Aging and Disability Resource Center Older Adult Behavioral Health Asset Mapping Supplement:

Provider Key Informant Results

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Introduction

This report is a supplement to the September 2014 report entitled *"Aging and Disability Resource Center Older Adult Behavioral Health Asset Mapping: Regional Focus Group Results"* ("Focus Group Report"). That report summarized a series of focus groups held during the summer of 2014 designed to explore the views of providers of behavioral health services to older adults, and persons who refer older adults to such 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 report. In order to supplement the focus group findings and explore provider views in more depth, the Older Adult Behavioral Health Workgroup requested that UConn Health's Center on Aging (UConn COA) conduct ten provider interviews, two in each of the five state regions as defined by Aging and Disability Resource Center catchment areas. This report summarizes the finding of the provider key informant interviews to the extent that they supplement or differ from focus group findings. Please refer to the Focus Group Report for a comprehensive background and introduction to the mission and guiding principles of the state's Older Adult Behavioral Health Workgroup, and the current asset mapping initiative.

Methodology and Analysis

Methodology

The key informant interview methodology and analysis were similar to those described in the Focus Group Report.

Provider instrument

The same semi-structured guide used for the focus groups was also used in the key informant interviews (Appendix A) and was developed by UConn COA researchers with input from the Older Adult Behavioral Health Workgroup. Guiding questions sought provider input on a range of topics including:

- the extent of available older adult behavioral health services
- the use of evidence-based behavioral services and interventions
- referrals (i.e., why they are made and where people needing services are referred to)
- the unique needs of older adults
- service barriers and gaps
- underserved subgroups
- resources agencies need to fulfill their service goals
- groups to include in the statewide survey
- questions to include in the statewide survey

Research sample

The Workgroup was primarily responsible for identifying provider key informants in each region. Some individuals were referred for participation by other key informants, and one interview included multiple providers.

Providers represented all regions of the state and included psychiatrists, primary care physicians, advanced practice registered nurses (APRNs), behavioral health directors, a healthcare liaison, and clinicians (i.e., licensed clinical social workers, licensed marriage and family therapists).

Recruitment

Potential informants were initially contacted by email and invited to participate in a phone interview. The email invitation described the purpose and where appropriate listed the name of the person who referred them. All potential participants, regardless of whether they responded to the first invitation, were offered additional opportunities to respond. A total of 17 people participated in the key informant interviews. This group included two providers in each region with the exception of the South Central region where three providers participated and Eastern where one provider and seven clinicians participated (Table 1).

Table 1. Regions and number of participants

Region	Number of participants
South Central	3
Western	2
North Central	2
Southwestern	2
Eastern	8

Types of organizations represented by participants included: two community hospitals, two medical schools, two community health clinics, and two behavioral healthcare organizations, one of which provides services for patients living in skilled nursing, rehabilitation, and assisted living facilities. All key informant interviews were conducted by an experienced interviewer between October 31, 2014 and December 19, 2014 and lasted an average of 20 minutes.

Analysis

Key informant interviews were recorded and analyzed by researchers to identify and interpret each individual's responses. Major concepts or areas of interest were organized into common themes using the constant comparative technique (Glaser & Strauss, 1967; Hill, Knox, Thompson, Williams, & Hess, 2005; Hsieh & Shannon, 2005). Additional themes were included until no new topics were identified.

Results

Provider interviews, similar to focus groups, explored the extent of older adult behavioral health services, the use of evidence-based behavioral health services and interventions, why and where referrals are made, the unique needs of older adults, services barriers and gaps, under-served subgroups and resources agencies need to fulfill their goals. They also asked for suggestions regarding groups that should be included in the planned statewide survey distribution and questions that should be included when developing the provider statewide survey on older adults and behavioral health. Results of the analyses fall into the nine major themes noted below. As in the Focus Group Report, some aspects of the nine themes are closely linked and overlap. Although key informants provided similar information to focus group participants, providers were able to offer greater detail and specificity regarding the topics queried. As a result, the additional process of interviewing providers was beneficial in adding greater depth of understanding to the themes listed below.

- Older adults in need of behavioral health services
- Extent of behavioral health services provided
- Evidence-based tools
- Behavioral health referrals
- Unique needs of adults 55 and older
- Service barriers and gaps
- Underserved subgroups
- Resources agencies need to fulfill their goals
- Suggestions for the statewide survey

Older adults in need of behavioral health services

Providers were asked to describe the frequency with which they encounter older adults with behavioral health needs in their practice, the indicators observed, and types of services that appear to be needed.

How often older adults with behavioral health needs are encountered

Most providers, like focus group participants, reported encountering older adults with behavioral health needs on a daily basis. The most frequent answer was “daily” or “very often.” One provider’s entire caseload is comprised of adults age 55 and older. For several providers, however, less than 25 percent of their practice involves older adults.

> *My entire caseload is 55+.* [North Central]
>
> *The majority of my patients are younger than age 55. Only about 10 percent are 55 and older.* [Eastern]

Most providers reported that older adult patients are typically seen for psychopharmacology, or medication management. Many of these patients are also referred further for psychotherapy or other treatment requiring different provider skills. Some providers mentioned that they frequently

encounter older adults needing behavioral health services during a crisis situation that could be related to trauma, substance abuse, and/or addiction. Some providers also stated that the majority of the older adult patients they encounter have been through the system many times and are in need of a lot of social services – housing in particular.

> *The patients I see very often need medication management and counseling. About 50 percent need individual or group counseling.* [Western]

Indicators observed and types of supports, skills and/or services needed

Providers have observed a broad range of behaviors in people appearing to need behavioral health services including existing mental health issues (e.g., schizophrenia, bipolar disorder, anxiety/panic disorder), depression, sadness, loneliness, lethargy, suicidal ideation, self-neglect, substance abuse (e.g., alcohol and opiate prescription misuse), and issues related to sleep hygiene, such as insomnia. Many providers reported that depression is the most common behavioral health issue in the older adults they treat. The majority of providers underscored that most indicators observed present first to primary care physicians, who subsequently refer them to behavioral health services for further treatment.

Medication and counseling support

Participants were asked whether older adults in need of behavioral health services asked for or received medication, counseling, or both. Although providers reported that patients most often are seen for psychopharmacology, they frequently refer patients for either individual or group therapy.

> *I see patients primarily for psychopharmacy; of these about one-third are referred for psychotherapy.* [North Central]

> *I provide medication management, but refer patients for subspecialty needs, such as individual counseling or to various groups for therapy or substance use groups* [South Central]

Extent of behavioral health services provided

Key informants described the range of behavioral health and supplementary services currently being offered to older adults by participants and their agencies. Providers' responses focused primarily on the services they provide, such as medication management and counseling.

"Traditional" behavioral health services

The majority of providers interviewed work in outpatient settings and focus on medication management and counseling. When appropriate, they refer patients to a licensed clinical social worker (LCSW) or clinical psychologist for additional behavioral health services. Patients needing higher levels of psychiatric care are referred to a more intensive outpatient facility or psychiatric hospital. Depending on the region in which the provider works, there may or may not be a wide range of behavioral health services available. Providers in the North Central region, for example, reported having numerous options for behavioral health services while those in other regions of the state reported much more limited resources.

A few of the providers interviewed work at inpatient facilities and have psychiatric services on site. These providers offer extensive evaluations by a clinician and refer to other community resources as needed for additional services. Some providers mentioned that their facilities have access to a broad array of services, but others reported limited access to behavioral health resources in the community. For example, although there are plans to open a psychiatric geriatric unit at Saint Raphael's in the future, providers in the South Central region mentioned there aren't currently any inpatient geriatric programs in their region. One informant believed that the only inpatient geriatric unit in the state is a small 12-bed unit located in the Western region[1]. Thirty percent of patients come from within 25 miles of that facility while the majority of patients are referred there from other areas of the state. According to a provider in that facility, the capacity could double and still not be enough to meet the needs of older adults needing inpatient care in the state.

Although most providers interviewed are able to access additional behavioral health services, they agreed that more services and greater accessibility to services are needed throughout the state.

> *There is no robust outpatient facility for us to refer our patients to when they are discharged from our facility. There are limited resources in our region and many patients have to live in assisted living or nursing homes as a result.* [Western]

Supportive services

Providers listed many examples of ancillary services to which they are able to refer their patients.

- Community Passport to Care Program (CommPass[2C]) – 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 and improving integrated care
- Smoking cessation program
- Substance abuse (inpatient and outpatient)
- Community support programs/recovery pathways/assertive community treatment case management programs for the seriously mentally ill
- Clubhouse-socialization, case management/housing education
- Warmline – volunteers provide non-crisis peer support for people with chronic/severe mental illness, by phone
- Housing assistance program
- WISE (Mental Health Waiver) and nursing home diversion programs
- 211 Referral Program
- Town social services for food pantry and fuel assistance
- Husky Logisticare, Dial-A-Ride, ADA transportation services
- Meals on Wheels
- Visiting Nurse Association services
- A Place for Mom – explores eldercare options for nursing home, assisted living, etc.
- Adult day programs
- Respite care

[1] In actuality there is more than one inpatient geriatric unit in the state, but the point remains that availability is extremely limited.

- Senior centers
- Elderly Services Info Line – CT Department of Social Services
- Elder Protective Services – Hotline
- Fall assessment – Town Health Department
- File of Life – Town Fire Department (keeps contact information, medical history, etc. on file)

As mentioned, access to these services varies widely by region. Providers noted that in some cases they refer patients to supportive services in other regions if the programs there are willing to assist their patients and if the patients are able to travel to the location.

Evidence-based behavioral health services/interventions and tools

Providers reported using some of the same interventions and assessment tools listed by focus group members, such as cognitive behavioral therapy (CBT) (Table 2). In addition, providers reported using the PHQ-9, CAGE, AUDIT, MoCA, and the Geriatric Depression Scale. The MoCA and Geriatric Depression Scale were mentioned by focus group participants in the context of needing to educate professionals regarding current standards of assessment and the importance of integrating screening tools into accessible settings where older adult seeks treatment. Table 2 compares the reported use of evidenced-based behavioral health services/interventions and/or tools by focus group participants and the provider/clinician groups.

Table 2. Evidence-based behavioral health services/interventions and/or tools[1]

Evidence-based service/intervention	Description	Focus Group Participants	Providers and Clinicians
CBT	Cognitive Behavioral Therapy	☒	☒
DBT	Dialectical Behavior Therapy	☒	☐
IMPACT	depression care for older adults	☒	☐
Motivational Interviewing	Identification, examination, and resolution of ambivalence about changing behavior	☒	☒
PEARLS	Program for adults aged 60 and over to treat minor depression and dysthymic disorder	☒	☐
REACH Program	Intensive outpatient program, that provides intake assessments, medication management, group therapy, aftercare planning	☒	☐
Reminiscence Therapy	The use of life histories to improve psychological well-being	☒	☐
SBIRT	Screening, Brief Intervention and Referral to Treatment	☒	☐
TREM	Trauma Recovery and Empowerment Model	☒	☐
PHQ-9	Patient Health Questionnaire – multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression	☐	☒
PGDRS	Psychogeriatric Dependency Rating Scale – assessment for global functioning	☐	☒
CAGE	4-item assessment for alcohol abuse and the detection of alcoholism	☐	☒
AUDIT	Alcohol Use Disorders Identification Test	☐	☒
MoCA	Montreal Cognitive Assessment	☒	☒
Geriatric Depression Scale	self-report measure of depression in older adults	☒	☒

[1]X indicates implementation of evidence-based behavioral services/interventions and/or tools

Focus group participants, most of whom were not themselves providers, indicated they did not often use evidence-based behavioral health assessments and interventions due to barriers including staffing issues, lack of funding, and competing priorities, such as emergency treatment for behavioral and/or physical crises. However, the providers interviewed are using some of these assessments and routinely incorporate them into their practice when treating older adults with behavioral health needs.

Referrals to behavioral health services

Providers were asked to share their experiences regarding why or at what point referrals are made and where people needing behavioral health services are typically referred. Providers described both referrals by them to further services and people or organizations that typically refer people to them.

Why or at what point people are referred for further behavioral health services

Providers most often mentioned referring patients to behavioral health services when they become agitated, have problems related to trauma, have psychosis, suicidal ideation, profound depression, and/or when they require medication management.

Where people needing behavioral health services are referred

In most situations, providers were more likely to receive referrals than make them, but in situations where they did have an opportunity to refer, they were made to a much smaller list of clinicians or organizations (Table 3) than those mentioned by focus group participants. Many providers reported referring patients for neuropsychological testing. Others, especially those located in the Western region, noted the limited resources for behavioral health services.

Table 3. Behavioral health referral places

Behavioral health referrals
Physicians
Clinical services
Gero-psychiatrists
Various therapists
Recovery specialists
Intensive Outpatient Program
Neuropsychological testing
Rushford
Harvest Health Care
Hospital for an acute psychiatric stay
Middlesex Hospital Behavioral
Community resources

People or entities that typically refer people for behavioral health services

The majority of providers focused their comments regarding behavioral health service referrals on the people or entities that typically refer people to them. This list (Table 4) was also considerably smaller than the one generated by focus group participants.

Table 4. People or entities that make referrals for behavioral health services

People or entities that make referrals
Self
Family members (i.e., adult children)
General public
Case managers
Assisted living facilities
Long-term care facilities
Acute care hospitals
Senior centers
Department of Mental Health and Addiction Services
Medical offices
Doctors or primary care offices
Hospitals (includes Emergency Department)
Visiting Nurse Associations
Family court

Unique needs of persons age 55 and older

Providers reported a broad range of unique needs of individuals age 55 and older similar to those named in the Focus Group Report. The most frequently mentioned need was for geriatric provider services, including the ability to reconnect with a primary care physician the patient can trust and relate to after transitioning back into the community from inpatient care. Comorbidity or co-occurring illnesses, depression, adjustment disorders, concern regarding the awareness of substance use problems, and the need for age-specific groups were also frequently mentioned as unique needs of people age 55 and older. Themes mentioned by providers that were different from the themes reported in the Focus Group Report are described below.

Access to psychosocial supports

Providers mentioned that many older adults they encounter need more access to psychosocial supports than they currently have. To be effective, providers suggested the support for this population should be age specific.

> *This population needs more support from the community.* [Southwestern]

> *Older adults are often isolated and need support that is age-specific if it's to be effective.* [North Central]

Holistic care

Providers mentioned that many older adults are compromised in the activities of daily living and need resources to assist them with overall functioning. Several noted that physical problems often contribute to psychiatric symptoms and that it is important to take a holistic approach in putting the whole picture together when treating an older adult with behavioral health issues. Specialized treatment for geriatric patients was suggested to meet some of the unique needs of this population.

Staff are sometimes quick to say something is related to mental health, but it may be something more physical that contributes to mental health issues. We need more comprehensive services (the physical and the mental) to treat older adults. For example, pain sometimes impacts mental status, so it's important to educate staff about the effects of physical illness and/or pain. We need to put the whole picture together. [Southwestern]

Many patients have co-occurring illnesses and there is no one to help manage them holistically. Many older adults also take a lot of medications for physical illnesses and then add to that the psych meds they are prescribed. It all gets to be too much for them to manage and they need holistic care that addresses both the physical and mental health needs. [Eastern]

Some patients are just having their first brush with emotional issues or mental illness while others have more chronic problems. Geriatric outpatient services are limited. Often, group therapy is not readily available. Specialized treatment is needed to address their range of needs. There also needs to be better integration of services for this group, especially between primary care physicians and psychiatrists as well and more mindfulness of the side effects of medications. [South Central]

Case management

Providers mentioned that follow-through is difficult for many older adults who lack support, and suggested that case management is needed to enable older adults to successfully adhere to treatment plans.

Patients usually accept suggestions about the help they need, but the follow-through is challenging and they need someone to check in on them to see how they're doing. For this reason case management is crucial. [Eastern]

Better coordination of services is needed with primary care physicians and families. [Western]

Educational resources

More educational resources are needed to educate people about resources that are available for older adults and their families, where they are located, and how they can be accessed.

We need the necessary resources to educate people and their families about what supports are available and where to access them. [North Central]

Housing

Several providers expressed concern that lack of a safe place to live is a unique need of older adults. Providers noted that people with behavioral health problems often have exhausted their support network and as a result many important resources, including a place to live, have been lost.

There is limited access to resources and no good places for people diagnosed with mental illness to live. [Western]

Other unique needs

Other unique needs of older adults mentioned by providers included:

- Comorbidity
- Older adults may not recognize depression and have undiagnosed depression
- Loneliness may prevent older adults from reaching out for help
- Sleep disorders are common among older adults with behavioral health problems
- Older adults may not know how to access services
- Alcohol misuse and abuse – prescription drug abuse
- Limited or nonexistent family support

Barriers and gaps

For the purpose of this report, barriers are the limitations that cause gaps in access to services (e.g., lack of transportation). Barriers and gaps reported by providers that supplement those in the Focus Group Report are listed below.

Barriers

Barriers frequently mentioned by providers included lack of integrated services, stigma, assumptions, lack of continuity of care, insufficient community support, and issues related to limited Medicare reimbursement.

Lack of integrated services

Providers reported that lack of integrated services is a barrier to older adults receiving the mental health care they need. This included a limited pool of trained physicians but also the failure to use existing services, such as the Visiting Nurse Association, more effectively.

> *The ideal treatment setting for older adults would be a place that has an integration of both geriatric internal medicine and geriatric psychiatry. Such places are hard to come by because of the limited pool of trained physicians in each discipline. This unfortunately is a nationwide problem.* [South Central]

> *We need to consistently incorporate VNA services in home care for people struggling with mental illness and don't do this as vigorously as we should.* [Eastern]

Stigma

In the Focus Group Report, providers referred to stigma in the context of unique needs of older adults. However during key informant interviews, providers reported stigma or discrimination as a significant barrier to care.

> *A significant barrier to care is the double stigma that surrounds geriatric psychiatry. There is the stigma of having a psychiatric condition followed by the stigma of being "old."* [South Central]

Stigma of receiving help from a mental health professional. They have old school mentality and are more reluctant to get services in the community. [Southwestern]

Assumptions

Some providers indicated that certain assumptions impact patients, their families as well as some of the primary care physicians who provide treatment.

> *There tends to be an assumption that it is "normal" for older adults to be depressed or demented and so families or individuals do not seek treatment. Likewise, primary care doctors with little knowledge of geriatrics treatment may also fall victim to these same assumptions.* [South Central]

Lack of continuity of care

Lack of continuity of care was mentioned as a significant issue for providers, particularly those who don't provide outpatient care.

> *It's not easy to get people into a clinic quickly and our patients are low income so it's harder to find care in a timely fashion.* [Southwestern]

Insufficient community support

Providers also suggested that there is an insufficiency of community support because limited help is available from nursing homes and emergency departments.

> *The population I serve needs more support from the community, including nursing homes and more availability from emergency rooms.* [Southwestern]

Limited Medicare reimbursement

Providers suggested that licensed marriage and family therapists (LMFTs) could be helpful in counseling people, but it is difficult to get enough of them on staff because Medicare does not reimburse for services provided by LMFTs.

> *More older adults seek services from LCSWs than LMFTs because Medicare covers LCSWs but does not cover LMFTs or other licenses.* [Eastern]

Gaps

Providers mentioned many gaps which are listed in the Focus Group Report and added the gaps listed below.

Inadequacy of care

Inadequacy of care included gaps in a wide range of services including lack of adequate providers, a dearth of inpatient beds for acute geropsychiatry, and long waiting lists for appointments. In addition, inadequacy of care included lack of understanding of primary care

physicians regarding pharmacology and older adults and a paucity of regional services to meet the needs of geriatric patients.

> *There are many facets to the inadequacy of care and gaps in services in Eastern CT including: inadequate providers, no providers for house calls, a mobile crisis program for mental health that only addresses child-family clients and no older adults, a tendency for providers to prescribe psychiatric medication management only and not therapy, a poor response to psychiatric symptoms in local Emergency Departments ([Lawrence & Memorial], Backus), reluctance for MDs to implement Physician's Emergency Certificate when appropriate, difficulty in finding inpatient beds for acute geropsychiatry, and increasing cases of extreme self-neglect in the community.* [Eastern]
>
> *Finding someone who specializes in geriatrics in psychiatry who has expertise and who is aware of all the comorbidities that the elderly experience is a huge problem.* [Southwestern]
>
> *Many are not familiar with a geriatric expert like [the Institute of Living], but more of these are needed.*
> [Eastern]
>
> *Our clinic schedules are always full; there are long waiting lists of 4-6 weeks for an appointment.* [North Central]
>
> *In general, there is a lack of understanding on the part of primary care physicians when it comes to prescribing psychiatric medications and older adults.* [North Central]
>
> *Some patients come from further out because there's no one to provide the services they need in their region.* [North Central]
>
> *Sometimes we encounter gaps in services when referring patients. For example, we're not as comfortable referring patients who come to us from further out because we don't know those providers as well as those that are more connected with us and that are closer to our service area.* [Eastern]

Age-specific services

A number of providers underscored the need for age-specific services for those clients participating in substance abuse treatment and those experiencing depression.

> *Older adults get lost in our substance abuse treatment track. Because most of the substance abuse treatment clients are young, the older ones get distracted by the younger ones. An older adult track is needed.* [Eastern]
>
> *Some community docs assume depression is normal and don't refer enough in this age group. In addition, assessment and therapy are difficult in this age group.* [Eastern]
>
> *We don't offer any specialized elder services.* [North Central]

Limited home services and supports

Providers noted that there are limited visiting nurse services for people with mental health issues living in the community.

> *People with mental illness burn through their support systems over their life span and it also predisposes them to cognitive impairment in a way that's different from normal aging brain chemistry. As a result, they need regular services like the VNA to support them when they're living in the community, but VNA is limited for in-home behavioral health services.* [Western]

Barriers and gaps throughout the state and in rural areas

Providers did not differentiate between statewide and rural barriers and similar to focus group participants, these were reported much less frequently and were the same as in the Focus Group Report.

Underserved subgroups

When asked if they see any subgroups within the older population that are underserved, providers mentioned the age 55-64 group, who do not have Medicare, most often. Some providers primarily serve White clients and suggested there needs to be a greater awareness about who seeks mental health care and who does not. Several providers mentioned that they have a fair representation of minorities and of women and men. Other providers expressed concern about individuals who do not quite meet eligibility requirements and have difficulty getting the services they need.

> *Some are a little too well off and don't have Medicaid insurance so they can't get the same services as the younger Medicaid patients. Medicaid has good coverage and sometimes private insurance has stricter criteria for care. If a person makes just a little too much money he/she won't be eligible to be covered.* [Eastern]

> *Lower SES condition puts a patient at higher risk for not being able to access care.* [South Central]

Providers indicated that there is a dramatic difference when families are involved and engaged in the care of a person with mental illness. Those without a familial network of support are a subgroup of people at risk of being exploited and in need of protection as well as services.

Some providers indicated that the whole population with mental illness is underserved primarily because of issues people in that age group have related to lack of eligibility for Medicare and coverage for other services. Other providers specified that the chronically mentally ill that have experienced mental health problems throughout their lives, but never sought treatment, are an underserved subgroup. Providers expressed concern about older adults with comorbidities who have a primary diagnosis of mental illness and those who develop late-life depression. Late-life depression in particular is under-recognized and undertreated. An emerging issue is baby boomers with substance abuse, particularly opiate and alcohol abuse.

> *The chronically mentally ill are not organized enough to get the services they need on their own. They are always on the margins, especially with loss of family support.*

Sometimes we get people who come in in their 60s who have never been treated and we can't believe they've never sought or received any mental health help. [Western]

Resources needed to fulfill agency goals

Providers suggested a number of resources needed to fulfill their agency goals. Overall, these were consistent with responses to other questions asked during the interview and can also be viewed as recommendations for future behavioral health services and supports:

Collaboration – more interdisciplinary teams [North Central]

Nursing and home health aides to provide in-home care [North Central]

Need help with placement and stable living arrangement close to an outpatient facility. Some patients end up going to a hotel and can't afford it – they're struggling with depression and substance recovery and then lack of appropriate living arrangements make it difficult. [Eastern]

A plan to follow patients into the community and to better coordinate their care there [Southwestern]

The only resources I need is for hospitals to be more accessible and for the crisis centers to listen more. [Southwestern]

More education for staff [Southwestern]

Funding to develop more programs and to extend services [Southwestern]

Day programs are needed for elderly psychiatric patients [Southwestern]

Need more providers and more beds for older psychiatric patients [Western]

Need more clinicians – more LCSWs and psychologists to better accommodate geriatric patients; expand clinics' services to include more geriatric psychiatrists; need more physical space – some are handicapped and come in wheelchairs – need a facility that is more handicap accessible. [South Central]

Many of my mild dementia cases present primarily with substance abuse, anxiety, behavioral symptoms, apathy/depression, chronic pain, and insomnia, so please consider a cognitive impairment evaluation in any mental health state plan strategies, resources, or algorithms proposed. [Eastern]

Transportation to get to doctor visits – concerned about Logisticare and the long pickup times [North Central]

We just hired an APRN with geriatric experience, but need more, more inpatient beds, better access to treatment. [Western]

Suggestions for the statewide survey

Providers suggested many of the same groups of people as focus group participants.

Providers were asked to provide suggestions for questions to include in the statewide survey. Several providers suggested that behavioral health be more specifically defined to include, for example, sleep hygiene. All of the respondents agreed that the questions they were asked were relevant, comprehensive, and broad enough to capture a lot of information. One provider suggested that the statewide survey should ask respondents to identify one useful resource that would better enable them to serve older patients with behavioral health needs.

Conclusions

Providers from all five regions of the state reinforced data collected from focus group participants, and added additional insights. Providers, like focus group participants, are concerned about lack of insurance coverage for mental illnesses, housing, transportation, and other services and supports that are needed but unavailable.

Providers underscored that the unique needs of adults age 55 and older make it more challenging to effectively serve them and include: stigma or discrimination, the increase in comorbidity as people age, medication adherence, and addictions and substance use disorders.

While many barriers and gaps in behavioral health services exist throughout the state, there are existing strengths on which to build for those committed to improving access to service and supports. Building on existing community assets is a concrete strategy in beginning to develop and expand services and supports that will promote greater future change in needed behavioral health services.

One limitation of this supplemental study is that the individuals with whom providers have experience by definition are already connected, at least in a limited way, with behavioral health services. Persons with behavioral health needs who have had no contacts with any type of provider may have different or additional needs, and are not represented in these findings.

Appendix A: Older Adult Behavioral Health Provider Key Informant Guide

1. How often do you encounter older adults (age 55+) who might be able to benefit from behavioral health services? (In your answers, please define these services broadly including mental health, substance use, addictions, etc.)

2. What types of support, skills, and/or services do the people you encounter appear to need?

   Probes: Do they typically seek medication, counseling or both?

3. How do you assist people who appear to need behavioral health services?

4. For those of you who provide any type of behavioral health services, please discuss the extent of behavioral health services you provide to people age 55+.

   Probes: Advocacy and support, behavioral health recovery program (BHRP), mental health, crisis services, trauma-related services, suicide resources, substance use, addictions, gambling, hoarding, transportation, online services, other.

5. Does your agency provide any evidence-based behavioral health services/interventions for older adults?

   Probes: IMPACT, PEARLS, Cognitive Behavioral Therapy (CBT), Problem- Solving Treatment (PST), or Reminiscence Therapy (RT)?

   a. If yes, please identify them.

   b. If no, why not?

6. Do you use Evidence-Based Practice (EBP) screening tools for depression (i.e., Geriatric Depression Scale, Beck Depression Inventory, or PHQ-9, etc.) and alcohol abuse (i.e., CAGE or AUDIT)?

   a. If yes, please identify which EBP screening tools you typically use.

   b. If no, what are the barriers in using EBP screening tools?

7. For those of you who make referrals of older adults for further behavioral health services:

   a. Why or at what point do you refer them?

   b. Where do you refer them?

      Probes: DMHAS – specific regions, local mental health authorities (LMHAs), crisis psychiatric services, psychiatrist, psychologist, psychiatric mental health nurse or practitioner, physician assistant, licensed clinical social worker, licensed professional counselors, peer specialists, online resources, primary healthcare providers).

8. For those of you who receive referrals of older adults, what person or entities typically refer people to you?

9. What do you see as some of the unique needs of persons age 55+?

   Probes: Co-occurring illness, physical disability, acuity, stigma, reluctance to accept treatment, medication adherence?

10. What are the barriers for helping people who seek/need behavioral health services in accessing such services?

11. What do you see as some of the gaps in behavioral health services for older adults both in your region and statewide?

    Probes: Education, referrals, expertise of providers, geography, transportation.

12. Within the older adult population, do you see any subgroups as under-served?

    a. If yes, what are some of the reasons for subgroups being under-served?

       Probes: Age, diagnosis, income levels, insured status, rural/urban.

13. What resources do you currently need to fulfill your agency goals for older adults with behavioral health needs?

    Probes: Training and Technical Assistance, adoption/implementation of Evidence-Based Practices, community outreach and engagement, etc.

14. As we have discussed, this fall or early next year we will be doing a statewide survey of both providers of behavioral health services and referral sources to get more information about the availability of behavioral health services in all parts of the state, as well as any gaps in services and suggestions for improvements.

    a. Do you have any suggestions for groups of people who should be asked to participate in such a survey?

    b. Do you have any suggestions for questions we should be sure to ask?