challenges including:

- Shortage of individuals interested in careers in gerontology and geriatrics
- Inadequate professional education

- Lack of behavioral health training among individuals working with older adults

Shortage of individuals interested in careers in gerontology and geriatrics

Key informant providers in particular expressed concern regarding the current behavioral health workforce and the lack of interest among students in choosing to specialize in gerontology and geriatrics. Ageism, discrimination toward older adults, and less lucrative positions were mentioned as contributing to the avoidance of career choices in aging.

Inadequate professional education

Key informant providers were more likely than other respondents or participants to underscore the paucity of professional educational opportunities in geriatrics. Those representing academic institutions and medical schools noted that basic education in geriatrics for professional schools of medicine, nursing, psychology, and social work is inadequate, and that it is typically difficult to recruit students for such programs because of limited funding.

Lack of behavioral health training among individuals working with older adults

Data gathered across all groups show concern about deficits in behavioral health training among individuals working with older adults including people working in adult day centers, senior centers, home health care, friendly visiting, and care/care management. Lack of funding for training and limited organizational budgets to hire competent people to train staff were noted as reasons for not being able to provide behavioral health training.

Barriers to Remaining in or Returning to the Community

Some statewide respondents and participants in focus groups and forums expressed concern about barriers preventing older adults with behavioral health from remaining in or returning to the community. These same individuals agreed that aging in place is possible and nursing home care can be diverted if existing barriers are addressed. These barriers include:

- Limited access to home and community-based behavioral health services
- Shortage of housing alternatives to nursing homes
- Limited training in providing services in the community to individuals with significant behavioral problems
- Inadequacy of the behavioral health system to effectively serve individuals with chronic health conditions

Limited access to home and community-based behavioral health services

Numerous informants underscored limited access to home and community-based behavioral health services for older adults. Data from the statewide survey in particular indicate that services designed specifically for older adults and that support community-based living are lacking. Some of these services include: behavioral health outreach and education, age-appropriate group counseling, diagnostic screening and assessment, peer-to-peer support, tele-counseling, and supports for family caregivers.

Key informant providers noted that Visiting Nurse Association (VNA) services are not incorporated as vigorously as they should be for people struggling with behavioral health disorders. In addition, some participants noted significant gaps in the level of services and supports needed by consumers and that these gaps put them at risk when staff call out and replacement workers are unavailable.

Shortage of housing alternatives to nursing homes

Respondents and participants alike expressed concern about homelessness and the shortage of housing alternatives for individuals with behavioral health problems. While housing needs were mentioned as more problematic for rural areas, it remains a critical issue throughout the state. Focus group participants in particular underscored the tendency of people with behavioral health issues to be more socially isolated than others and the benefits of congregate and supported living. However, it was also noted that there are not enough supports or residential assistance available for those who need them and many resident services coordinators do not know how to effectively work with older adults who have behavioral health problems. Supportive housing was underscored as a particularly critical resource and source of stability for people with behavioral health issues, but long waiting lists, finding affordable and appropriate housing and environments make it difficult to improve housing and placement situations for this group of people.

Limited training in providing services to individuals with significant behavioral problems

Respondents and participants noted the difficulty home health care and other frontline workers have in dealing with individuals with significant behavioral problems (e.g., substance abuse/misuse, hoarding). Limited training prevents these workers from effectively providing the support these people need in order to safely remain in the community.

Inadequacy of the behavioral health system to effectively service individuals with chronic health problems

Some individuals with behavioral health conditions develop chronic health problems as they age and participants noted that the current behavioral health system does not have the capacity to meet the needs of these people in the community. As a result, they may be admitted to a nursing home or other long-term care facility. Key informant providers in the Western region stated there is no robust outpatient facility for them to refer patients to when they are discharged and as a result of limited resources, many patients in that region have to live in assisted living or nursing homes. Some statewide respondents noted that those with severe psychiatric problems that develop dementia are especially difficult to place even in nursing homes. Others reported that some people fall through the cracks and eventually end up in nursing homes because a lesser level of care is unavailable.

Other Systems Barriers

It was widely acknowledged by survey respondents, group participants, and key informant providers that one of the greatest barriers to getting behavioral health care is that behavioral and physical health care are treated in different systems and there is little coordination between providers of the two systems. This fragmentation of the behavioral health, physical health, and aging systems creates significant barriers to providing integrated care for older adults with behavioral health problems. Other factors contributing to systems barriers include:

- Silo mentality

Silo mentality

More often in focus groups, participants mentioned the detriments of the silo mentality, a mindset that is present when certain departments or sectors withhold useful information from other departments or sectors. Although psychiatrists, psychologists, other behavioral health providers, therapists, and social workers have different training and practice experiences which contribute to their varying philosophies and approaches to care, there was agreement the varying outlooks and expectations of departments and/or sectors can hinder efforts to promote integration. Participants suggested that this destructive organizational barrier needs to be addressed in order to improve the behavioral health system for older adults.

Financial Barriers

Respondents and participants underscored several financial barriers to meeting the needs of older adults with behavioral health problems including inadequate funding and restrictive funding structures.

Inadequate funding and restrictive funding structures

Inadequate funding relates both to inadequate coverage for behavioral health care for older adults and to inadequate funding to develop and/or support behavioral health programs in the community. Inadequate funding for behavioral health services included: Medicare and Medicaid, private insurance, out-of-pocket payments, and limited governmental grants. Restrictive funding structures referred most often to Medicare, Medicaid, and private insurance limits. Limits on the kind of services covered focused primarily on rates and on eligibility, but also on limited billing for behavioral health services by primary care physicians and other licensed providers, such as professional counselors. For older adults dependent on private insurance coverage, caps on rates and on the number of reimbursable sessions for behavioral health were problematic. While fewer older adults use out-of-pocket payments for behavioral health services, they are typically not possible for most, and finding funds to pay for co-pays are sometimes challenging enough for older adults needing behavioral health care.

Statewide survey respondents listed cost/limited or no health insurance coverage as a significant barrier in accessing older adult behavioral health care. Focus group participants and some providers underscored the difficulty those who are not eligible for Medicaid have; some are a little too well off for Medicaid to qualify and private insurance has stricter criteria for behavioral health care. Providers also noted those age 55-64 as a subgroup who do not have Medicare but may not have access to the care they need because they have private insurance. For those in the age 55-64 subgroup and who may still be working, employer-based insurance, assistance programs, and retirement planning are important services for older adults with behavioral health problems that should not be under recognized.

Respondents and participants across data collection groups frequently referred to funding issues that prevent the development of programs. Governmental grants were mentioned as a previous source of funds but more recently have become less available as the economy tightened up. Inadequate funding was further mentioned in regard to developing and supporting the health care workforce and thus becomes a barrier to a crucial aspect of providing behavioral health care.

Data from the statewide survey indicated that funding and/or funding restrictions was more likely to be a greater challenge for community-based behavioral health organizations than other types of organizations and restricted their ability to make referrals to behavioral health services for older adults.

Potential Areas of Coordination and Collaboration Noted by Respondents and Participants

Mental health and substance use problems rarely occur in isolation. In fact, they are more likely to accompany each other as do a number of physical illnesses, such as coronary disease, diabetes, and neurological diseases. Numerous respondents and participants underscored that typically, people with co-occurring illnesses have interactions with multiple providers that lack linkages among them. To improve health outcomes for older adults with behavioral health disorders, they suggested potential areas of coordination and collaboration that further the integration of mental and physical health and strengthen connections that promote the overall health of individuals.

Although coordination and collaboration require a significant change in practice, a paradigm shift is already beginning to occur in CT with 15 local mental health agencies that are currently serving as "behavioral health homes." These "homes" coordinate clients' medical and behavioral health care. Continuing to bring together behavioral health and primary care for older adults in this way will have the potential to strengthen coordination and collaboration in health care.

Statewide survey respondents and focus group participants frequently mentioned IMPACT (Improving Mood – Providing Access to Collaborative Treatment), a collaborative care model that is a federally recognized evidence-based intervention designed to identify and address depression in older primary care patients. As a collaborative care program, IMPACT is one approach to integration in which multiple providers (e.g., primary care providers, care managers, psychiatric consultants) work together to provide care and track patients' progress. More than 70 randomized controlled trials have demonstrated collaborative care for behavioral health disorders, including depression, to be more effective and cost effective than care that is not coordinated (Unützer, Schoenbaum, & Druss, 2013). While reducing overall healthcare costs, IMPACT has also been effective in improving physical and social functioning and patients' quality of life. The IMPACT Implementation Center provides a wide range of material, training, and technical help to assist organizations implement and adapt IMPACT – http://impact-uw.org/

Another potential area for coordination and collaboration mentioned by respondents and participants is SBIRT (Screening, Brief, Intervention, and Referral to Treatment). This model of care was designed to identify and address substance abuse and misuse and can be delivered by a broad range of providers including primary care physicians, psychologists, registered nurses, and social workers. SBIRT programs are typically located in primary care settings and emergency departments, but can also be delivered in community mental health centers or aging services settings. Additional information is available at: http://www.samhsa.gov/sbirt

Areas of potential coordination and collaboration mentioned by focus group participants included the creation of a network with professionals in various fields that share information and practices, identify older people needing behavioral health services, and direct them to the appropriate resources. An example provided occurs in one CT town, where behavioral health professionals work with the local fire, police, and health departments to identify various issues

including those related to hoarding. They continue to refine protocols and have had success in working together with other departments so people in need receive the right resources.

Provider meetings in the Southwestern region (Greenwich, Stamford, Norwalk, Westport, and Bridgeport) that meet monthly or bimonthly with other providers serving older adults were noted to be a positive forum for collaborating with other people in the community that specialize in working with older adults. Forums such as this have the potential to spark additional opportunities for coordination and collaboration.

Other suggestions included developing a network of providers that work for the towns to help connect them and enable them to communicate more effectively. Participants suggested that such formal networking has the potential to alleviate some of the disadvantages of town-based services in the state.

Community Passport to Care Program (CommPass^{2C}) was mentioned in particular by Key Informant Providers as a way to improve integrated care and provides in-home behavioral health assessments, referrals and care coordination to older adults who have been recently discharged from inpatient medical care with the goal of preventing re-hospitalizations.

Community forum participants in the Western region noted that following the Sandy Hook Elementary School shooting in December, 2012, the Waterbury police department was among the first in CT to participate in the CT Alliance to Benefit Law Enforcement (CABLE's) Crisis Intervention Team (CIT). The training is an innovative police-based first responder program that enables police to refer people in psychiatric crisis to appropriate community based services and helps them access a system of needed services.

Finally, other areas of coordination and collaboration mentioned by respondents and participants that have the potential to benefit older adults needing behavioral health services include the following:

- United Way of CT's Infoline (2-1-1), a free service offering help with a range of problems including substance abuse and suicide prevention (http://www.infoline.org),

- Connecticut Clearinghouse is CT's premier library and resource center for information and materials on behavioral health, prevention and health promotion, treatment and recovery, wellness, and other related topics. The Clearinghouse, located in Plainville, is a program of Wheeler Clinic's Center for Prevention, Wellness and Recovery and is funded by DMHAS. Resources include books, DVDs, and curricula available for loan. Pamphlets, posters, and fact sheets on behavioral health and related topics are also available. In addition, the Clearinghouse maintains a statewide prevention listserv and calendar of events, publishes a monthly online newsletter, provides reference services, and hosts informational events. Additional information is available at www.ctclearinghouse.org

Recommendations

The recommendations offered below are a compilation of suggestions from both UConn COA researchers and Workgroup members after reviewing all of the primary data from the focus groups, provider interviews, community forums, and statewide survey. They are organized to address the major issues described by informants in all phases of this study. Because each recommendation has merit, they are not prioritized in this report. Some may be accomplished in the short term with limited resources while others would require significant resources and a longer time horizon. Required resources may go far beyond the Workgroup and include additional personnel, funds, cooperation of other organizations, policy changes, or legislation. The Workgroup should consider each recommendation in the context of its own resources and priorities, and act as a catalyst to marshal other organizations and interested parties who may be required to implement each one. For example, some of the recommendations on provider education will doubtless require the cooperation of physicians' and other providers' professional organizations. By leveraging collaboration with such organizations, the Workgroup can accomplish more than its own resources would allow. The major categories of recommendations include:

- Education and Awareness
- Integration of Behavioral Health, Physical Health and Aging Services
- Workforce Development
- Strengthen Community Assets
- Policy
- Research

Education and Awareness

By far the most common refrain heard from informants was the need for education, both to recognize the need for behavioral health services in many older adults, and to find those services once the need is recognized. Addressing these educational needs will require a many-pronged approach, which may be aided by some combination of the suggestions below.

- Develop new and identify existing educational materials to disseminate to older adults, their families, and caregivers that include information on identifying behavioral health issues and accessing behavioral health care. Partner with organizations that have regular contact with older adults and caregivers to aid dissemination. Information should be available across all cultural and socioeconomic spectrums.

- Provide cross-training opportunities for the current workforce of behavioral health, physical health, and aging services to enhance knowledge of their complementary skills and improve cultural competence. Promote awareness particularly among primary care physicians and caregivers by including information on co-morbidity with alcohol and substance abuse/misuse and possible indicators, such as frequent falls.

- In all training where appropriate, include information on the unique needs of older adults and psychosocial problems they encounter. Examples may include: family changes, retirement, awareness of one's own mortality, widowhood, declining physical reserves, changes in income, and, for some, isolation and loneliness.

- In all training where appropriate, address the common myths of aging (e.g., “Senility comes with age,” “Old people are unhappy,” “Old people are sick and disabled”) through outreach and the use of a range of media.

- Provide educational support on substance abuse. Consider using the 2014 National Drug Control Strategy that serves as the blueprint for reducing drug use and its consequences in the United States and includes continuing efforts to reform, rebalance, and renew the national drug control policy to address current public health and safety challenges. SAMHSA’s 2008 manual, *Substance Abuse Among Older Adults*, also provides guidelines for identification, screening, and treatment of older people for alcohol abuse, abuse of prescription drugs or over-the-counter drugs. A desk reference physician’s guide of this resource is available (*Prescription Medication Misuse and Abuse Among Older Adults, 2012)* and suggests strategies for education, screening, and early interventions for the prevention of prescription medication misuse and abuse.

- Increase awareness of working networks related to behavioral health, such as the existing provider forum in Southwestern CT, and encourage replication of their success in other regions of the state.

- Conduct awareness campaigns to reduce stigma and ageism surrounding behavioral health disorders of older adults through targeted public education activities (e.g., personal stories told through television, video, the Internet, print media) that are designed to provide the public with facts about behavioral health and ways to encourage recovery. These might include direct, consumer-to-target audience and/or interpersonal contact methods (e.g., dialogue meetings, speakers’ bureaus).

- Develop educational programs and awareness outreach around prevention and early intervention.

    - Target older adults, their families, caregivers and primary care providers to engage them in prevention services and early interventions.

    - Build upon the success of the highly regarded Gatekeeper Program and train a wide variety of community members to be gatekeepers who can identify and refer at-risk older adults living in CT communities who might benefit from free and confidential medical, social, behavioral health, or other services. In particular, work with home health agencies to educate their personnel to recognize such risks in their clients and refer appropriately.
    - Educate professionals regarding the current standards of assessment instruments, and the importance of integrating screening tools into accessible settings frequented by older adults.

    - Recruit organizations of the targeted older adult population to conduct preventions and early intervention outreach in partnership with aging services, primary care, and behavioral health programs.

    - Encourage primary care physicians to conduct an annual depression and alcohol misuse screening under an older adult’s Medicare benefit to identify individuals who are at risk of depression, substance use or other mental health conditions.

- Identify, develop, refine, and standardize core competencies in geriatric behavioral health for all personnel caring for older adults including: primary care physicians, psychologists, nurses, social workers, physician assistants, substance use counselors, rehabilitation counselors, marriage and family therapists, direct care workers, and peer support specialists.

- Educate and train behavioral health professionals using evidence-based guidelines to better prepare them for actual practice.

- Train primary care providers to screen all older adult patients for depression, substance abuse, and suicide.

- Although mental illness in prisons and among ex-offenders was not often mentioned by project respondents and participants, there is a need to increase awareness of the number of mentally ill in CT's prison system, which has a growing number of older adults. A 2011 survey reported that 18 percent of CT's prison population was receiving psychotropic medication (Torrey et al., 2014). Annual costs to treat a mentally ill prisoner in CT is 2.5 times the cost of other incarcerated individuals indicating a need for greater awareness of the situation and better ways to treat the mentally ill in CT prisons (Torrey et al., 2014). The Workgroup should increase awareness of the need for continuing behavioral health services for ex-offenders in the community when they are released.

- Increase awareness of veterans with behavioral health issues as an underserved subgroup. Latest estimates show that 75 percent of veterans are age 55 and older (RAND Corporation, 2015), and older veterans are at a greater risk than the general public for behavioral health disorders including depression (U.S. Department of Veterans Affairs, 2011), PTSD (Durai et al., 2011), and suicide (Wood, 2012). CT's veterans are committing suicide at approximately twice the rate of non-veterans with an estimated high of 54 veterans committing suicide in CT in 2011 (Radelet, 2014).

- Provide outreach to older veterans designed to overcome stigma, a barrier to the use of available services.

- Provide increased education and training for primary care and mental health providers in the community regarding the culture and unique needs of older veterans.

- Foster state level partnership opportunities between CT's public health and behavioral health networks to promote awareness of older adult mental health issues and offer state public health districts opportunities to fund evidence-based behavioral health programs, such as Healthy IDEAS, through the use of CDC Block Grant funds.

Integration of Behavioral Health, Physical Health, and Aging Services

Another prominent concern that arose in all aspects of the study is that behavioral health, physical health, and other aging services are not well integrated for most older adults.

- Identify local practices or SAMHSA-supported models that successfully integrate behavioral and physical health care (e.g., Bridging Resources of an Inter-disciplinary Geriatric Health Team via Electronic Networking – BRIGHTEN; Senior Reach; The Brief Intervention and Treatment for Elders – BRITE). Use as examples of best practices to

develop and disseminate information to other providers that highlight strategies for improving coordination of care among all care providers.

- Work with other professionals to develop fact sheets for a variety of disciplines that underscore the benefits of integrated care models of health care and how to effectively use the expertise of other health care professionals as team members.

- Encourage wider utilization of integrated models of care referred to in this report as best practices (e.g., IMPACT). In addition, consider promoting other integrated models of care that hold promise for treating late-life depression, such as PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial), an intervention study modeled on the premise that the most effective approach to preventing suicide is in eliminating its primary risk factor, depression. More information on PROSPECT is available at http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=257

- Encourage use of the Toolkit on Evidence-Based Programming for Seniors to engage individuals and their communities in programs that improve older adult health and well-being. More information on the Community Research Center for Senior Health (CRC-Senior Health) and the Toolkit is available at http://www.evidencetoprograms.com/

- Advocate for integrated models of care, such as Cherokee Health Systems in Tennessee, community-based health services that for over 30 years have successfully blended behavioral health and primary care services. Uniting the skills of mental health and primary care providers in the system reduces the usual isolation of mental health services and blends behavioral health interventions into primary care visits. More information is available at http://www.cherokeehealth.com/

- Advocate for and where possible implement the co-location of primary care and behavioral health services in community mental health centers (CMHC), federally qualified health centers (FQHC), satellite clinics, or elsewhere so individuals seeking services are treated holistically. This would ideally allow expanded screenings of behavioral health disorders and include screenings for primary care issues, such as diabetes.

- Advocate for the inclusion of evidence-based behavioral health programs, such as Healthy IDEAS, as a reimbursable service under the CT Home Care Program for Elders Medicaid Waiver to encourage the integration of behavioral health and physical health and strengthen community-based partnerships between behavioral health and aging.

- Identify a designated subcommittee of the Workgroup or other community group to lead statewide efforts to improve the integration of services. A 2011 Issue Brief by the National Council on Aging (NCOA) identified central factors to successfully integrating services in implementing evidence-based interventions that improve the health of older adults, including those with, or at risk of, behavioral health conditions. These include a partnership between the State Unit on Aging and the State Mental Health Authority (may also include other entities, such as public health, addiction services providers, and aging coalitions), advocates from *outside* government (e.g., community leaders, faith-based organizations, volunteer groups, health care providers), leadership *inside* state agencies, federal or state funding, and linking aging and behavioral health service systems. Specific partnerships highlighted in the NCOA brief that may be used as examples

include Michigan Partners on the PATH (MI PATH), Maine's Healthy Choices, and Massachusetts's Healthy Living Center of Excellence (National Council on Aging, 2011).

- Identify a "champion" in a primary care setting who is willing to advocate for the integration of services and who will be involved in program design and implementation.

- Encourage community health centers to partner with Area Agencies on Aging, senior centers, and other community providers to provide behavioral health and primary care services to older adults. Most community health centers accept Medicare and Medicaid payment and most provide services regardless of the individual's ability to pay.

- Advocate for greater implementation of the Health Information Technology for Economic and Clinical Health (HITECH) Act passed in 2009 that has the potential to support electronic sharing of clinical data among health care stakeholders and leads to more effective communication between behavioral health and primary care providers and more successful outcomes.

- Encourage the use of case management services for patients who over-utilize emergency department services for behavioral health issues. Small demonstration projects have observed positive outcomes for high-use patients using case managers to coordinate care (e.g., arranging for transportation, locating housing, assisting with use of or obtaining medication). In addition, promote collaboration between hospital Community Care Teams, which meet regularly to identify high-use patients and more effective interventions to decrease inappropriate or unnecessary emergency department services.

- Promote the integration of telehealth or telemonitoring into healthcare delivery systems to: increase patient access to providers, particularly in medically underserved areas; improve quality and continuity of care; provide better and more convenient treatment resulting in a reduction of lost work time and patient travel costs; and lower overall healthcare costs (Majerowicz & Tracy, 2010).

- Promote the use of assistive technology for people with behavioral health challenges.

- Promote recovery by implementing a program similar to New Hampshire's REAP (Referral, Education Assistance, & Prevention) Program that seeks to improve the quality of life for older adults through free preventative home and community-based counseling and education services. REAP services were initially offered to people living in low-income housing, but have been expanded to include people over age 60 living in their own homes and to caregivers of "at risk" elders to educate them how to intervene if an older adult becomes unable or unwilling to receive assistance. More information is available at http://www.smhc-nh.org/services/reap/

- Identify and measure evaluation indicators relevant to various behavioral health partners. Evaluation is an important tool for obtaining and maintaining support, whether financial or other, of the partners in an integrated initiative.

- Provide training and ongoing technical assistance to promote and sustain an integrated service delivery system.

- Consider financing options for supporting integrated care. For example, Medicare will cover annual alcohol screening and up to four brief, face-to-face behavioral counseling interventions per year for those that test positive. Counseling must be provided by qualified primary care physicians in a primary care setting (More information is available at http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=249. Medicare also covers annual screening for depression for beneficiaries in primary care settings that have staff-assisted depression care supports to assure correct diagnosis, effective treatment, and follow-up (More information is available at http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=251).

- Consider a tested strategy to finance integrated care, such as Depression Improvement Across Minnesota, Offering New Direction (DIAMOND). This strategy employs a "bundled payment" approach to finance the delivery of integrated behavioral health and physical health care using the IMPACT model. More information is available at https://www.icsi.org/_asset/1rq9xl/DIAMOND-Program-Wins-National-APA-Gold-Award.pdf and https://www.icsi.org/health_initiatives/mental_health/diamond_for_depression/

Workforce Development

Informants across the board noted that the best education and awareness campaigns will be ineffective without a significant increase in the number of providers with sufficient training in geriatrics available to provide older adult behavioral health services. Although Workgroup members may have limited ability to directly address workforce issues, they may be able to collaborate with other organizations to further workforce goals.

- Provide incentives, such as scholarships, higher compensation, and career ladders to become geriatric behavioral health, physical health, and social service professionals and paraprofessionals.

- Develop initiatives to expand education in professional schools of medicine, nursing, psychology, and social work to provide improved geriatric education.

- Develop initiatives in paraprofessional schools to educate students in aging and behavioral health.

- Recruit mentors for students who are pursuing a career in aging to assist them with networking and gaining access to work.

- Recruit bilingual and minority individuals for professional and paraprofessional positions in older adult behavioral services that reflect an older population increasing in diversity.

- Increase compensation for direct care workers.

- Promote cross-training in the workforce, not only on aging but also on mental health and addictions. Given the diversity of the population, older adult behavioral health services should be linguistically, culturally, ethnically, and age appropriate. A 2012 Institute of Medicine Report, *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hand?*, outlines recommendations for workforce preparation to meet the needs of the aging population.

- Provide educational support and strategies for family caregivers of older adults with behavioral health problems. Examples might include methods for working with an older adult using reminiscence therapy, or appropriate humor to lighten a moment. Through individual and counseling groups, education and support should also include helping the caregiver take care of his/her own physical and emotional well-being, learning stress-reducing strategies, seeking legal and financial advice to plan for the future, how to communicate with medical and/or psychiatric providers, and navigating the system of services and programs.

- Advocate for best employer practices to support family members who are caring for people with behavioral health conditions. An estimated 66 million informal caregivers or 29% of the adult U. S. population are caring for someone who is ill, disabled, or aged (Family Caregiver Alliance, 2015). Best employer practices could show value for this important part of the workforce by providing workplace flexibility for alternate work arrangements, compressed workweeks (i.e., working 10 hour days), education and training for supervisors regarding employees who are informal caregivers and on what constitutes caregiver discrimination, and resources and/or referral services to employees with caregiving responsibilities (Family Caregiver Alliance, 2015).

- Recruit retired older adults to work in peer-to-peer initiatives. The University of Pennsylvania developed a peer support curriculum that results in individuals becoming Certified Older Adult Peer Support Specialists. Massachusetts recently started using the same curriculum to train specialists. Outcomes include: increased access to/utilization of services for older adults; decreased isolation for older adults with depression; development of a support network for older adults; increased availability of older adult peer specialists and services; increased competencies of peer specialists statewide; availability of services in non-traditional settings by non-traditional providers; and increased linkages between mental health and aging systems. More information on the Pennsylvania initiative is available at http://www.parecovery.org/services_peer.shtml

- Develop a training program, or consider accessing the BU CADER program, for staff in CT senior centers and other locations where older adults may congregate that focuses on gaining competencies in areas of older adult behavioral health such as mental health and aging, resilience, suicide prevention and substance abuse.

- Unbundle current roles and establish paraprofessional initiatives that older adults can participate in under professional supervision.

- Create and promote volunteer roles for older adults including friendly visitors, telephone support, or respite care.

Strengthen Community Assets

While study informants noted a number of "community assets" already in place, the Workgroup has some opportunities to promote additional links with existing assets and enhance partnerships with other local and statewide efforts.

- Link existing clearinghouses and web-based databases to avoid duplication of services and link with CT's other "No Wrong Door" system organizations efforts, such as Community Choices (CT's ADRC), Centers for Independent Living (CILs) and Area Agencies on Aging (AAAs). Examples of other opportunities for linkage include United Way's 2-1-1 Information and Referral System, My Place CT website, the CT Clearinghouse library and information center on substance use and mental health disorders, and the Office of Healthcare Advocate's (OHA) Behavioral Health Clearinghouse, currently under development. The OHA effort will provide an informational website with a searchable directory of behavioral health providers and a call center staffed with clinicians to assist consumers with insurance questions and connecting them with behavioral health providers. More information is available at www.ct.gov/oha/bhc.

- Strengthen and expand the more than 60 My Place CT partnerships to support CT's rebalancing efforts and focus on collaborations to improve housing and transportation needs for people with behavioral health needs.

- Collaborate with the CT Commission on Aging on its "livable communities" initiative to ensure that behavioral health issues of older adults living in the community are addressed, including housing and transportation.

- Develop and link community and/or regional websites to provide comprehensive information about behavioral health services. This could include a listing of town directories, lists of providers, and lists of organizations and institutions not usually published. Bulletin boards – physical or virtual boards, and community-calendar type listings might also be included in linked websites.

- Promote networks of behavioral health professionals, such as the provider forum in Southwestern CT, who can train each other or participate in joint training on a variety of topics.

- Monitor the effectiveness of the three recently-awarded SDA "Healthy IDEAS" grants and expand to additional grantees when funding is available.

- Designate regional providers in CT to coordinate outreach and education on access to behavioral health services for older adults and informal caregivers (e.g., a designated unit within AAA or LMHA).

- Promote and expand peer-to-peer services, such as Warmlines.

- Expand opportunities for the evidence-based Mental Health First Aid (MHFA) training course among professionals and the public who come into contact with older adults. MHFA trains adults age 18 and older to help a person experiencing a mental health challenge, disorder, or crisis. The MHFA older adult module builds on core curriculum,

adds information on dementia and delirium, and includes scenarios specific to older adult settings. MHFA increases knowledge and understanding, encourages people helping people, supports people getting help, decreases social distance, and improves mental wellness.

Policy

One of the most effective ways to improve behavioral health services to older adults is to work with others to modify some of the policies that are obstructing progress. Informants noted a number of existing policies that were frustrating their efforts to provide effective service. Workgroup members may be able, directly or indirectly, help to enlighten policy makers and advocate for a number of changes.

- Routinely communicate with elected officials and policy makers at all levels on issues of importance to older adults with behavioral health needs, suggestions for improvement, and areas of need.

- Advocate for the revision of privacy laws to allow behavioral health and primary care providers to collaborate on care and communicate patient information more effectively. Integrated communication has the potential to increase the quality of care and diminish adverse prescription drug reactions.

- Advocate for billing reforms that would allow for more flexible funding streams covered by Medicare and Medicaid. In particular, advocate for expansion of Medicare provider classifications eligible for reimbursement to a wider array of professional such as marriage and family therapists.

- Advocate for increases in provider reimbursements and expanded licensed provider reimbursements in order to attract and retain quality providers.

- Advocate for Medicare reimbursement policy changes including expanded coverage of methadone and other opiate substitution treatment, especially for those who are experiencing a disruption in their treatment when aging into Medicare. There has been a significant increase in use of methadone in persons age 50+ and in nursing homes.

- Advocate for grant funding to enable policy-makers to develop and shape quality behavioral health programs. “Without adequate financing, mental health policies and plans remain in the realm of rhetoric and good intentions” (World Health Organization, 2003, p. viii). Advocate specifically for reauthorization of The Older Americans Act (OAA) in order to retain the mental health provisions (e.g., screening and treatment services and programs to increase public awareness and reduce the stigma of mental illness) that were part of the Act’s 2006 amendments. Specific funding should be appropriated to assure implementation. In addition, advocate for the re-establishment of the SAMHSA Older Adult Americans Behavioral Health Technical Assistance Center and grant programs to support implementation of behavioral health evidence-based practices.

- Maximize use of OAA dollars in the state for transportation.

- Advocate for implementation of telehealth services (e.g., video-conferencing and streaming services) to facilitate long-distance health care. Current standards for this are

minimal. Areas needing to be addressed include standards for allowable services, eligible providers, and telehealth reimbursement rates.

- Encourage policy action to advance both standards development and additional informatics research to develop IT tools, including EHRs, to improve coordination among patients and providers. Working toward more adequate functionality in EHRs and health information exchanges has the potential to improve care coordination and facilitate caregiver collaboration.

- Advocate for the improvement of Medicare and Medicaid programs including: accessibility and affordability of services, prescription drug coverage, opiate substitution therapy (OST) as a Medicare benefit, clarification of coordination of benefits between Medicare and Medicaid programs, support for evidence-based services and supports, support for self-direction, choice of health care services and resources, and outcomes and accountability. One of the conclusions of 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 policies present a significant barrier for older adults in obtaining care for mental health and substance use disorders. Treatment settings for older adults, especially those with behavioral health needs, have moved from institutions to the entire long term care system, including the network of aging services, the mental health system, correction institutions, private practices, and an individual's own home. Medicare and Medicaid policies often limit services accessibility to clinical settings only and should be expanded.

- Advocate for funding for the use of non-traditional behavioral health services, particularly outreach and service delivery in the home and in community locations, such as senior centers and Naturally Occurring Retirement Communities (NORCs). Lack of reimbursement for in-home services was noted often by study participants as a barrier for older adults whether homebound, lacking transportation, or reluctant to see an office-based behavioral health provider. Many federally qualified health centers (FQHC) are prohibited by license from providing in-home medical or behavioral services: consider partnering with CT FQHCs, most of whom provide behavioral health services, to advocate for a change in that policy to increase their scope of services.

- Advocate for funds and workforce provisions that authorize training, scholarship, and loan forgiveness for individuals who work with or are preparing to work with older adults with behavioral health needs. This could include: Psychiatrists, psychologists, psychiatric nurses, social workers, behavioral health counselors, and other specialists who require skills and knowledge of both geriatrics and behavioral health. It could also include: Primary care providers, including geriatricians and other physicians; RNs, APRNs, and physician assistants (PAs); potential care managers in behavioral health; faculty in medicine, nursing, social work, psychology, substance use counseling, and other specialties; direct care workers and other frontline employees in home health agencies, nursing homes, and assisted living facilities; family caregivers of older adults with behavioral health disorders.

Research

Although this study was able to obtain input from a large number of providers, referral sources, and community members in its four phases, it is only a first step in the analysis of the strengths,

challenges, gaps and opportunities in the state's behavioral health system for older adults. There are additional steps that may be taken by the Workgroup to build upon this knowledge and help to set future direction. Steps to consider include:

- Undertake a comprehensive review of all existing CT state-specific data on older adults with behavioral health concerns, payment issues, etc. Examples of possible data that could be compiled and analyzed include a breakdown of DHMAS data by age and diagnosis, ChimeData for acute care hospital discharges from the CT Hospital Association, community referrals data from the CT Gatekeeper Program, DSS Medicaid data on certain diagnoses (e.g. depression), nursing home and Money Follows the Person data on mental health and substance use issues, and state census data on mental health disability by age. A compilation of such existing data, where available, will give the Workgroup a more comprehensive picture of issues and potential solutions.

- Since primary care providers were difficult to reach and underrepresented in this study, work with physicians' organizations to supplement research on physicians' attitudes, knowledge of older adult behavioral health issues, reimbursement issues, and other challenges. Consider adding questions to other approved physician surveys.

- Research on national data may be another fruitful source of information on best practices that may work in CT. In addition to traditional literature-based research methods, networking with other states' colleagues in aging, mental health, substance use, medicine, geriatrics, etc. either directly or through conferences and professional groups may yield insights into approaches that may be replicated.

- Gather data on Medicare payment issues to enhance advocacy efforts on Medicare issues. Consider approaching the Center for Medicare Advocacy, Inc., the national organization located in CT providing education, advocacy and legal assistance on Medicare issues, for data exchange and possible advocacy and policy collaboration.

- Encourage research on best practices of integrated health among culturally and linguistically diverse people, and consider exploring how factors of diversity including race/ethnicity, gender, sexual orientation, disability, socioeconomic status, family structure, and immigration status affect access to and utilization of health care services.

- Monitor federal and state grant proposals related to this area; propose and urge state agencies and organizations to participate in any research that promises to further knowledge of best practices.

- Develop partnerships among providers, academic institutions and other researchers to improve translation of research into practice and to further research beneficial to older adults with behavioral health needs.

- Since many older adults with a primary mental health diagnosis also have co-occurring health diagnoses, conduct further research to ascertain if individuals who are home bound as a result of a health condition are receiving the most appropriate care for their mental health disability. Visiting nurse agencies must provide specialized care for individuals with a primary psychiatric diagnosis, but the main focus and diagnosis at discharge can be the health condition at the expense of mental health treatment.

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Appendix A: Abbreviations and Acronyms

The list below provides an explanation of abbreviations and acronyms used for agencies, therapeutic interventions, and other terms referred to in conducting research for this report.

AA	Alcoholics Anonymous
AAA	Area Agencies on Aging
AARP	American Association of Retired Persons, Inc.
ADA	Americana with Disability Act
ADRC	Aging and Disability Resource Centers
ADRCs	Alcohol and Drug Recovery Centers, Inc.
AIDS	Acquired immune deficiency syndrome
AMH	Advanced Medical Home
AMI	Any mental illness
APRNs	Advanced practice registered nurses
AUDIT	Alcohol Use Disorders Identification Test
BH	Behavioral health
BIP	Balancing Incentive Program
BRASS	Bringing Resources to Action to Serve Seniors
BRFSS	Behavioral Risk Factor Surveillance System Survey Data
BRIGHTEN	Bridging Resources of an Inter-disciplinary Geriatric Health Team via Electronic Networking
BRITE	Brief Intervention and Treatment for Elders
BU CADER	Boston University Center for Aging & Disability Education & Research
CABLE	Connecticut Alliance to Benefit Law Enforcement
CAGE	4-item assessment for alcohol abuse
CAPE	Coalition for Abuse and Prevention of the Elderly
CARE	Center for Assessment, Respite, and Enrichment
CBT	Cognitive Behavioral Therapy
CCCI	CT Community Care Incorporated
CDC	The Centers for Disease Control and Prevention
CHCPE	CT Home Care Program for Elders
CHH	Charlotte Hungerford Hospital
CIT	Crisis Intervention Team
CLAS	Culturally and Linguistically Appropriate Services
CMHC	Community Mental Health Centers
CMS	Centers for Medicare and Medicaid Services
CommPass^{2C}	Community Passport to Care Program
ConneCT	Informational services through DSS
CRC-Senior Health	Community Research Center for Senior Health
CT	Connecticut
CTBHP	CT Behavioral Health Partnership
DBT	Dialectical Behavioral Therapy
DIAMOND	Depression Improvement Across Minnesota, Offering a New Direction
DMHAS	Department of Mental Health and Addiction Services
DSS	Department of Social Services
DVD	Digital versatile disc or digital video disc
EBP	Evidence-based practices
EHR	Electronic Health Records
EMDR	Eye Desensitization and Reprocessing Therapy

EMS	Emergency medical services
ER	Emergency room
FMD	Frequent Mental Distress
FQHC	Federally qualified health center
FY	Fiscal year
HITECH	Health Information Technology for Economic and Clinical Health
IBM	International Business Machines Corporation
IDEAS	Identifying Depression, Empowering Activities for Seniors
IDDT	Integrated Dual Disorder Treatment
IMPACT	Improving Mood – Providing Access to Collaborative Treatment
IOL	institute of Living
IOP	Intensive-Outpatient Program
IT	Information Technology
LADC	Licensed Alcohol and Drug Counselor
LCSWs	Licensed Clinical Social Workers
LMFT	Licensed Marriage and Family Therapist
LMHA	Local Mental Health Authorities
LPC	Licensed Professional Counselor
MBSR	Mindfulness Based Stress Reduction
MCCA	Midwestern CT Council of Alcoholism
MD	Medical Doctor
MFP	Money Follows the Person
MH	Mental Health
MHFA	Mental Health First Aid
MHN	Mental Health Network
MI PATH	Michigan Partners on the PATH (Partnership, Accountability, Training, Hope)
MMSE	Mini-Mental State Examination
MoCA	Montreal Cognitive Assessment
MSW	Masters in Social Work
NAMI	National Alliance on Mental Illness
NASW-CT	National Association of Social Workers – CT Chapter
NCOA	National Council on Aging
NORCs	Naturally Occurring Retirement Communities
OAA	Older Americans Act
OHA	Office of Healthcare Advocacy
OHCA	Office of Healthcare Access
OST	Opiate substitution therapy
PA	Physician assistant
PCPs	Primary care physicians
PEARLS	Program for adults aged 60 and over to treat minor depression
PGDRS	Psychogeriatric Dependency Rating Scale
PhD	Doctor of Philosophy
PHQ-9	Patient Health Questionnaire
PROSPECT	Prevention of Suicide in Primary Care Elderly: Collaborative Trial
PSAs	Public service announcements
PSE	Protective Services for the Elderly
PTSD	Posttraumatic stress disorder
REACH	Bridgeport Hospital's IOP program
REAP	Referral, Education, Assistance, & Prevention
REDCap	Research Electronic Data Capture

RMHB	Regional Mental Health Board
RN	Registered Nurse
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention and Referral to Treatment Program
SDA	State Department on Aging
SIM	State Innovation Model
SMHA	State Mental Health Authorities
SMI	Serious Mental Illness
SPSS	Statistical Package for the Social Sciences
SUA	State Units on Aging
SWAT	Special Weapons and Tactics
TARGET	Target Affect Regulation: Guide for Education and Therapy
TEDS	Treatment Episode Data Set
TREM	Trauma Recovery and Empowerment Model
UConn COA	UConn Health, Center on Aging
UTI	Urinary tract infection
VA	Veterans Affairs
VNA	Visiting Nurse Association
WCAAA	Western CT Area Agency on Aging
WCMHN	Western CT Mental Health Network
WISE	Working for Integration, Support, and Empowerment – DMHAS MH Waiver
ZCTA	Zip Code Tabulation Area

Appendix B: Older Adult Behavioral Health Workgroup – Mission Statement and Goals

- Mission Statement: The Workgroup is committed to working towards an accessible, integrated, multi-disciplinary system of behavioral health services that promote improved health, wellness, and recovery for older adults in Connecticut.

- Goals:

1. Develop a model of collaborative problem-solving by public and private organizations and consumers to improve the availability and quality of behavioral health preventive and treatment strategies.

2. Promote implementation of evidence-based practices, specifically the use of screening, assessment, and referral tools.

3. Promote workforce development efforts that increase the number of providers with expertise in geriatrics, including geriatric behavioral health.

4. Promote education and outreach to older adults with emphasis on prevention, early