

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

Statewide Survey Results

September 2015

Prepared by

Kathy Kellett, PhD
Noreen Shugrue, JD, MBA, MA
Alison Kleppinger, MS
Alba Santiago, BA
Azucena Minaya, BA
Julie Robison, PhD

UConn Health | Center on Aging
263 Farmington Avenue
Farmington, CT 06030-5215

Table of Contents

Introduction	1
Methodology and Analysis	1
Statewide Results	7
Comparison: Community-Based Behavioral Health and Other Organizations	16
Regional Results	18
North Central	37
Eastern	44
Western	50
Southwestern	60
South Central	68
Conclusions	76
References	77
Appendix A: Older Adult Behavioral Health Asset Mapping Survey	79

Introduction

Led by a partnership between the CT Department of Mental Health and Addiction Services (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 Older Adult Behavioral Health Workgroup engaged UConn Health, Center on Aging (UConn COA) to assist with an asset mapping project of the behavioral health and substance use resources in CT that serve older adults (age 55+). 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 have the potential to 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 Older Adult Behavioral Health 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 State regions, between October 31, 2014 and December 19, 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.

This report includes outcomes from the last phase of the project, the electronic statewide survey.

Methodology and Analysis

Methodology

Older Adult Behavioral Health Asset Mapping Survey Instrument

The Older Adult Behavioral Health Asset Mapping Survey was developed by UConn COA with input from the Older Adult Behavioral Health Workgroup (see Appendix A for a copy of the survey). Study data were collected and managed using REDCap (Research Electronic Data Capture) electronic data capture tools hosted at UConn COA. REDCap is a secure, web-based application designed to support data capture for research studies, providing: 1) an intuitive interface for validating data entry; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for importing data from external sources (Harris, Taylor, Thielke, Payne, Gonzalez, & Conde, 2009). Questions sought provider input on a range of topics including:

- The extent of older adult behavioral health services provided and target populations covered

- Significant barriers older adults face when accessing behavioral health services
- Payment methods accepted by the behavioral health services organization
- Significant challenges faced by the organization regarding the provision of or making referrals to behavioral health services for older adults
- Best practices used or observed in 1) providing behavioral health services to older adults; 2) enabling referrals to such services; and/or 3) educating the public about such services
- Strengths of Connecticut's behavioral health system for older adults
- Suggestions for improving behavioral health services for Connecticut's older adult population

Research sample

While snowball sampling, or chain sampling, is not representative of the larger study population, it was used for exploratory purposes in this study (Teddlie & Yu, 2001). The non-probability sampling technique was appropriate in locating members of the target population and then asking them to locate other members of the target population whom they know. The Workgroup was primarily responsible for identifying organizations throughout the State that either provide behavioral health services or refer older adults to those services. Their suggestions were augmented by UConn COA researchers. Table 1 shows organizations (listed in no particular order) that were directly contacted, provided with information on how to participate in the survey, and requested to forward the information to other interested parties.

Table 1. Agencies and organizations contacted

Agencies and organizations
Wheeler CT Clearinghouse
Health Disparities Institute
UConn Health Geriatric and Psychiatric Physicians
Office of Healthcare Access (OHCA)
Institute of Living (IOL)
Connecticut Association for Healthcare at Home
Connecticut Chapter – National Alliance on Mental Illness (NAMI)
National Association of Social Workers – Connecticut Chapter (NASW-CT)
Department of Mental Health and Addiction Services (DMHAS)
Connecticut Department on Aging
Mental Health Connecticut, Inc.
Bringing Resources to Action to Serve Seniors (BRASS)
Coalition for Abuse and Prevention of the Elderly (CAPE)
Connecticut Counseling Association
Connecticut Association of Addiction Professionals
Connecticut Psychiatric Association
Connecticut Psychological Association
Primary Care Coalition of Connecticut
Medical and Scientific Advisory Council
Connecticut Legal Rights Project

In addition, persons who participated in previous focus groups or individual interviews during earlier phases of the asset mapping project were asked to participate in the survey and to circulate information about the survey within their organizations and professional circles. Information about the survey and how to access it was circulated by a Workgroup member in a newsletter that went out weekly to Natchaug Hospital, Rushford, and the Institute of Living. In addition, Workgroup members forwarded email invitations to other groups of providers (e.g., gambling treatment providers). Persons who received an email were asked to forward the email and link to the survey to other interested persons. The sample included psychiatrists, primary care physicians, advance practice nurses (APRNs), behavioral health directors, healthcare liaisons, and clinicians (i.e., licensed clinical social workers, licensed marriage and family therapists) throughout the State.

It should be noted that while physicians were a targeted group due to the valuable perspective they have to offer, physicians completed very few surveys. Requests for permission to send an email survey invitation through several physician organizations were declined. Physicians are often characterized by low survey response rates and are usually difficult to gain access to (VanGeest, Johnson, & Welch, 2007). Montauk (2000) noted that physicians are frequently approached for surveys and are typically inundated with what they think of as “medical junk mail.” As a result, it is not surprising that physicians are reticent to participate in surveys or that receptionists and other “gatekeepers” (e.g., Boards) protect physicians from unwanted intrusions on their time. As a result, response rates among physicians are about 10 percent lower than studies with the general population (Cummings, Savitz, & Konrad, 2001).

Recruitment

Recruitment was done through email requests with an embedded hyperlink to a Web site containing the survey. Benefits of Web-based (online) surveys include: low cost; wide availability of survey design and implementation of tools; ease of implementation, including reminders; and built in features that enable data cleaning and improve the survey experience for respondents (Dillman, Smyth, & Christian, 2009; Israel, 2011).

Snowball/social network or respondent-driven recruitment was employed and involves referral chains of sampling. According to the literature, this creates a sampling frame that increases representation in health and medical research and among community groups (Bonevski et al., 2014). Both active and passive snowball recruitment strategies were employed. In active snowball recruitment, Workgroup members volunteered the contact information of potential organizations and individuals to be contacted. In passive snowball recruitment, participants responding to the survey were asked to contact others and forward them the survey link so that they could independently volunteer to participate. While the validity and reliability of data obtained online are comparable to those obtained by other survey methods, selection bias contributes to issues of generalizability (Wright, 2005). Web-based surveys also tend to have low response rates and are approximately 11 percent lower than mail or phone surveys (Archer, 2008; Petechenik & Watermolen, 2011).

To increase response rates, every effort was made to ensure the email correspondence appeared legitimate. Words typically associated with spam email (i.e., "Respond Now") were not used in the subject line (Kaplowitz, Hadlock, & Levine, 2004). Other widely followed elements suggested by Dillman et al. (2009) for mail surveys and that translated to response rate benefits for Web surveys were employed. A survey title was created that described the survey topic. Details about the survey were included in the body of the email and the link was clearly provided. While incentives are useful in encouraging respondents to complete a survey, due to budget limitations no incentive was offered. Contact information was included in the email so respondents could call or email if they encountered problems accessing the survey or had questions about the survey or the group conducting it.

The initial email with Web survey link was deployed on February 13, 2015 to 683 recipients on a master list. Emails that were returned as undeliverable were removed from the master list. Because the survey was anonymous and there was no way to determine who had responded, the remaining potential participants were offered additional opportunities to respond or to forward the link to others. A second email invitation was deployed on March 3, 2015 to 611 recipients. Following the removal of additional addresses that were determined undeliverable, a third and final invitation was deployed on March 31, 2015 to 579 recipients. Data were captured through May 10, 2015.

Analysis

Prior to analyzing the data, definitions were established to distinguish between surveys that were not completed, those that were partially completed, and those that were completed (see below).

Not completed – no data or only questions 1-2 answered

Partially completed – questions 1-3 or more but fewer than half of the 10 questions answered

Completed – more than half of the 10 questions completed

Of the total of 945 surveys begun, 87 were categorized as not completed and were not included in the dataset. For purposes of this analysis, data from the partially completed surveys (n=312) were combined with data from the completed surveys (n=546) for a total of 858 completed surveys.

Descriptive statistical methods using the IBM Statistical Package for the Social Sciences (SPSS) 19.0 were used to analyze and summarize data. Bivariate analyses were also used to identify patterns, note trends, and draw conclusions. Data were analyzed question by question, with a series of basic tests computed: frequency, average, and percentage. Basic descriptive statistics were produced for the statewide data. For regional analysis, zip codes were used to separate data by the five Aging and Disability Resource Center (ADRC) regions. Chi square tests were then done to compare regions and to test for significant regional differences.

Qualitative data from the open-ended questions were analyzed primarily by region to identify and interpret 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.

In addition, UConn COA researchers enlisted the help of the University of Connecticut Libraries' MAGIC (Map and Geographic Information Center) to further explore data outcomes. MAGIC staff created an online dashboard based on the geographical identifiers (zip codes) incorporated in the survey, along with the various categorical data, to create maps and graphs depicting the number of respondents and types of services provided. The first map, "Services for older adults by zip code," shows the number of respondents for each Service Category, with the option to filter the results by Age Group Served (to, for example, show only services designed specifically for older adults 55+) and/or to select whether services are *Addiction Specific* or *Mental Health Only*. A second map, "Ratio of older population to number of respondents," shows the ratio of responding service providers to the 2010 total age 50+ population in the corresponding Census Zip Code Tabulation Area (ZCTA) according to the 2010 U.S. Census. ZCTAs are statistical areas made up of the Census Blocks within the postal Zip Code boundaries. While not an exact match to zip code boundaries, ZCTAs give a comparable estimate of the population. In this case, it might show where older populations are underserved by behavioral health providers.

Examples of the maps are shown in the following figures. Figure 1 shows behavioral health services for older adults 55+ for both categories (e.g., "Addiction Specific" and "Mental Health Only") by zip code and indicates that the greatest number of respondents (n=24) reporting the use of behavioral health services were from zip code 06457. Figure 2 shows the ratio of population age 50+ to the number of respondents in a particular region. Exploration of additional details by town, region and service by using the Interactive maps for the study, can be accessed at

<https://public.tableau.com/profile/publish/OlderAdultBehavioralHealthAssetMappingSurvey/Story1#!/publish-confirm>

Figure 1. Behavioral health services for older adults 55+ by zip code

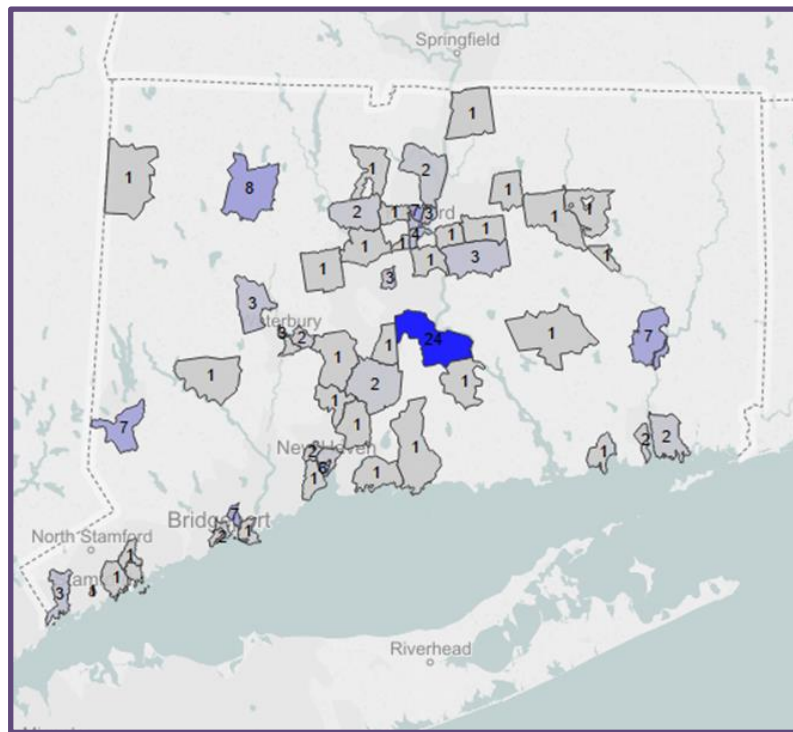
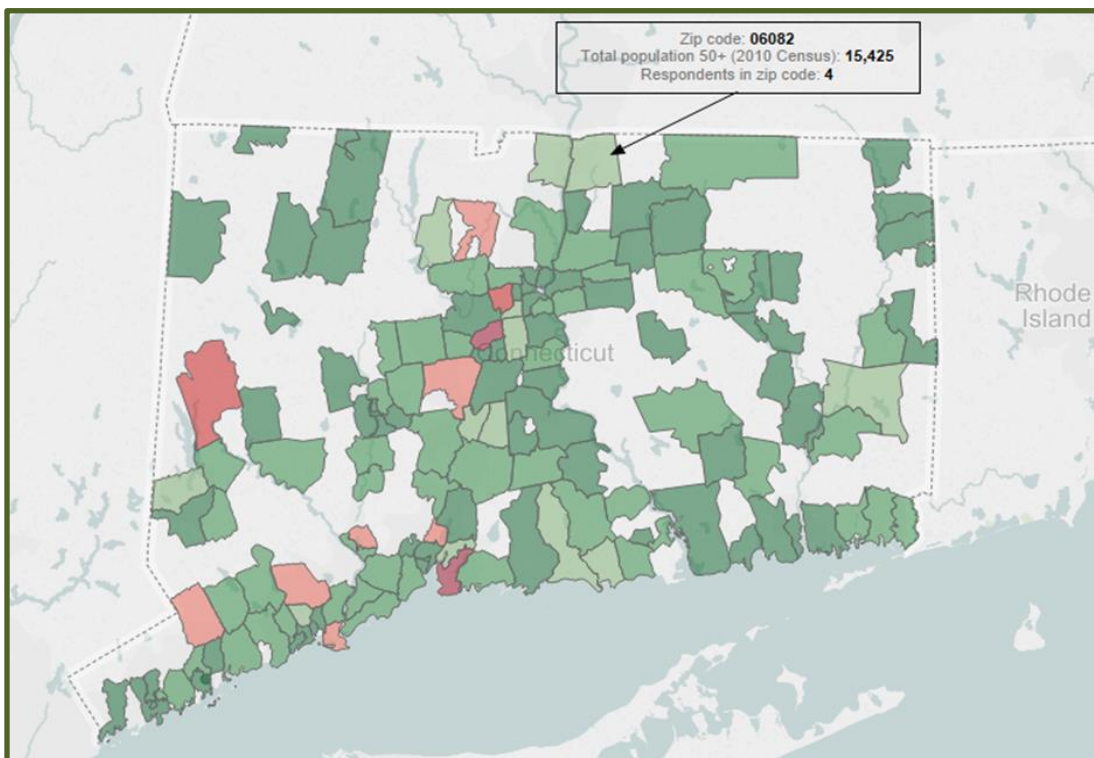


Figure 2. Ratio of population age 50+ to number of respondents

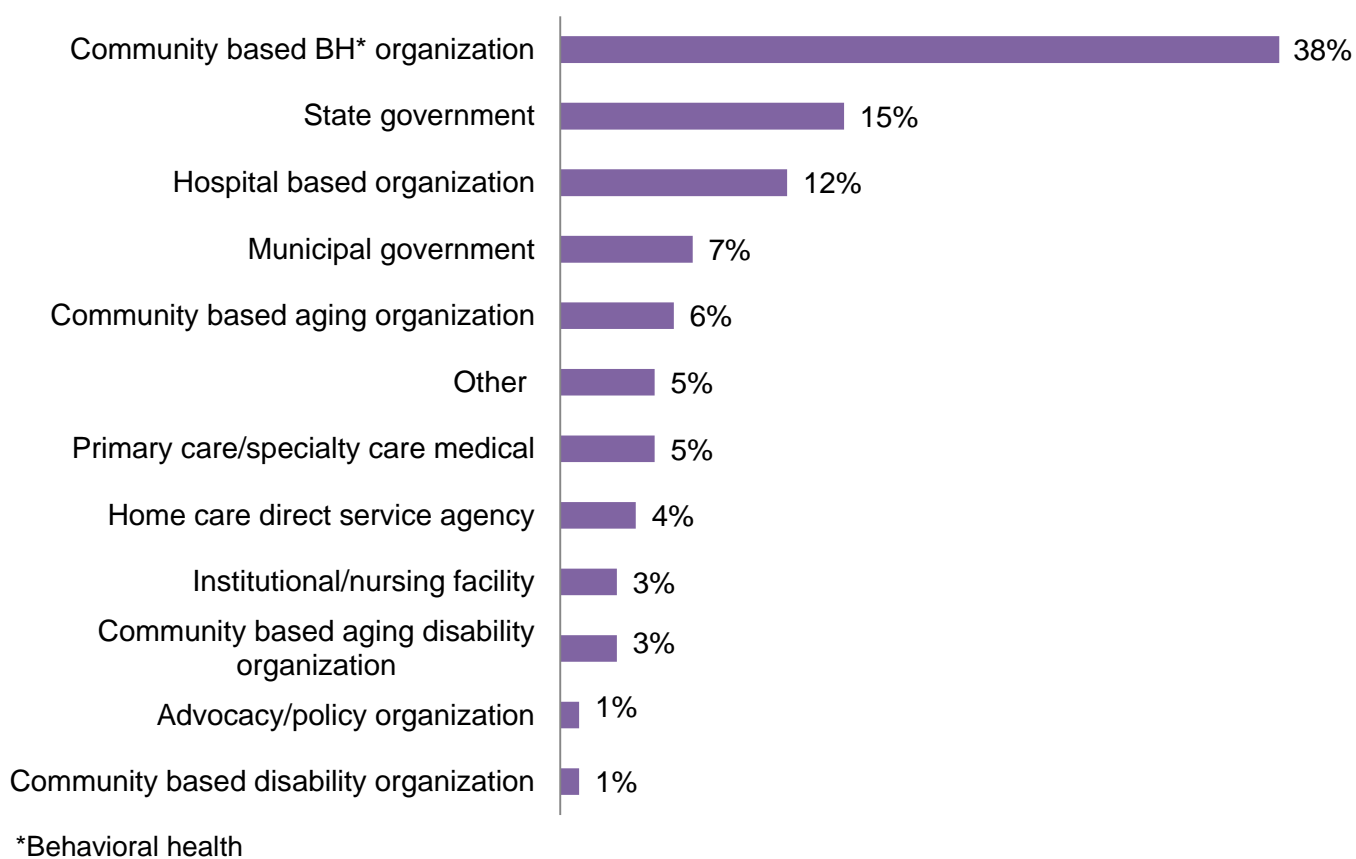


Statewide Results¹

Type of organization

Respondents were asked what type of organization most accurately represents where they work. The type of organization most frequently reported was community-based behavioral health organization (38%, n=331). This was followed by state government (15%, n=131), and hospital based (12%, n=103) organizations. All other types of organizations were represented much less frequently (Figure 3).

Figure 3. Type of organization



¹ See Regional Results section for detailed results on each of the five ADRC regions.

Service area

Respondents were asked to describe the size of their service area. The majority reported their service area as region/county (52%), followed by town/city only and statewide (28% and 20%, respectively) (Table 2).

Table 2. Service area

Service area	% (n)
Town/city only	28 (238)
Region/county	52 (443)
Statewide	20 (175)

Services related to behavioral health

In addition, respondents were asked if their organization provides a range of services related to behavioral health, both “addiction specific” and “mental health only.” They were also requested to differentiate between services provided for consumers ages 18 and older and those designed specifically for ages 55 and older. Of 858 respondents 213 skipped this question and were removed from the denominator for this analysis. Across all service categories a greater percentage of services were reported for ages 18+ than for 55 and older for both addiction specific and mental health services (Table 3).

The four most frequently reported services for both age groups and both service types, in slightly different order, were:

- Information and referral via telephone
- Individual counseling services
- Diagnostic screening and assessment
- Group counseling/support group services

Although older adults may be served as part of the “18+” category, this data strongly suggests that mental health and addiction services designed specifically for them are lacking in every category.

Table 3. Service categories by age group and type of service

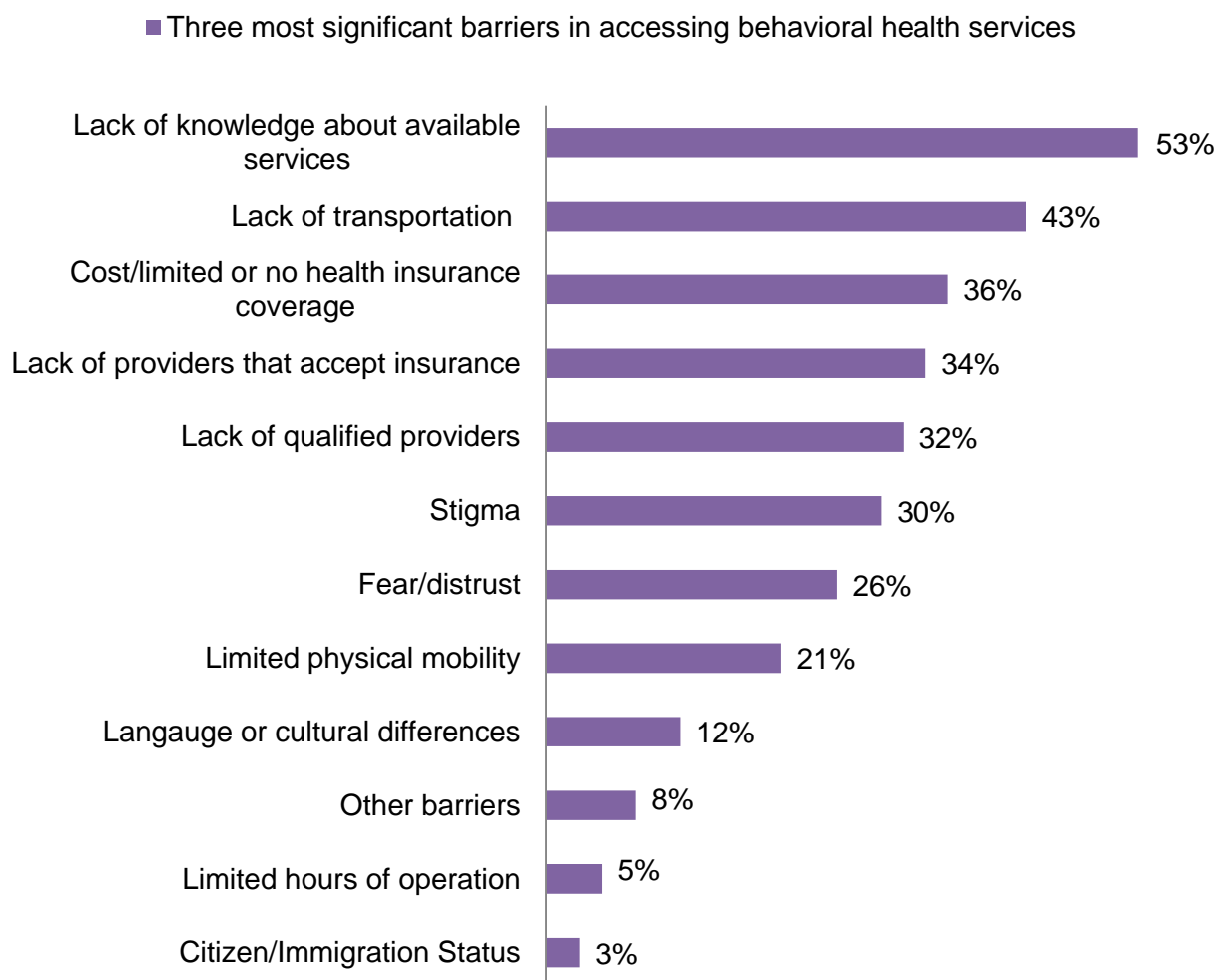
Service Categories	Provide to Ages 18 + (Addiction Specific)	Designed Specifically for Older Adults Age 55+ (Addiction Specific)	Provide to Ages 18 + (Mental Health Only)	Designed Specifically for Older Adults Age 55+ (Mental Health Only)
	N=645 % (n)	N=645 % (n)	N=645 % (n)	N=645 % (n)
Advocacy/Policy Development	28 (178)	14 (92)	32 (208)	18 (115)
Legal Assistance	13 (81)	6 (39)	14 (92)	8 (54)
Information & Referral via Telephone	43 (274)	25 (160)	48 (309)	29 (187)
Information & Referral via Internet	20 (131)	12 (80)	22 (144)	14 (87)
Behavioral Health Outreach (brochures, PSAs, ads etc.)	32 (204)	16 (103)	36 (234)	20 (126)
Behavioral Health Education (presentations, classes, workshops)	31 (201)	16 (102)	36 (233)	20 (128)
Individual Counseling Services	47 (294)	23 (145)	61 (396)	32 (207)
Group Counseling/Support Group Services	41 (267)	19 (122)	48 (309)	23 (146)
Federally Recognized Evidence Based Interventions (i.e. PEARLS, IMPACT, CBT...)	30 (192)	14 (89)	37 (240)	17 (107)
In-Home Counseling Services	10 (65)	7 (44)	13 (86)	10 (63)
Diagnostic Screening and Assessment	43 (278)	23 (145)	51 (330)	29 (185)
Services to Non-English Speaking Populations	36 (234)	17 (112)	42 (273)	20 (129)
Peer - to - Peer Support	24 (157)	10 (66)	29 (188)	12 (75)

Service Categories	Provide to Ages 18 + (Addiction Specific)	Designed Specifically for Older Adults Age 55+ (Addiction Specific)	Provide to Ages 18 + (Mental Health Only)	Designed Specifically for Older Adults Age 55+ (Mental Health Only)
	N=645 % (n)	N=645 % (n)	N=645 % (n)	N=645 % (n)
Peer - to - Peer Support Training	14 (93)	6 (38)	19 (120)	7 (43)
Care Management	30 (194)	16 (100)	38 (246)	21 (136)
Tele-Counseling (use of telephone/video for consultation)	8 (49)	5 (29)	10 (61)	7 (42)
Integrated Teams of Behavioral Health and Primary Care Providers	20 (128)	12 (74)	25 (158)	14 (87)
Co-location of Behavioral Health and Primary Care Providers	15 (97)	7 (46)	19 (123)	8 (53)
Supports for Family Caregivers	23 (146)	13 (85)	32 (207)	20 (129)
In-Patient Services	20 (131)	10 (64)	22 (140)	11 (71)
Housing for Consumers w/ Co-Occurring Physical & Mental Health Conditions	14 (93)	6 (41)	18 (114)	7 (43)
Other Services (Please specify)	7 (42)	3 (22)	7 (48)	6 (38)

Three most significant barriers in accessing older adult behavioral health services

Respondents were asked for their opinion on the three most significant barriers faced by older adults ages 55+ when trying to access behavioral health services. The most significant barrier was lack of knowledge about available services (53%, n=321), followed by lack of transportation (43%, n=263) and cost/limited or no health insurance coverage (36%, n=221) (Figure 4).

Figure 4. Three most significant barriers in accessing behavioral health services



Payment methods accepted for services

Respondents were asked to indicate which methods of payment their organization accepts for services. Figure 5 shows that three-quarters of organizations (75%, n=441) reported they accept Medicaid. This was followed by Medicare (65%, n=383), and private insurance (62%, n=363). Forty percent (n=233) reported some services were free of charge. Seven percent (n=41) reported other payment methods, such as cash, out of pocket, or credit card.

Figure 5. Payment method

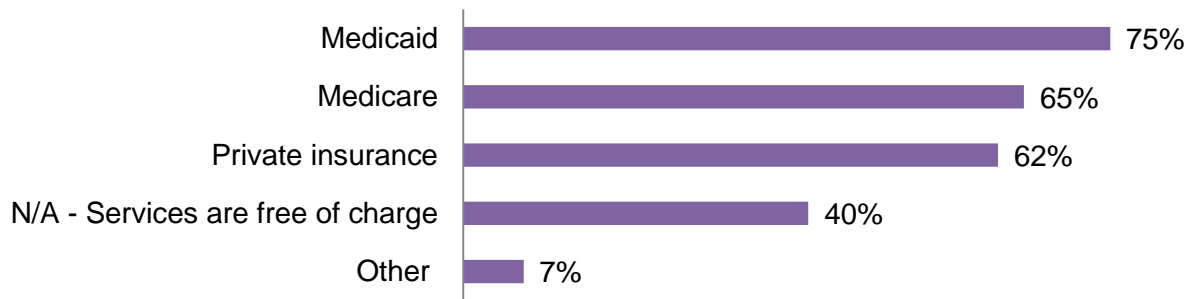
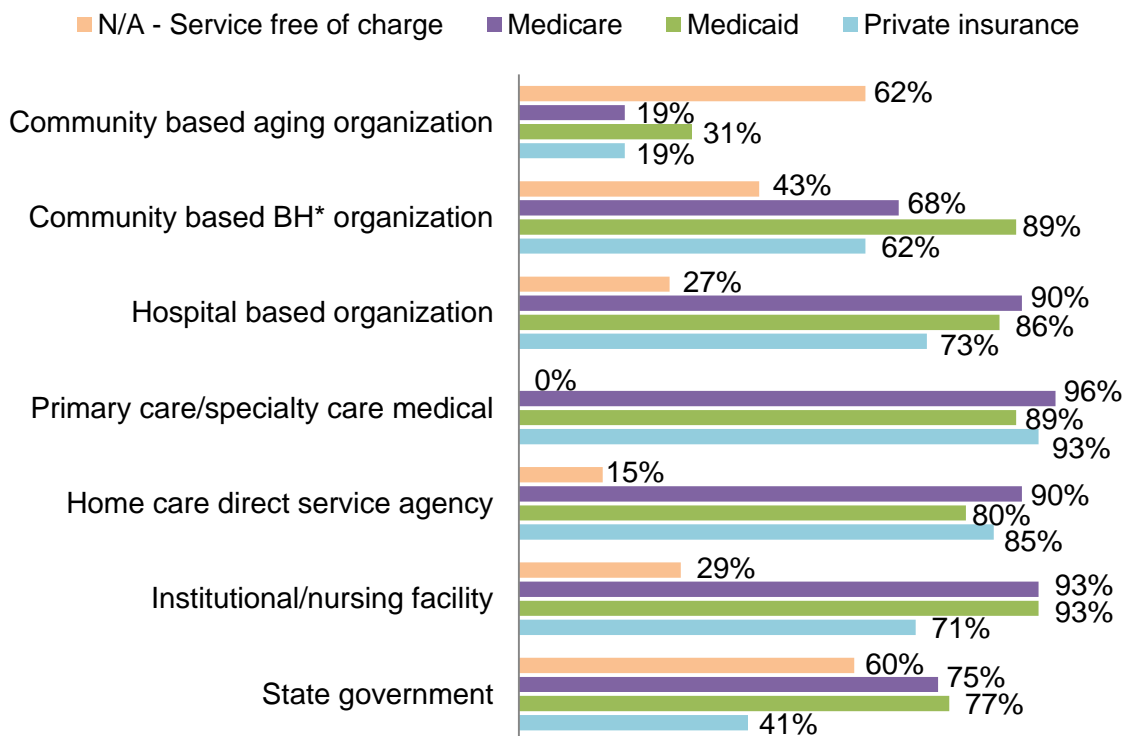


Figure 6 shows a breakdown of payment method by organization. Of 858 respondents, 272 did not check any payment method and were removed from the analysis. Organizations (i.e., Advocacy and Policy, Community-Based Disability, Community-Based Aging Disability, Municipal, and Other) and “Other” payment types that had low response rates for this question were also excluded from the analysis. Not surprisingly, respondents in primary care/specialty care, institutional/nursing facilities, and hospital based organizations reported Medicare as the most common payment method (96%, n=27, 93%, n=13, and 90%, n=64, respectively). Medicaid was also a common payment method reported by respondents in institutional/nursing facilities, community-based behavioral health organizations, primary care/specialty care medical organizations, and hospital based organizations (93%, n=13, 89%, n=147, 89%, n=25, and 86%, n=61, respectively). Private insurance payment method was most frequently reported by respondents in primary care/specialty care medical organizations and home care direct service agencies (93%, n=26 and 85%, n=17).

Figure 6. Payment method by type of organization

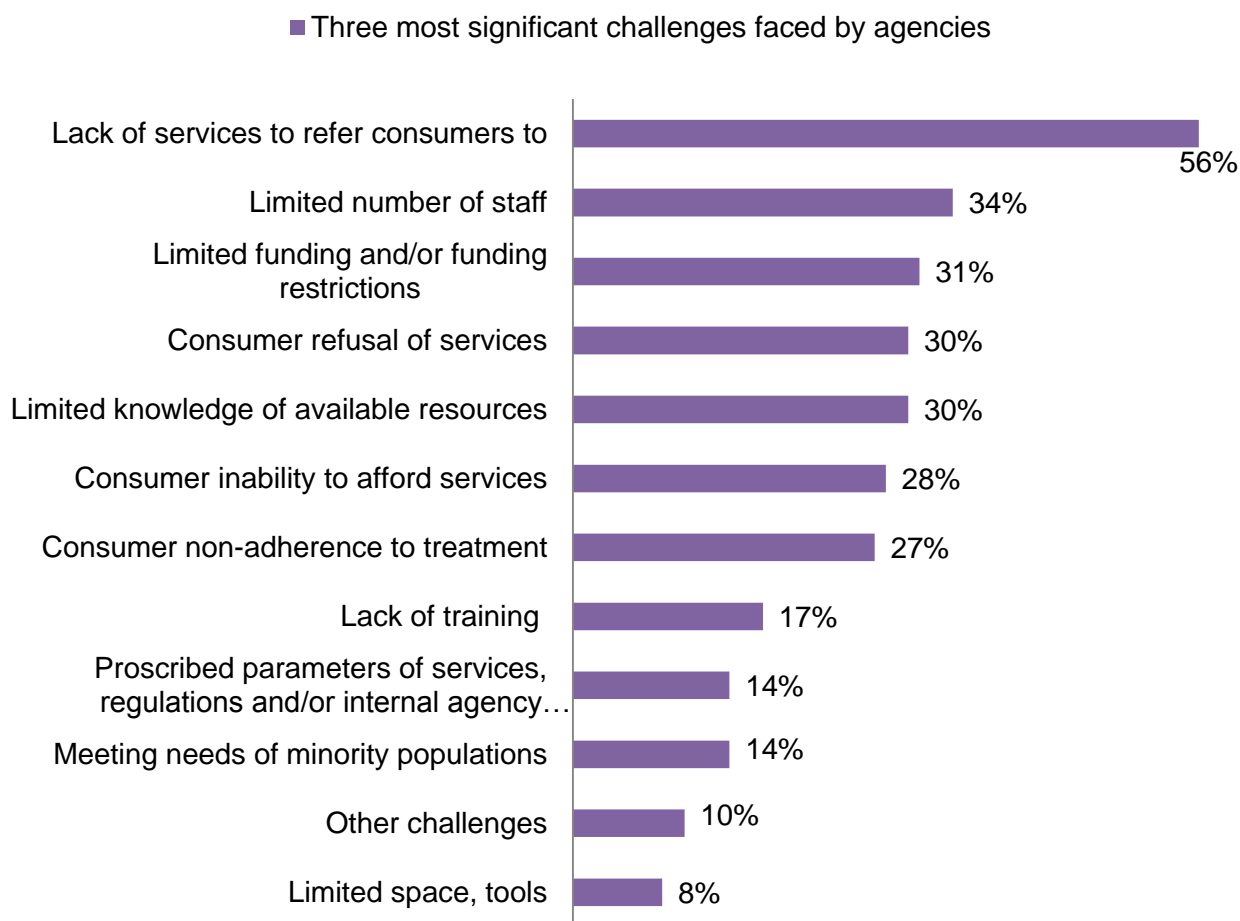


*Behavioral health

Three most significant challenges in providing or making referrals to behavioral health services

Figure 7 shows the three most significant challenges faced by agencies in providing or making referrals to behavioral health services. The most frequently reported challenges were lack of services to refer consumers to (56%, n=320), limited number of staff (34%, n=180), and limited funding and/or funding restrictions (31%, n=170).

Figure 7. Three most significant challenges faced by agencies



Statewide Qualitative Results

Survey participants were asked to respond to three open-ended questions describing their opinions on the following topics:

- Best practices used or observed in 1) providing behavioral health services to older adults; 2) enabling referrals to such services; and/or 3) educating the public about such services.
- Strengths of Connecticut's behavioral health system for older adults.
- Suggestions for improving behavioral health services for Connecticut's older adult population.

Qualitative data from the open-ended survey questions were initially analyzed regionally and are reported in the “Regional Results” section of this report. Outcomes from that analysis are summarized and reported below for an overview of statewide qualitative results.

Statewide best practices

Best practices used or observed were for the most part fairly generic, and included the broad categories of behavioral health services provided to older adults, enabling referrals to behavioral health services, and educating the public about such services.

Providing behavioral health services to older adults

Respondents shared a wide range of best practices related to providing behavioral health services, with Cognitive Behavioral Therapy (CBT) the most frequently mentioned therapeutic practice (Table 4). Less frequently mentioned best practices included group therapy/counseling, integrating services between behavioral health professionals and primary care physicians, case management, outreach programs at senior centers, public education regarding older adult services, and in-home services. In some cases, specific organizations were mentioned as modeling best practices for older adult behavioral health (i.e., Bridgeport Hospital, Connecticut Geriatric Society, Greenwich Hospital’s Center for Healthy Aging, Masonicare, Gatekeeper Program).

Table 4. Best practices: Behavioral health services

Best practices	
Cognitive behavioral therapy (CBT)	Trauma Recovery and Empowerment Model (TREM)
Group therapy/counseling (i.e., family therapy, couples therapy, in-home counseling)	Target Affect Regulation: Guide for Education and Therapy (TARGET)
Integration of services between behavioral health professionals and primary care physicians	Trauma Informed Care
Case management	Motivational Interviewing
Outreach programs at senior centers	Integrated dual disorder treatment
Screening, Brief Intervention and Referral to Treatment (SBIRT) Program	Medication management
Dialectical Behavior Therapy (DBT)	Geriatric providers
Eye Desensitization and Reprocessing Therapy (EMDR)	Support groups
Patient Health Questionnaire (PHQ-9)	Awareness and education regarding older adult services
Dialectical Behavioral Therapy (DBT)	Advocacy
Integrated Dual Disorder Treatment (IDDT)	In-home based services

Enabling referrals to behavioral health services

Additional best practices focused on enabling referrals to behavioral health services. Most frequently mentioned was the DMHAS WISE Program. Other programs mentioned included the Behavioral Health Partnership (integrated behavioral health system for Medicaid recipients), and Elderly Protective Services. Less frequently mentioned were interdisciplinary teamwork referrals, referrals to community providers and services, implementing clinical team meetings between collaborators on a regular basis, combating stigma related to mental health, integrating primary and mental health care to increase referrals for older adults, and educating providers about the best time to refer.

Educating the public about behavioral health services

Best practices in educating the public about behavioral health services included various types of advertising (i.e., pamphlets, brochures, and the Internet) and group setting outreach (i.e., senior centers, health fairs, workshops, education forums). Educational topics included mental health, chronic illness, grief, loss, and stigma. Best practices also included education and outreach in other languages, such as Spanish.

Statewide: Strengths

Respondents noted the strengths of particular programs and organizations, such as, the WISE Program, Area Agencies on Aging, Gatekeeper Program, CT Home Care Program for Elders (CHCPE), DMHAS wraparound supports, Senior Grant from DMHAS, and the CT Behavioral Health Partnership (CTBHP). In more general ways, participants underscored staff training, care management services, and education provided to consumers as additional strengths. Many respondents mentioned the dedication of existing providers and specialists providing behavioral health care to older adults (e.g., geriatric psychiatrists) as a strength. Other less frequently mentioned strengths included awareness and recognition, communication and collaboration with agencies and hospitals, the availability of inpatient, outpatient and community services, and contributions made by medical schools and academic institutions.

Statewide: Weaknesses

While not asked specifically about weaknesses in the open-ended survey questions, many respondents nevertheless offered their views on weaknesses of the behavioral health system. The most frequently mentioned weaknesses were lack of well-trained or insufficient availability of providers, limited resources, and poor insurance coverage. Less frequently mentioned weaknesses included lack of awareness and education, and insufficient housing.

Statewide: Suggestions

Although a wide range of suggestions were mentioned, the primary suggestions focused on awareness, access to services (i.e., age group specific services, in-home services, family services, counseling), insurance coverage, education, geriatric providers, funding, and integration of services. Less frequently mentioned suggestions included the need to reduce stigma/discrimination, improve housing and placement, and provide better transportation options.

Comparison: Community-Based Behavioral Health and All Other Organizations

The Workgroup requested an additional analysis comparing community-based behavioral health organizations and all other organizations to determine if there were any differences between them in the barriers, challenges, best practices, strengths, weaknesses and suggestions they reported. The results of that analysis follow.

Five most significant barriers in accessing older adult behavioral health services: Community-based behavioral health organizations and all other organizations

Workgroup members asked to explore barriers in accessing older adult behavioral health services between community-based behavioral health organizations and all other organizations. Four of the five most significant barriers reported by both groups were the same: lack of knowledge about available services; lack of transportation; cost/limited or no health insurance coverage; and stigma. Community behavioral health providers also mentioned lack of providers that accept insurance, while other organizations mentioned lack of qualified providers (Table 5).

Table 5. Five most significant barriers in accessing older adult behavioral health services:
Community-based behavioral health and all other organizations

Rank	Barriers: Community-based behavioral health organizations	Number of Responses N=325	Barriers: All other organizations	Number of Responses N=533
1	Lack of knowledge about available services	118	Lack of knowledge about available services	202
2	Lack of transportation	115	Lack of transportation	148
3	Lack of providers that accept insurance	93	Cost/limited or no health insurance coverage	130
4	Cost/limited or no health insurance coverage	90	Lack of qualified providers	120
5	Stigma	82	Stigma	102

Five most significant challenges faced by agencies in making referrals to behavioral health services for older adults: Community-based behavioral health organizations and all other organizations

Also explored between community-based behavioral health and all other organizations were the challenges faced by agencies in making referrals to behavioral health services for older adults. Three of the five most significant challenges reported by both groups were the same: lack of services to refer consumers to; consumer inability to afford services; and limited knowledge of available resources. The other top challenges mentioned by community behavioral health organizations were limited number of staff and limited funding and/or funding restrictions. Additional top five challenges mentioned by other organizations were consumer refusal of service and consumer non-adherence to treatment (Table 6).

Table 6. Five most significant challenges faced by agencies in making referrals to behavioral health services for older adults

Rank	Challenges: Community-based behavioral health organizations	Number of Responses N=325	Challenges: All other organizations	Number of Responses N=533
1	Lack of services to refer consumers to	115	Lack of services to refer consumers to	194
2	Limited number of staff	81	Consumer refusal of service	119
3	Limited funding and/or funding restrictions	78	Limited knowledge of available resources	102
4	Consumer inability to afford services	67	Consumer non-adherence to treatment	95
5	Limited knowledge of available resources	61	Consumer inability to afford services	94

Best practices: Community-based behavioral health organizations and all other organizations

Providing behavioral health services to older adults

A comparison between community-based behavioral health organizations and all other organizations shows they were mostly similar in opinions regarding best practices in providing behavioral health services to older adults. Respondents in both types of organizations referred to the benefits of therapeutic services, integration of services, and outreach. Respondents from community-based behavioral health organizations, however, were much less likely than respondents from other organizations to report on case management and to give examples of organizations that provide behavioral health services to older adults.

Enabling referrals to behavioral health services

Responses for community-based behavioral health organizations and all other organizations regarding referrals to behavioral health services were similar in referencing the importance of teamwork referrals, referrals to community providers, efforts to combat stigma, integrating primary and behavioral health to increase referrals, and educating providers about the best time to refer. Differences between the organizations were present only in reference to implementing clinical team meetings between collaborators with other organization respondents mentioning this more than those in community-based behavioral health organizations.

Educating the public about behavioral health services

Responses for community-based behavioral health organizations and other organizations regarding referrals to behavioral health services were also mostly similar regarding educating the public about behavioral health services with the exception that respondents from other

organizations were more likely to mention the value of advertising and outreach in group settings.

Strengths of CT's behavioral health system: Community-based behavioral health organizations and all other organizations

Responses for community-based behavioral health organizations and other organizations regarding strengths of CT's behavioral health system were similar with the exception that other organizations more frequently reported the availability of inpatient, outpatient, and community services as a strength.

Weaknesses of CT's behavioral health system: Community-based behavioral health organizations and all other organizations

Both types of organizations noted similar weaknesses, but community-based behavioral health organizations were much more likely to report the lack of awareness and education regarding behavioral health services.

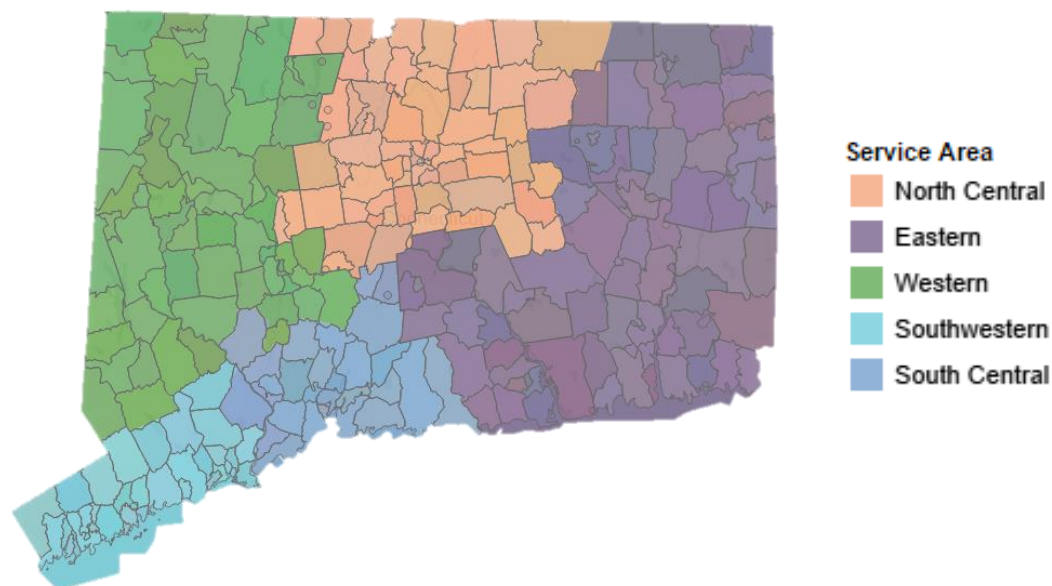
Suggestions for improving behavioral health services: Community-based behavioral health organizations and all other organizations

Both types of organizations made similar suggestions with the exception that other organizations were more likely to suggest the need for greater access to services, more geriatric providers, and better provision of transportation options.

Regional Results

In addition to statewide outcomes, data were analyzed by the five ADRC regions (Figure 8).

Figure 8. ADRC Regional Map of Connecticut



For the most part, regional differences were slight, and could be attributable to the “chain sampling” process which did not ensure a random sample of providers and referral sources in all regions. Nevertheless, a good cross-section of respondents from all five regions participated, ranging from 14 percent of total participants in the Southwestern region to 28 percent in North Central (Table 7). Persons interested in regional data on behavioral health resources and needs of older adults can profit from reviewing this report section, and in particular the extensive qualitative responses of participants from that region presented at the end of this report.

Regional responses by zip code of work location

The distribution of regional responses was determined using zip codes of respondents’ work location. The highest percent of responses was from the North Central region (28%) followed by the Eastern, Western, Southwestern, and South Central regions (27%, 16%, 15%, and 14%, respectively) (Table 7). Region could not be determined for 12 respondents.

Table 7. Responses by region

Region	% (n)
North Central	28 (233)
Eastern	27 (225)
Western	16 (137)
South Central	15 (126)
Southwestern	14 (125)
Total	100 (846)

Type of organization

Figures 8a and 8b show regional responses by type of organization. There were few significant differences between regions. Although community-based behavioral health organizations were selected most frequently in all regions of the state, they represent over half (52%, n=65) of South Central region respondents and only about a third in North Central (32%, n=73).

Figure 8a. Type of organization

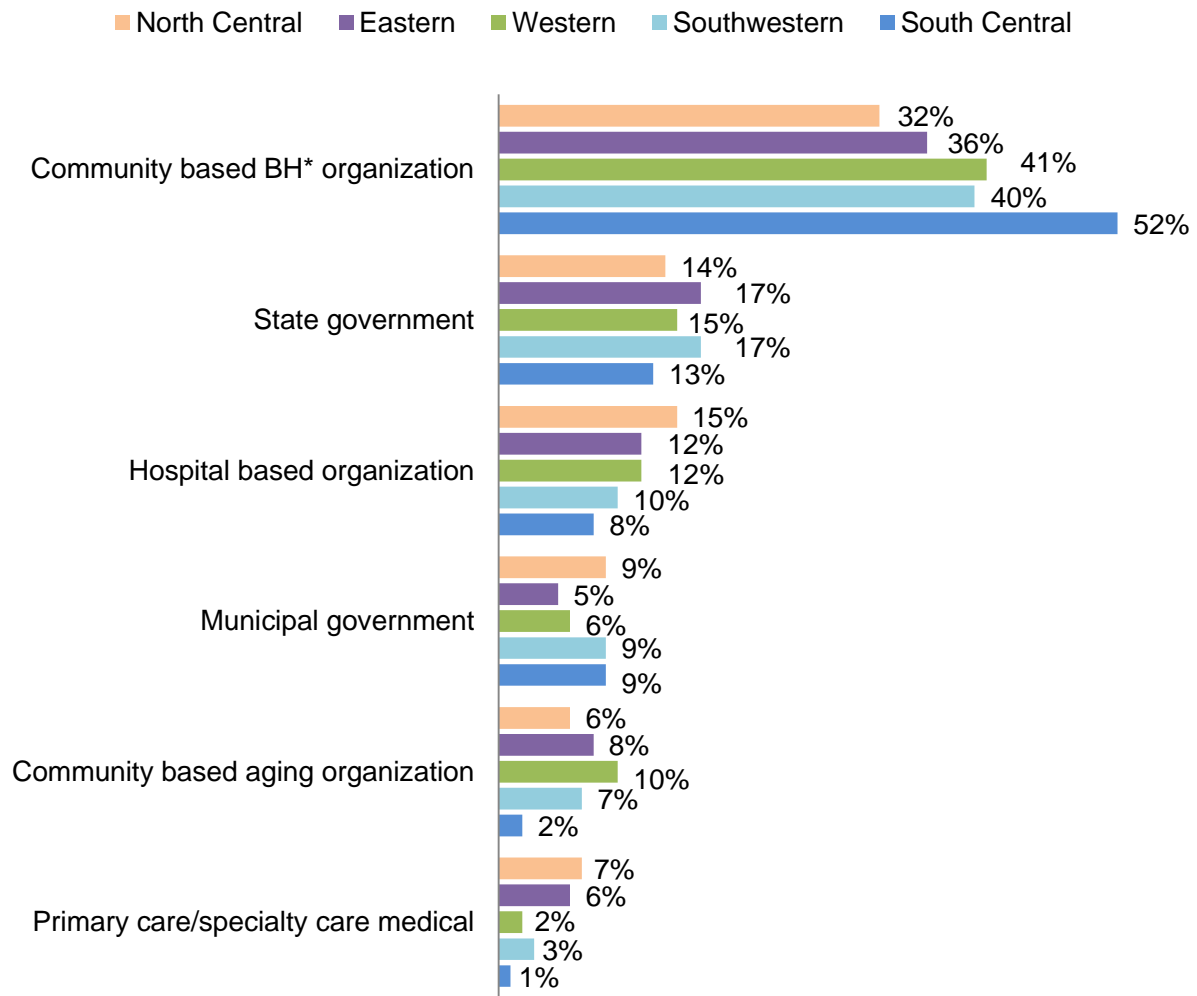
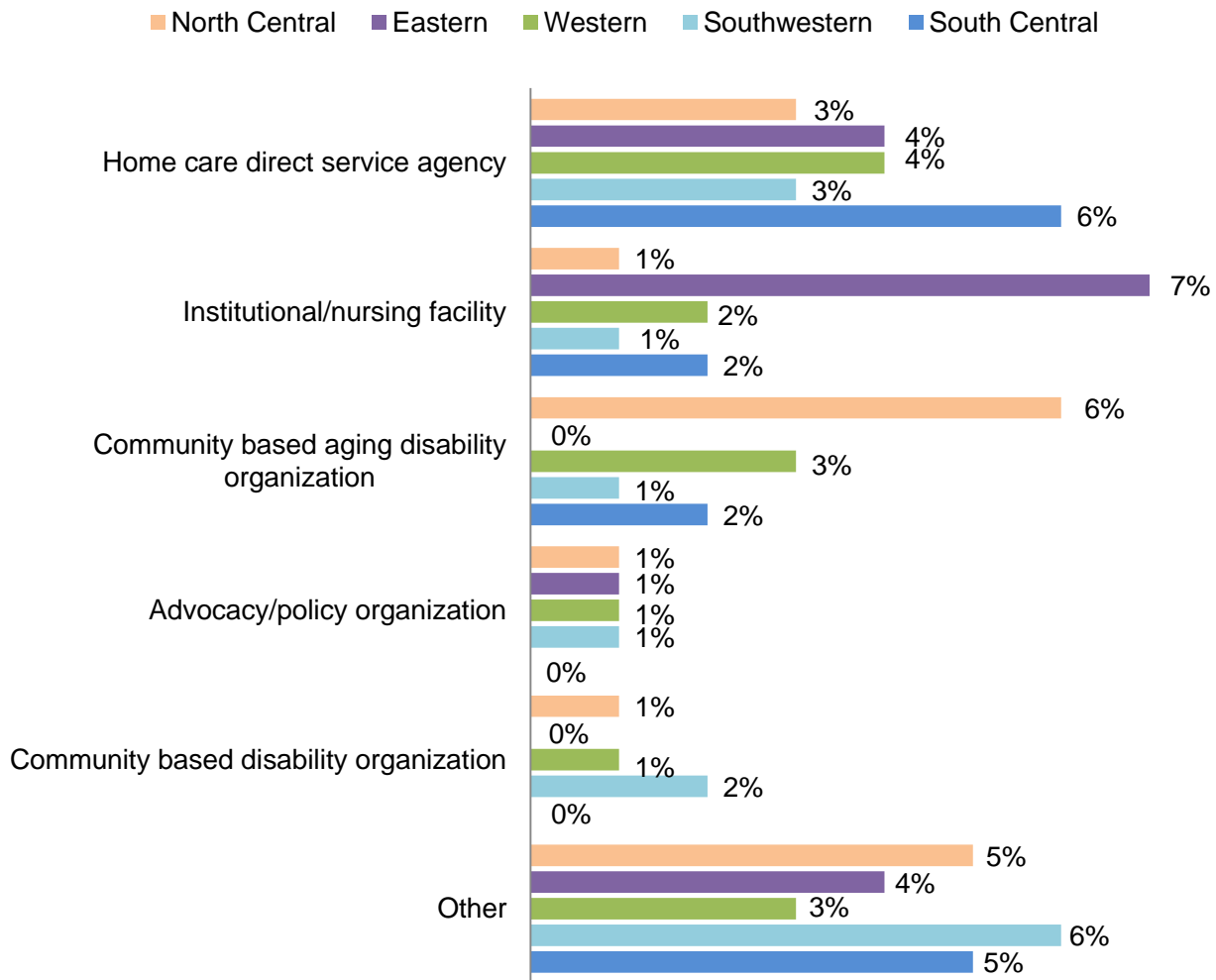


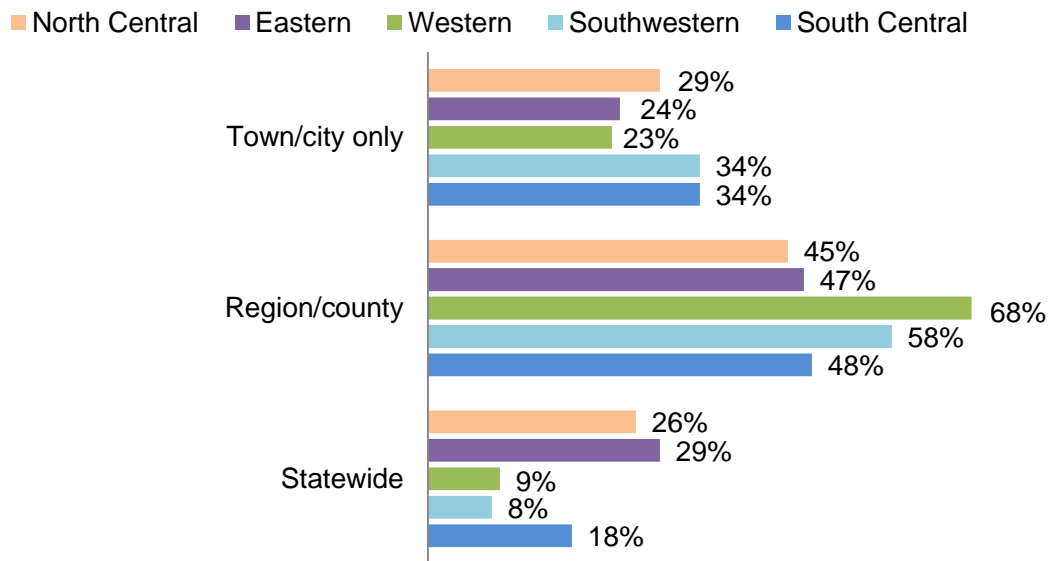
Figure 8b. Type of organization



Service area

There were some significant differences between regions in the breadth of their service areas. Although region/county was selected more frequently than town/city only or statewide in all regions, more than two-thirds of respondents (68%, n=93) from Western reported region/county as a service area, compared to less than half from North Central, Eastern and South Central. More than a quarter of respondents from North Central and Eastern reported a statewide service area compared to less than ten percent from Western and Southwestern (Figure 9).

Figure 9. Service area



Services related to behavioral health

Respondents were asked if their organization provided any of 21 specific services related to behavioral health, both “addiction specific” and “mental health only.” They were also asked to indicate the target population covered (ages 18+ and/or 55+). Of 858 respondents, 213 skipped this question and an additional 6 did not list any region. As a result, 219 were removed from the denominator for this analysis. Results below are shown with a separate figure for each of the 21 service categories listed in the survey (see Figures 10 through 30.) As noted in the statewide report section, services for persons age 18+ may include services to older adults, but those marked “55+,” are specifically designed for that age group.

For every region and for most services, the major statewide finding remains true, that mental health and addiction services designed specifically for older adults are found far less frequently than those for all adults age 18+.

Figure 10. Advocacy/Policy development

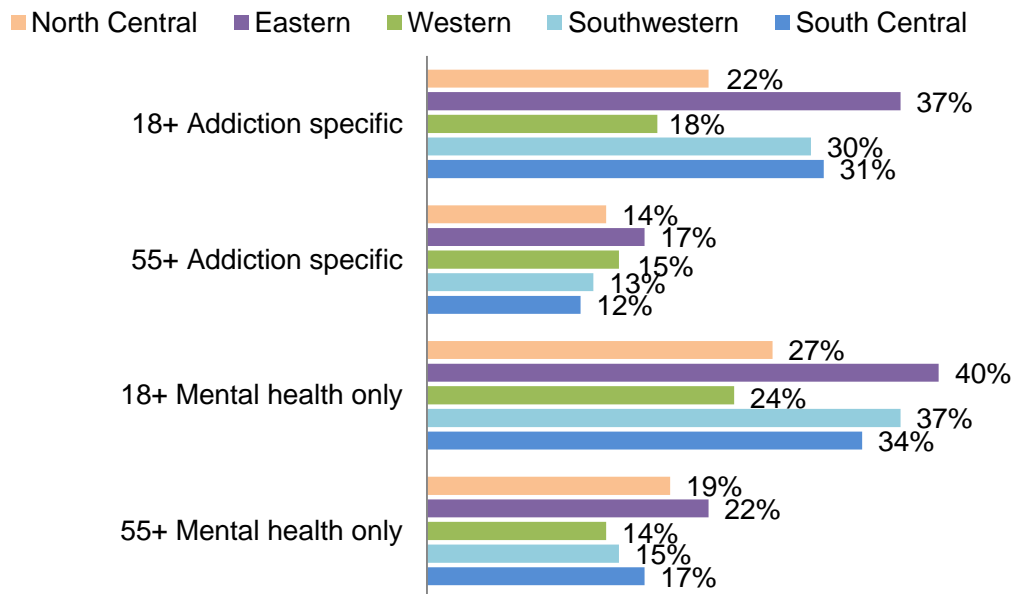


Figure 11. Legal assistance

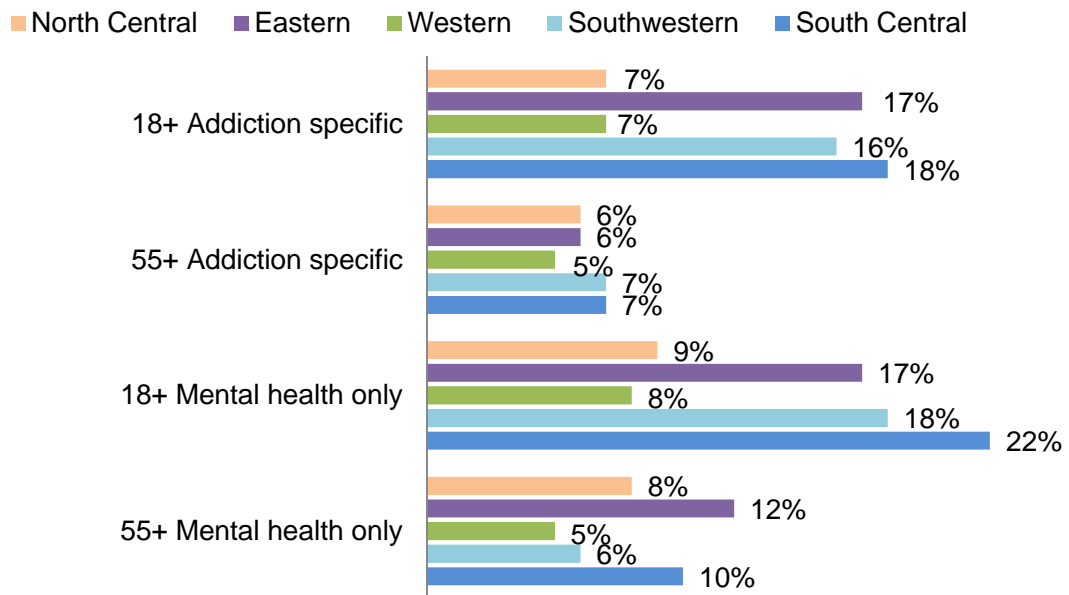


Figure 12. Information and referral via telephone

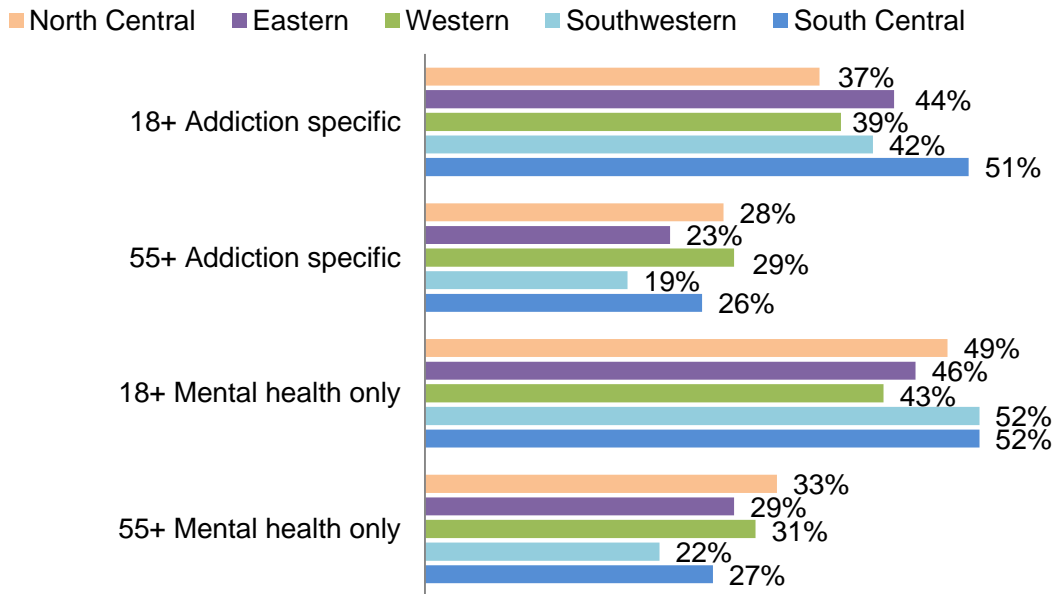


Figure 13. Information and referral via Internet

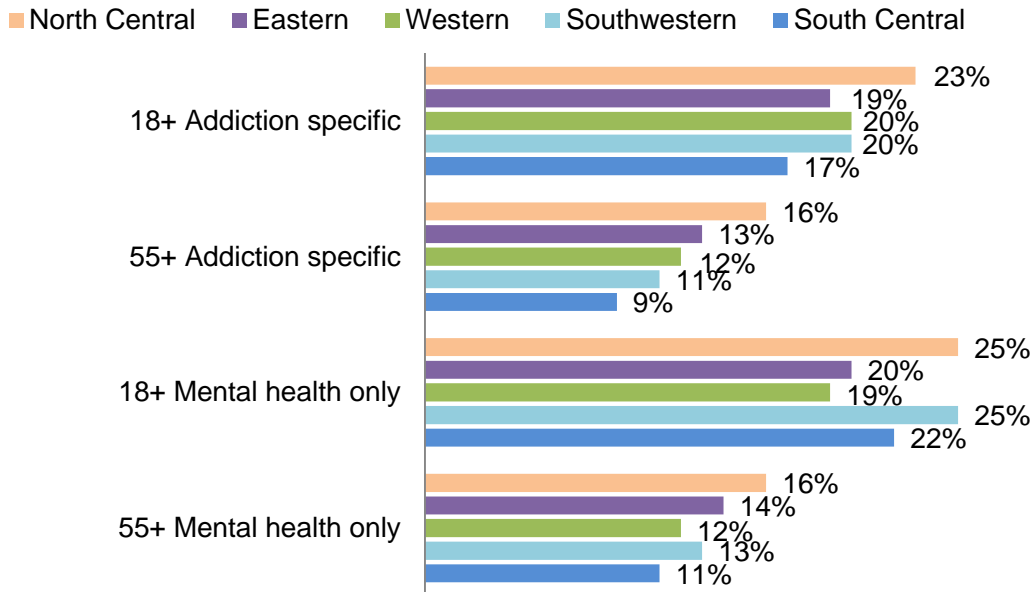


Figure 14. Behavioral health outreach

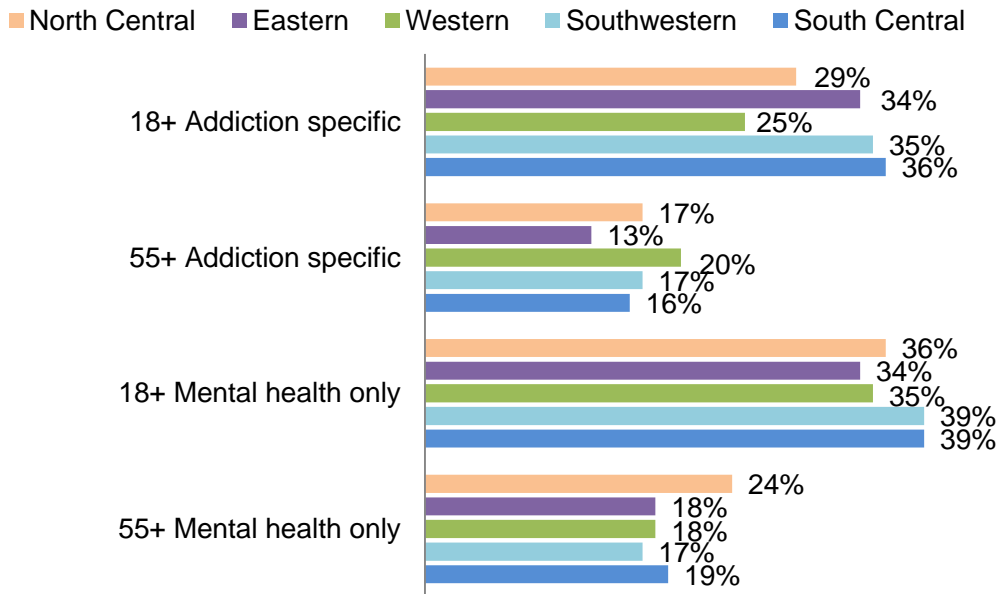


Figure 15. Behavioral health education

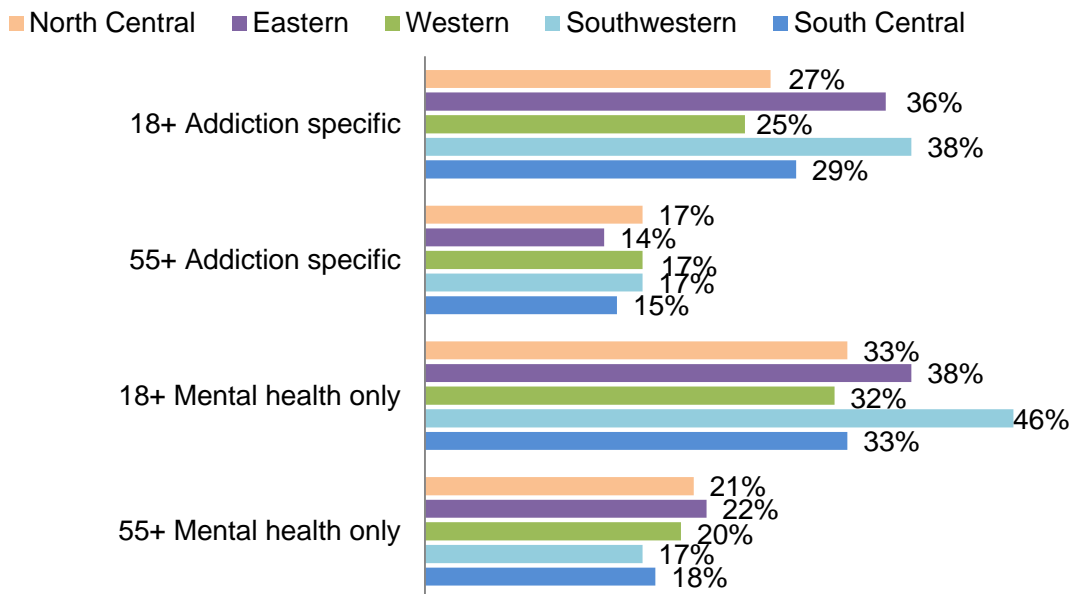


Figure 16. Individual counseling services

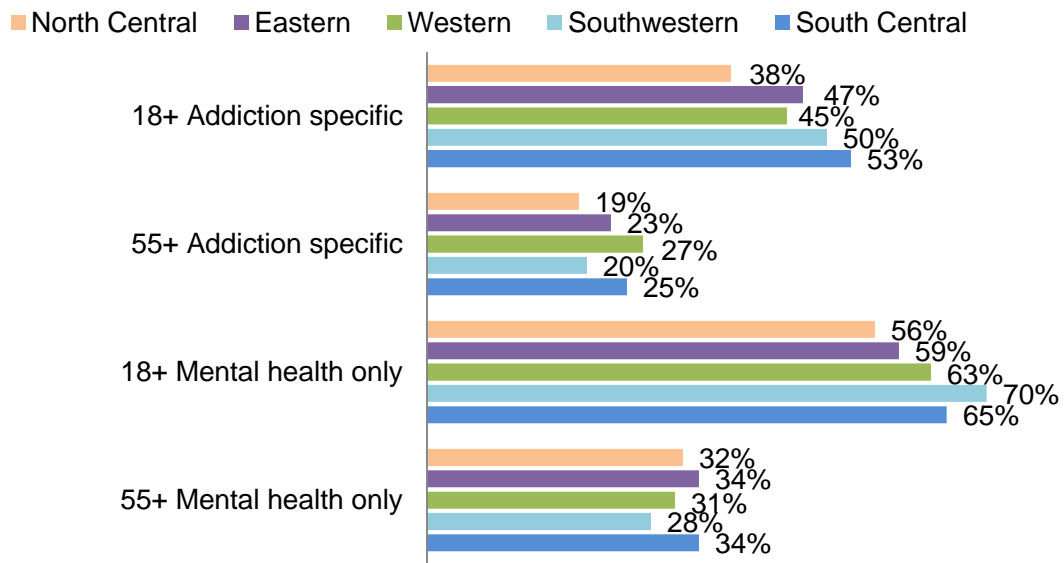


Figure 17. Group counseling/support group services

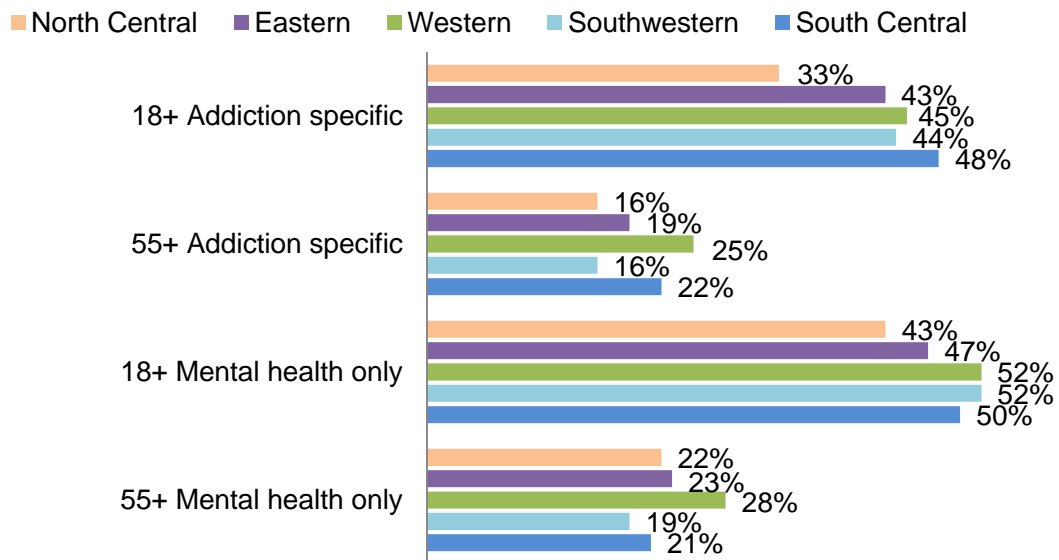


Figure 18. Federally recognized evidence based interventions

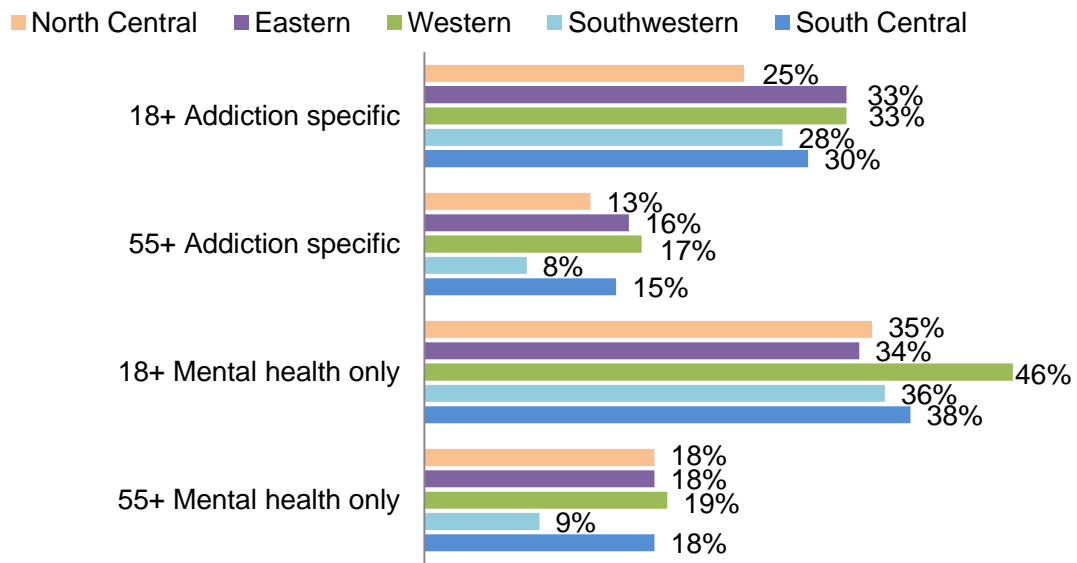


Figure 19. In-home counseling services

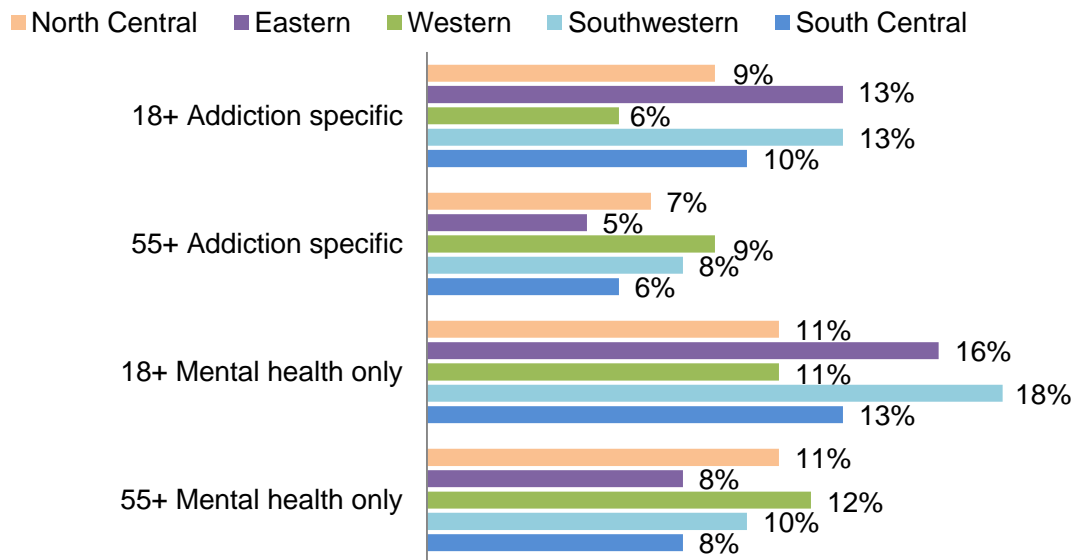


Figure 20. Diagnostic screening and assessment

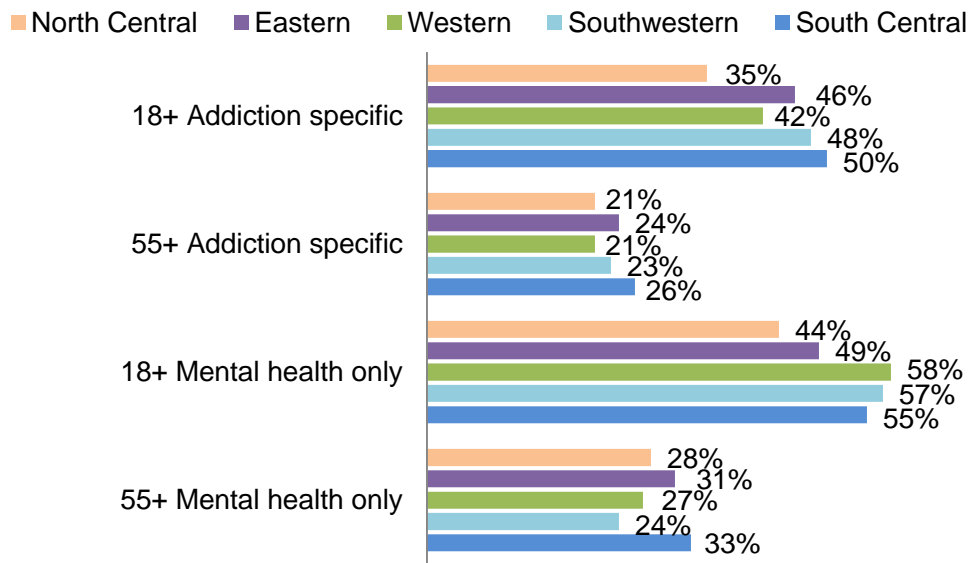


Figure 21. Services to non-English speaking populations

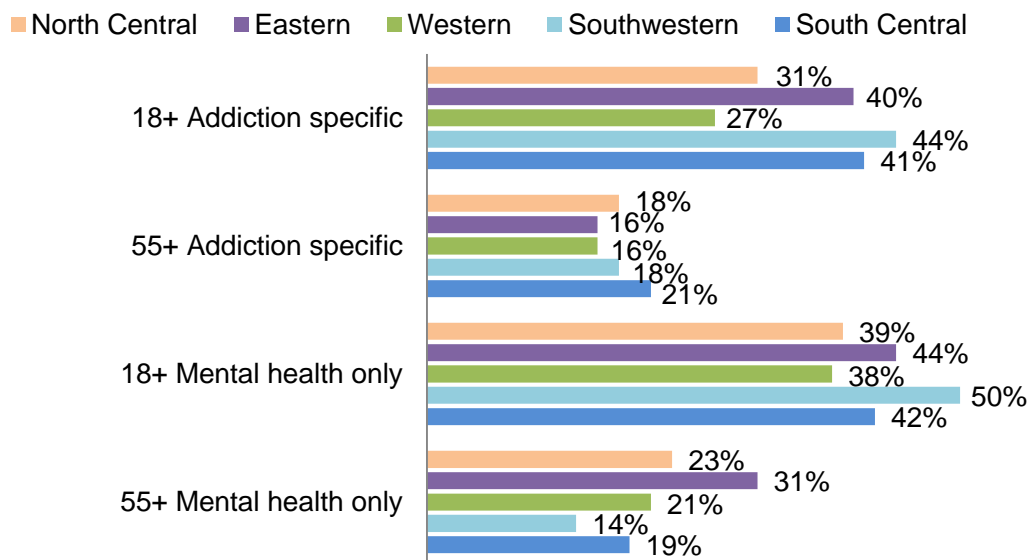


Figure 22. Peer-to-peer support

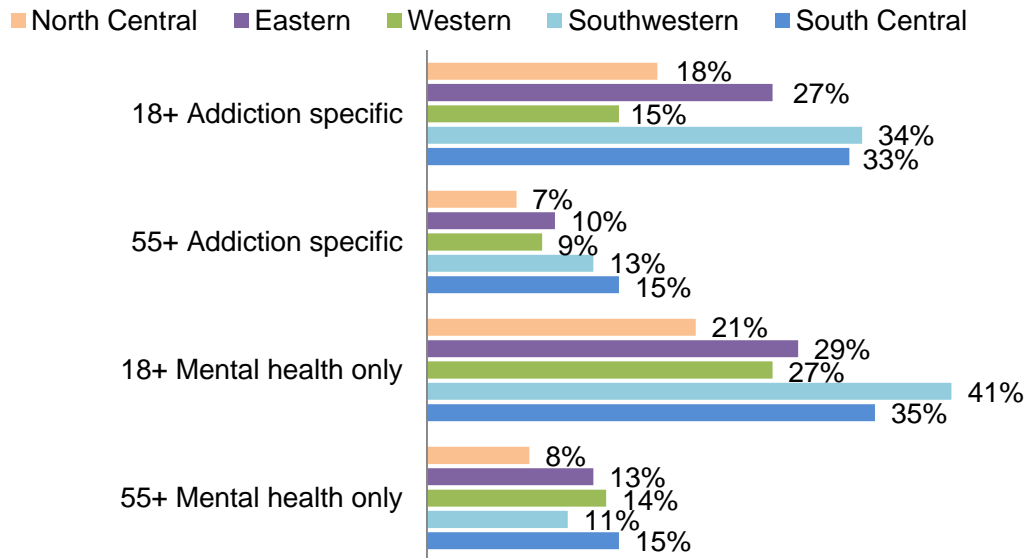


Figure 23. Peer-to-peer support training

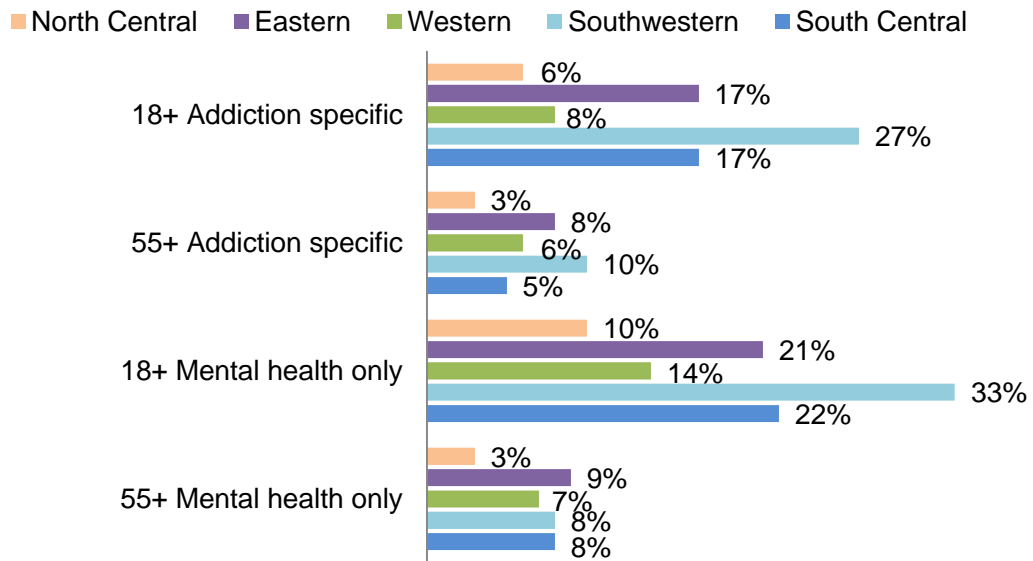


Figure 24. Care management

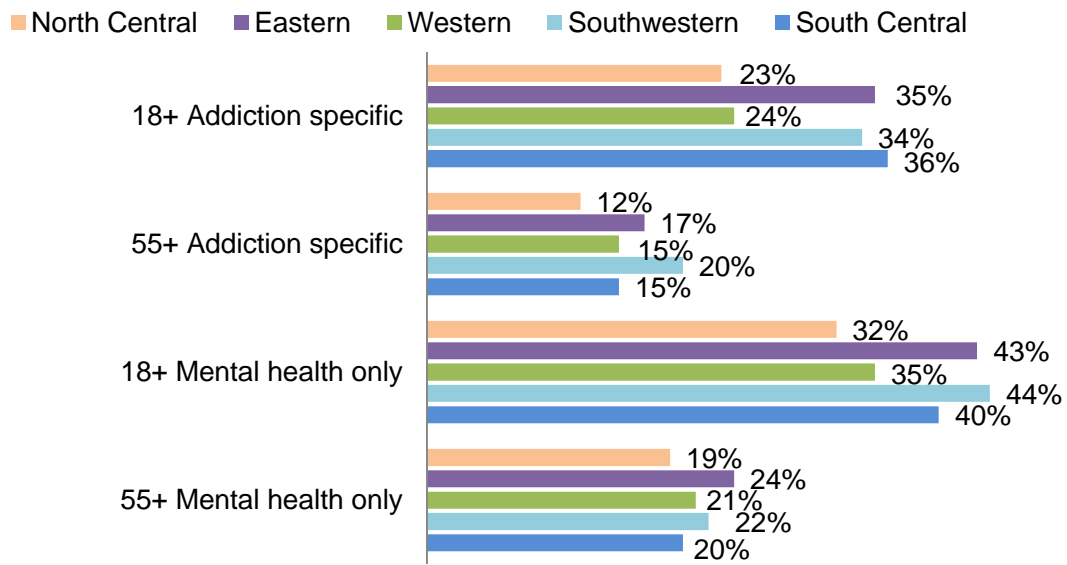


Figure 25. Tele-counseling

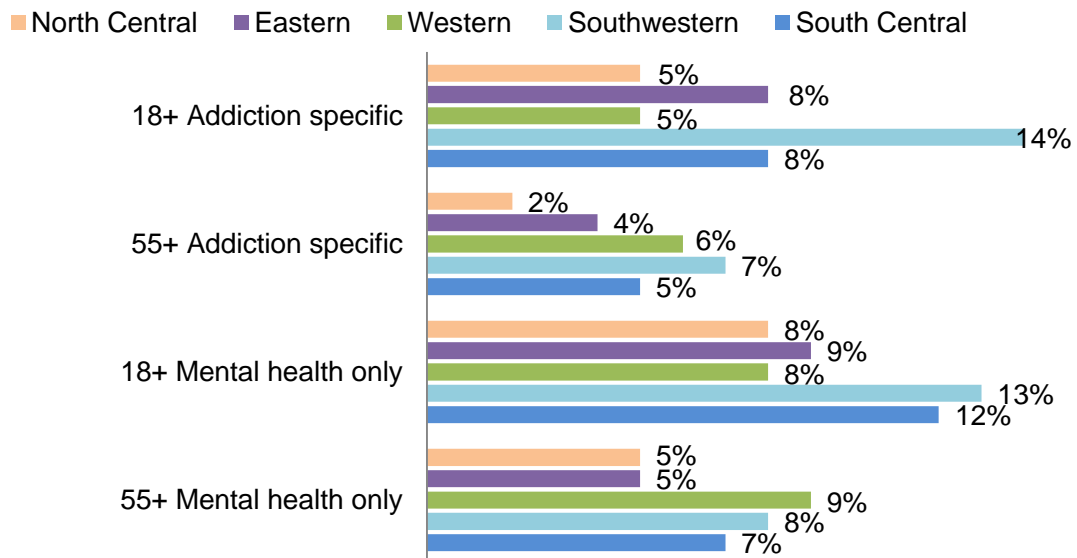


Figure 26. Integrated teams of behavioral health and primary care providers

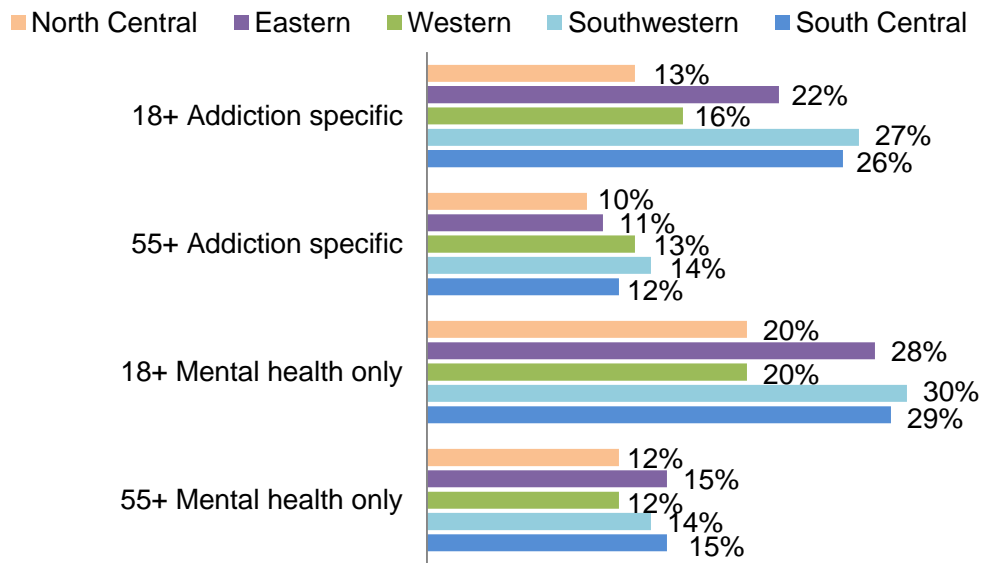


Figure 27. Co-location of behavioral health and primary care providers

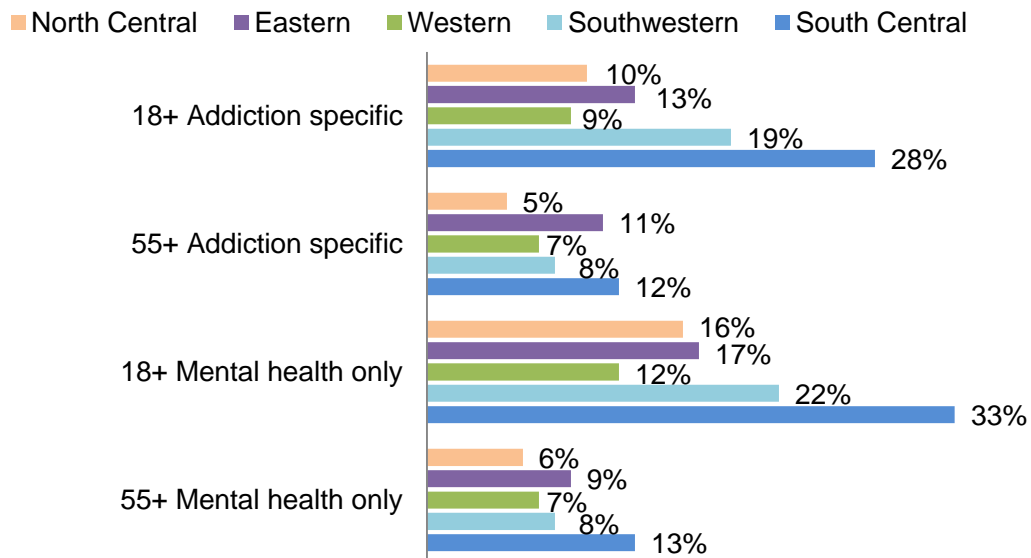


Figure 28. Supports for family caregivers

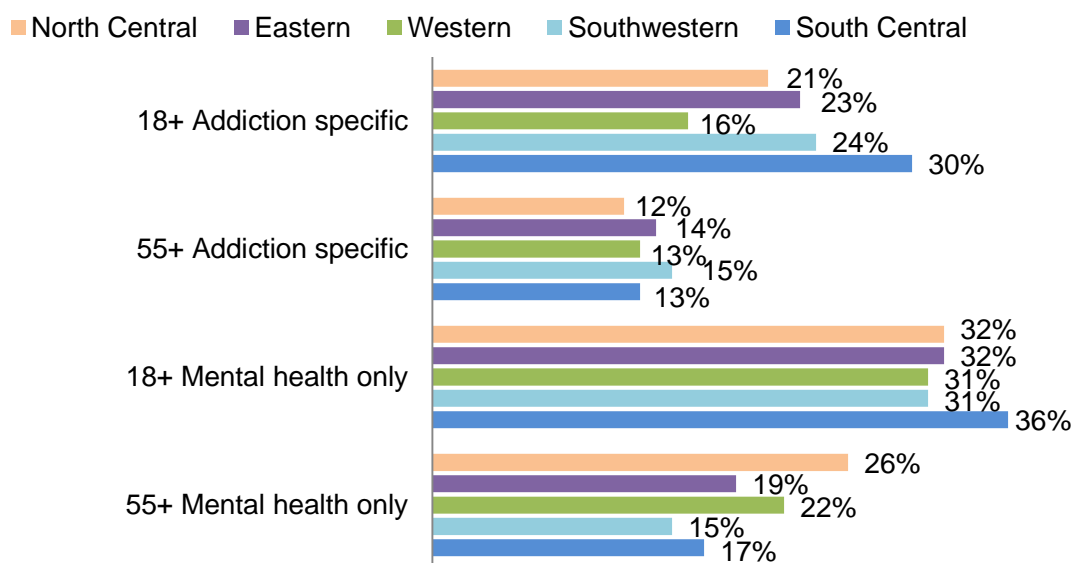


Figure 29. In-patient services

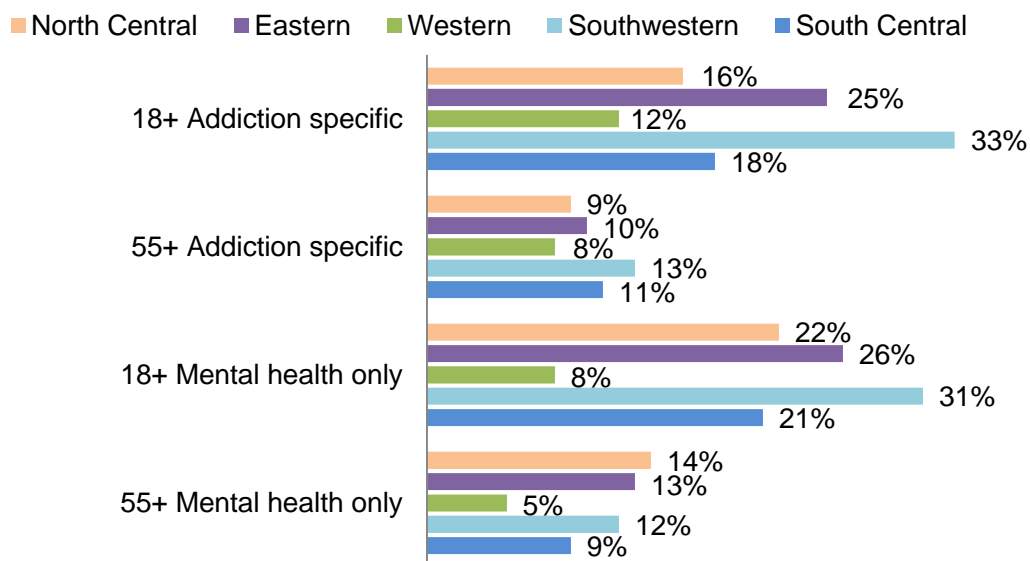
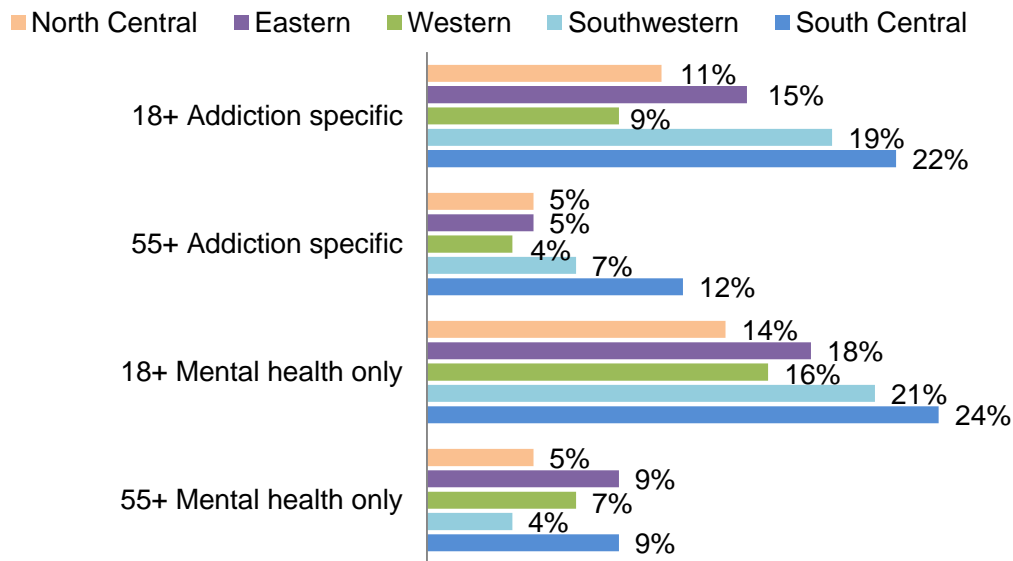


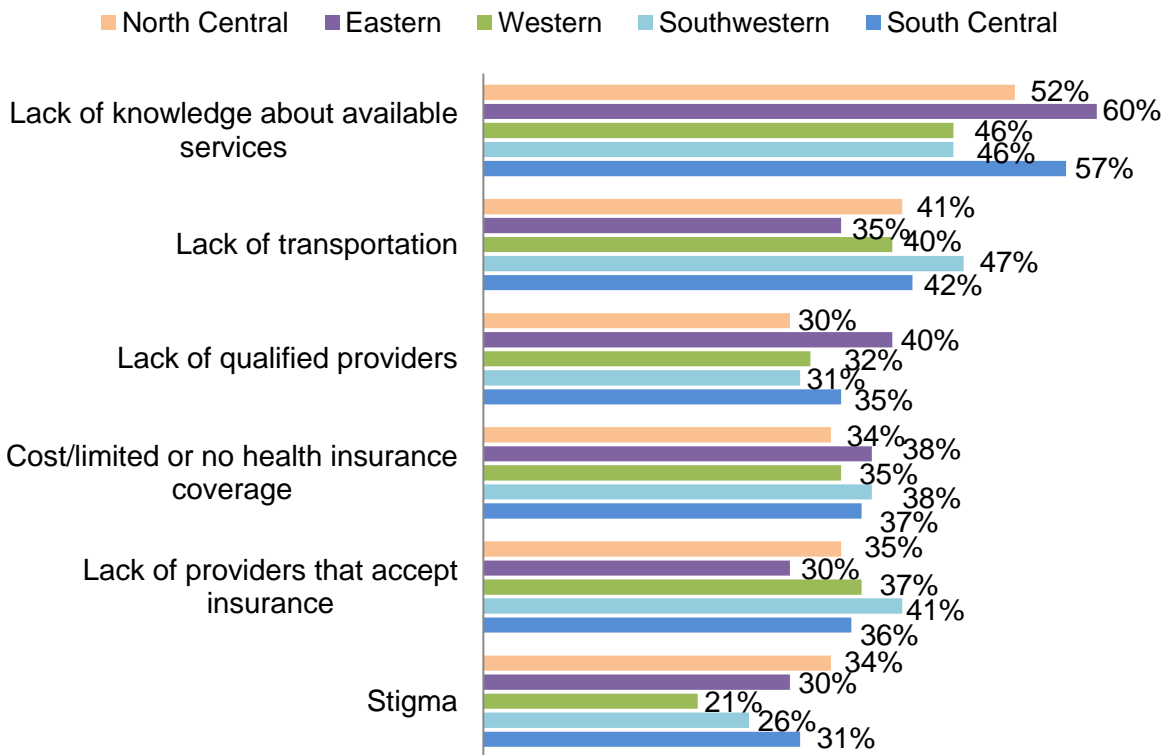
Figure 30. Housing for consumers with co-occurring physical and mental health conditions



Most significant barriers in accessing older adult behavioral health services

Figure 31 shows regional results for the most significant barriers in accessing older adult behavioral health services. Lack of knowledge about available services was selected by the greatest percentage of respondents in North Central (52%, n=81), Eastern (60%, n=95), Western (46%, n=49), and South Central (46%, n=51). Lack of transportation was noted as the most significant barrier in Southwestern (47%, n=45). There were some other variances between regions. For example, Eastern (40%, n=63) was more likely to report lack of qualified providers than other regions. Other significant barriers included lack of qualified providers, cost/limited or no health insurance coverage, lack of providers that accept insurance, and stigma. Barriers listed much less frequently are not included in Figure 31 (e.g., limited hours of operation, fear/distrust, limited physical mobility, language or cultural differences, and citizenship/immigration status).

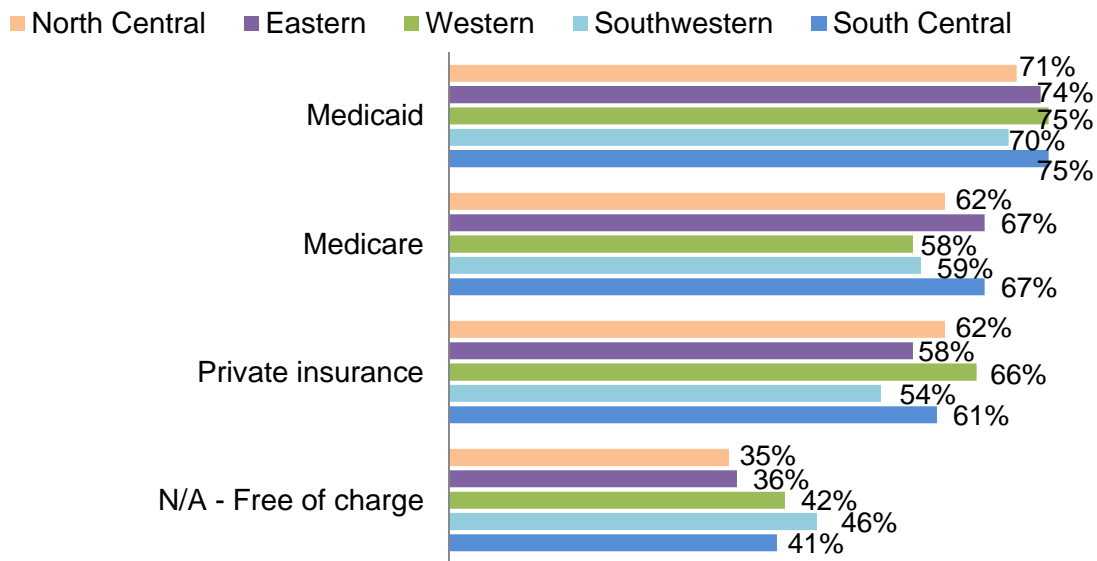
Figure 31. Most significant barriers in accessing older adult behavioral health services



Payment methods accepted for services

Respondents in all regions indicated that Medicaid is the most commonly accepted payment method, followed by Medicare and private insurance (Figure 32). There were no significant differences between regions by payment method accepted for services. Regional analysis of payment methods, however, is not particularly useful. More significant is the analysis of payment method by type of organization. For that discussion, see Figure 6 in the Statewide Results section of this report.

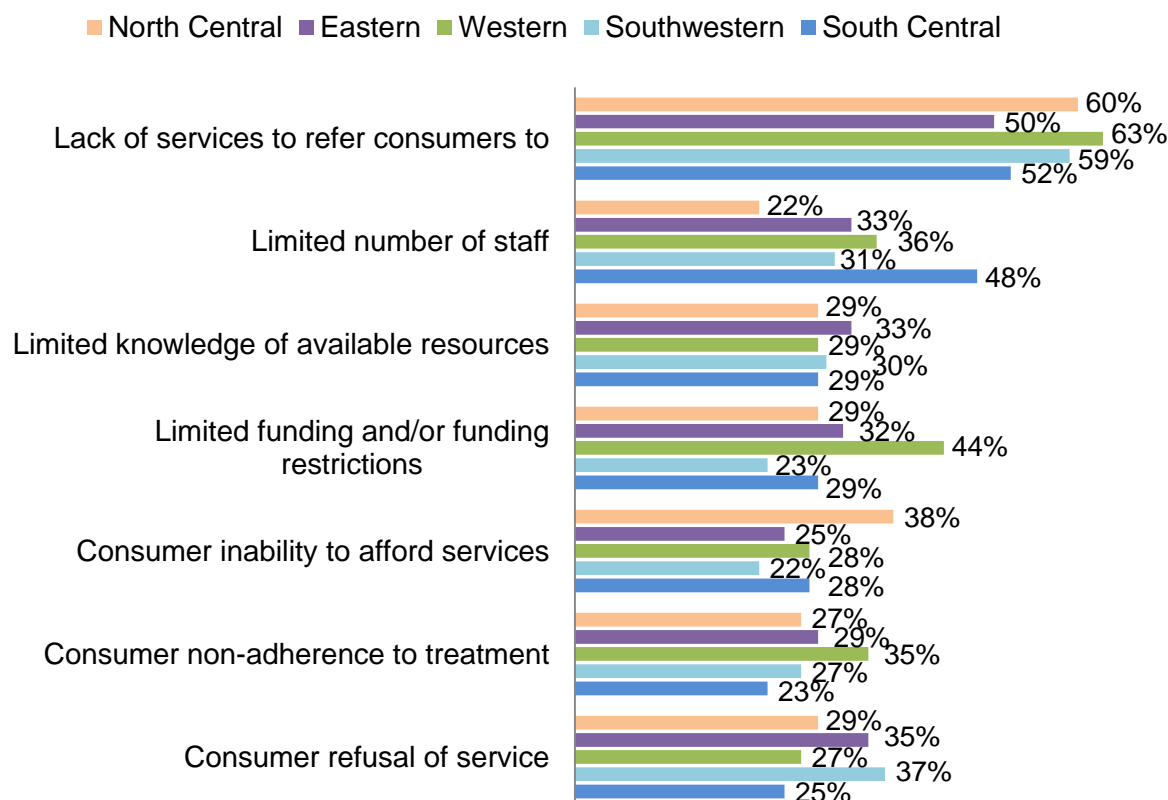
Figure 32. Payment methods accepted for services



Most significant challenges in providing or making referrals to behavioral health services

Figure 33 shows the most significant challenges in providing or making referrals to behavioral health services. Lack of services to refer consumers to was clearly the most significant challenge for all regions. Other significant challenges included: limited number of staff, limited knowledge of available resources, limited funding and/or funding restrictions, consumer inability to afford services, consumer non-adherence to treatment, and consumer refusal of services. Variances between regions in these challenges were small. Barriers listed much less frequently are not included in Figure 33 and include: Limited space, tools; lack of training; proscribed parameters of services, regulations and/or internal agency scope limitations; and meeting needs of minority populations.

Figure 33. Most significant challenges in providing or making referrals



Regional Qualitative Results

As noted in the statewide section of the report, three open-ended questions were asked in which respondents were asked to share their opinions on the following:

- Best practices used or observed in 1) providing behavioral health services to older adults; 2) enabling referrals to such services; and/or 3) educating the public about such services.
- Strengths of Connecticut's behavioral health system for older adults.
- Suggestions for improving behavioral health services for Connecticut's older adult population.

Qualitative results were analyzed by the five ADRC regions and are reported below. See the Statewide section for a summary of common statewide themes.

Respondents shared a broad range of best practices as well as specific strengths, such as the Working for Integration, Support, and Empowerment (WISE) program, Area Agencies on Aging, DMHAS staff training, care management services, education provided to consumers, and the commitment to providing services. Respondents also mentioned a number of general strengths including: caring professionals, the many services available, teamwork, infrastructure and programs at senior centers. Some respondents answering this question also pointed out that the system has many challenges and weaknesses. Finally, many respondents listed their top

suggestions for improving behavioral health services for Connecticut's older adult population. Suggestions focused on insurance coverage, education, transportation, providers, in-home services, funding, and integration of services. All major themes are listed by region with representative quotes to provide additional detail. Responses are listed according to frequency mentioned with those mentioned most listed first.

North Central: Best practices

Providing behavioral health services to older adults

North Central respondents mentioned a variety of services and tools used to treat the older adult population with behavioral health needs. The most frequently mentioned included: Cognitive Behavioral Therapy (CBT), collaboration between geriatric psychiatry and primary care providers, group therapy/counseling, and the Screening, Brief Intervention and Referral to Treatment (SBIRT) Program. Less frequently mentioned were depression screening, family therapy, couples therapy, in-home counseling, integrated dual disorder treatment, Dialectical Behavior Therapy (DBT), Eye Desensitization and Reprocessing Therapy (EMDR), and motivational interviewing.

We provide geriatric psychiatric treatment using a team of a psychiatrist and clinician so that medication and therapy are combined with strong support to family through education, particularly around dementia care. I also work for Elder Path LLC and provide consultation, assessment, and care plan in the family or client's home.

The integrated geriatric medicine/geriatric psychiatry model appears to be the most effective method for providing behavioral health services to older adults.

Group counseling meets the needs of many older adult clients since isolation is one of the major problems faced by this population.

Provision of Intensive Outpatient Program and Partial Hospital Program (IOP/PHP) services/tracks specifically tailored to meet the needs of older adults, addressing issues of loss and grief, declining health and mobility, cognitive decline, life skills/self-care and social stigma.

Enabling referrals to behavioral health services

The most frequently mentioned comments on referrals to behavioral health services were the DMHAS WISE program and taking services to senior centers to then network within the community. Less frequently mentioned were the Behavioral Health Partnership (integrated behavioral health system for Medicaid recipients), interdisciplinary teamwork referrals, and referrals to community providers and services.

Referred an elder to DMHAS WISE program, which provided intensive in-home services (both mental health and medical). She was at risk of nursing home placement prior to these services.

Behavioral Health Partnership (Integrated behavioral health system) is a great model for those covered by Medicaid. DMHAS also has a nice services array for those who are eligible.

Using senior community health services to network with the behavioral health community to address these needs and provide training and referral for their clients.

Closing the loop with clients on their referrals – that they actually got the service.

Interdisciplinary teamwork referral.

Educating the public about behavioral health services

Respondents in the North Central region most frequently mentioned the need for advertising and group setting education to inform the public about behavioral health services for the older adult population. Other less frequently mentioned ways to educate the public included: in-home counseling, health fairs, cultural competency and education forums.

➤ Advertising

Outreach to this demographic with presentations that are simple to understand and materials/ brochures that are simple to read, have large print and pictures and offered in other languages, reflecting cultural competence.

Community-based education. Creating flyers/brochures with list of resources available to them in the community.

Having information in center, on bulletin board and publicized about resources available to older adults with mental health and/or substance use/abuse issues.

Literature and internet resources.

Having promotional/educational materials available in seniors' languages, using media (i.e., cultural radio stations) used by seniors, partnerships with local senior centers to identify seniors in need of behavioral health services.

*Cultural competency, particularly for Asian and Latino clients [Culturally and Linguistically Appropriate Services – CLAS – in Health and HealthCare].
Integrated approach or emphasizing the strong connection between physical health and mental health.*

➤ Group setting education

Providing education or services in a group setting where the seniors are actually located to increase participation and reduce stigma.

Integration of behavioral health needs into community-based settings (i.e., support groups at senior center, education forums at library, etc.).

Creating more support groups for older adults.

Peer support program to allow them to socialize/have someone to talk too.

Presentations to community agencies.

Geriatric depression screening tool education through health fairs and coordinated services through senior centers. Available in both English and Spanish.

North Central: Strengths of Connecticut's behavioral health system

The most frequently mentioned strengths by North Central respondents were existing providers and specialists who are dedicated to the older adult population and behavioral health issues, the awareness of need to improve services/resources, and insurance coverage. Other mentioned strengths included advocacy, the availability of senior centers, integrative behavioral health care, and the value placed on cultural competency.

- Providers and specialists dedicated to the older adult population and behavioral health issues

Providers willing to advocate and speak to consumer needs.

Caring providers who are willing to cross-refer and support each other.

Knowledge of the areas where your consumers live for other supports and services that are available.

Many skilled specialty providers.

Experienced clinicians.

Primary care physicians who are trained in the psychological needs of older adults. 55+ programs provided by the State.

- Awareness of need to improve services

Awareness of need.

Recognizing that there is a significant lack of services and resources.

People are starting to look into the needs of older adults.

Desire to improve.

- Insurance coverage

There are many options for publicly insured individuals.

This care is covered by insurance.

Access to insurance for underemployed adults and adults without children.

North Central: Weaknesses of Connecticut's behavioral health system

Many North Central respondents underscored weaknesses in Connecticut's behavioral health system including lack of well-trained or insufficient availability of providers, limited resources, and poor insurance coverage.

➤ Lack of strengths in general

I do not find that a strong system for behavioral health exists for older adults in CT.

There are not too many strengths for behavioral health system for older adults.

Not enough [strength] to be the sole source of care for a blooming aging population.

➤ Lack of well-trained or insufficient availability of providers

There are insufficient providers and difficult for elders to get to them

There are very few providers available to do home visits.

Unfortunately, there just are not enough of the 'good' providers out there.

I venture to say the general population knows very little about behavioral health support for older adults. Their primary care provider is their best contact, but many individuals don't consider their primary a source of information. The Regional Mental Health Boards are critical to keeping government aware of grass roots needs.

I can't say because I don't really know of any behavioral health services that specifically target older adults except for an older adult's addiction group that Wheeler Clinic operates in Manchester.

➤ Limited resources

I think that the services for this population are rather weak. Many of them have so many financial problems, and very limited resources that can help solve some of the older adult main problems.

We serve Limited English people and have found few appropriate services that meet their needs.

I don't think that CT has a strong behavioral health system. Often times there are not enough spaces for a senior that needs help or it is very difficult to have them assessed and meet the criteria for hospitalization.

Lack of transportation and long waiting times for appointments.

Programs that come to the seniors as access is limited.

➤ Poor insurance coverage

Reimbursement rate is terrible.

The only way for anyone to receive quality mental health services in CT is to pay for it yourself. I realize this is not an option for most people. Medicare, and private insurance companies have unrealistic expectations of the time frames needed to effect change.

I don't understand why Medicare is not allowed to panel Licensed Professional Counselors. I would imagine that there would be many more providers to help individuals in the 55+ age bracket. We have recently brought on three new patients: 60-75 age range, all three former professionals working high level positions. In general about 40% of our population is 55+. Two with Medicare insurance, which we cannot bill not even submit a claim, in order to be processed by their supplemental insurance! We accept Medicare D now, and we have been able to help more people.

We will see if Access Health CT improves service access.

North Central: Suggestions for improving behavioral health services

The most frequently mentioned suggestions by North Central respondents were the need for better insurance coverage, education for providers and the public, outreach to the community, transportation, increase geriatric providers, in-home services, funding, and integration of services. Less frequently mentioned suggestions included the need to reduce stigma/discrimination and improve housing and placement.

➤ Insurance coverage

Medicare needs to be able to increase payment at least at the level of cost of living to keep professionals in the field accepting Medicare payment, this is also true of Medicaid.

Increase Medicaid coverage of the services/ facilitate practitioners accepting Medicaid or Medicare/Medicaid.

Seniors need more psychiatrists who will take Medicare.

More providers taking managed Medicare w/out excessive co-pays on a daily basis for Intensive Outpatient Program.

Increase the reimbursement rates for all behavioral health services. As a state, advocate to expand the licensed providers who can bill for behavioral health services provided to consumers with Medicare health insurance (i.e., Licensed Professional Counselors).

Make insurance companies provide parity in mental health services. While the statutes say physical and mental health services should be provided at the same level, this never happens. Perhaps the insurance commissioner should oversee this.

➤ Educate providers

Educate the professionals who are dealing first hand with this population.

Provide training to more providers in identifying, to accept and treat older adults with behavioral problems.

Educate primary care physicians about mental health services for older adults.

More education/training for providers on how to successfully work with this population and navigate the system to ensure they get the adequate services they need.

Educating community physicians and families.

Education on preventive care--enhanced training of care providers.

Train counselors on aging processes.

Increase awareness about available resources.

➤ **Educate the public**

Educating older adults and the service system about the developmentally unique features of older adulthood and more specifically the manifestation of behavioral health and addiction in this age group.

Offer ongoing education programs in elderly and disabled housing locations to talk about mental health topics, life changes.

Providing more education to the public as to signs we should look for.

Provide opportunities/trainings/incentives to incorporate screenings and consumer education into every day practice across multiple sites and settings.

Implementing services to teach older adults how to use social media to stay connected but to stay safe.

➤ **Outreach**

Provide more outreach to the public on the different programs that are available.

Develop a database of services that is user-friendly for older adults and their families.

A directory of which providers specialize in both psychiatric gerontology and accept Medicare.

Have one point of access with a detailed directory listing specific programs/services geared towards older adults.

➤ **Transportation**

Consider the transportation needs of older adults, specifically those that don't live in areas where public transportation is provided.

Enhanced public transportation for medical appointments.

Transportation needed at low cost to consumer.

Access to transportation improved quality of neighborhoods improved and availability of quality services in neighborhoods (i.e., grocery stores, plowing).

Transportation to meet the needs of the population in order to receive services, goods, and socialization is key.

➤ Increase providers

Need more clinicians trained in gerontology.

Develop larger network of providers specifically trained to work with this population.

Need for increased numbers of geriatric psychiatrists.

Facilitate practitioners specializing in treating older adults.

Culturally sensitive providers (able to communicate and understand various cultures).

➤ In-home services

Lack of in-home services, many clients unable to leave home with ease. Many in-home services for mental health do not have clinicians of varying languages. Increase in-home services for the most difficult of behavioral health population.

Permit in-home services for behavioral health.

In-home behavioral health visits by prescribing professional would support clients who are unable physically to go to behavioral health appointment.

➤ Increase Funding

Address policies that limit collaboration and funding for needed services.

With our state's rapidly aging Baby Boomer population, the number of individuals in need of this service is exploding while funding remains flat or is slated for budget cuts.

Awareness funding for services parity.

Increase in funding and training opportunities.

Increased slots and funding.

Increase funding for in-home services.

➤ Integration of services

There needs to be more integration of medicine and behavioral health outpatient services (one-stop shopping as well as less stigma).

Help make behavioral health services connected with other health services to make it less stigmatizing.

Combining behavioral health and primary care so it's automatically part of health exams/screening and the care system or better coordination of care to insure holistic approach.

Integrated behavioral health care that includes community health workers, behavioral health specialists, pharmacists and chronic disease management.

Care coordination cap services to bridge the gap between primary care physicians and behavioral health providers to decrease over medication addiction propensities and side effects.

Eastern: Best practices

Providing behavioral health services to older adults

The most frequently mentioned behavioral health services noted by Eastern respondents included Cognitive Behavioral Therapy, collaboration between geriatric psychiatry and primary care providers, Patient Health Questionnaire-9 (PHQ-9) screenings, case management, and mobile crisis units. Less frequently mentioned were in-home services, reality therapy, one-on-one counseling, nursing advocacy, and the Gatekeeper program.

Cognitive Behavioral Therapy practices using positive thinking is very effective. Promoting expressive activities (i.e., art or journaling) is also helpful. Best practices are collaborative efforts between primary care, psychiatrists, local mental health professionals, and home health care specialized nurses.

Patient Health Questionnaire-9 (PHQ-9) used for initial and follow up assessment as primary tool for depression assessment.

Case management services – in-home caseworkers providing transportation to behavioral health appointments.

Use of our Mobile Outreach Team aids us in providing screening tools, alerts to our group to engage clients and to provide behavioral health support during off hours. Our Mobile Outreach hotline is available 24/7/365.

Enabling referrals to behavioral health services

Several Eastern respondents noted the benefits of enabling referrals to behavioral health services. One participant mentioned making referrals to Elderly Protective Services.

Referrals, resources, and collaboration with other agencies is usually a positive experience and beneficial to the residents.

Referrals to yoga classes designed for the elderly are also extremely beneficial.

Educating the public about behavioral health services

Eastern respondents most frequently referred to the benefits of public education and awareness regarding the aging process or older adult services and particularly underscored topics, such as chronic illness, grief, and loss.

Providing education, perhaps at senior centers about these types of services to increase awareness and normalize the benefits of talking to someone else about stressors faced in older age (i.e., chronic illness, grief & loss, etc.).

Public education to help raise awareness of conditions which come with older age, de-stigmatization of help-seeking for mental illness.

Groups that educate and empower people; groups that encouraged participation in one's own care and functioning.

Educating the patient about the potential benefits of services.

Education about prescription medications.

Eastern: Strengths of Connecticut's behavioral health system

Recognizing the shortage of providers that specialize in providing care for older adults, Eastern respondents most often noted that awareness and recognition is a strength of Connecticut's behavioral health system. Other strengths mentioned included communication and collaboration with agencies and hospitals, and the availability of inpatient, outpatient and community services. Participants also mentioned specific programs they saw as strengths for serving the older adult population (i.e., Gatekeeper and WISE programs).

➤ Awareness and recognition

CT embraces recovery and at the same time recognizes that many of the people in the 55+ age group were institutionalized, and developed habits and attitudes in a different era that leaves them expecting to be taken care of.

The new recognition that older adults have unique specialized needs for care and services.

Increasing emphasis on meeting the needs of older adults.

Acknowledgement that many older adults are in need of services.

➤ Collaboration and communication

Collaborative efforts to refer to home based services where needed and working with connecting resources for Intensive Outpatient and other community-based services.

Ability to communicate with other agencies and to have discussion with legislators.

Collaboration between local resources.

Communication with all applicable resources is paramount.

➤ Hospital and community services

Inpatient services availability.

The diverse programs patients are offered within the hospital setting.

There are a variety of services available at the outpatient level.

Solid community system, good number of rehab services and nursing homes, availability of in-home services.

Provision of short term recovery assets that enable adults to at least pause their destructive habits that negatively impact employment, family, and society.

Husky Customer Service very good at locating behavioral health Therapists for ... individuals who have Medicaid Title 19.

➤ Providers

CT has a lot of very motivated providers who want to be sure to offer services to meet the needs of the state's population.

Many caring staff/providers in terms of psychotherapists, prescribers, and case managers.

Availability of providers for in-home care services.

➤ Specific programs

The Gatekeeper Program also provides a safety net by trying to identify seniors at risk and connect them to community resources before their situation becomes dire.

[The] Working for Integration, Support, and Empowerment (WISE) Program is a strength.

The Institute of Living has both a geriatric unit and dementia care unit.

Waiver programs and services through Connecticut Community Care, Inc.

There are some promising new programs, especially the Mindfulness Based Stress Reduction (MBSR) workshops that are offered around the state at hospitals and churches.

The police and fire departments have been extremely important in identifying persons with behavioral health issues especially after regular hours. There is strength in this network.

ConneCT informational services through DSS.

Eastern: Weaknesses of Connecticut's behavioral health system

Some Eastern respondents reported some of the same themes as respondents from other regions: lack of well-trained or insufficient availability of providers, limited resources, and poor insurance coverage. Comments addressed lack of awareness and education about services as well as the behavioral health system itself.

➤ Lack of well-trained or insufficient availability of providers

I don't think there is a strength, it is based on controlling behaviors for those in long term care with the use of medications rather than behavioral interventions and for those in the community, there is a dearth of providers that specialize in this age group and their unique needs.

None - behavioral health isn't well treated, I have a spouse and it took years to get him properly diagnosed and treated. Physicians throw drugs at mental health issues and assume his drug issues are an addictive behavior versus mental health issue. The local partial hospitalization recommended made the situation worse because then those clients showed up at my home.

➤ Limited resources

I don't think there is a strength. Each time I have reached out on behalf of someone I'm always told why services cannot be provided by that agency.

None, because it is so limited for those in need and also because those in need typically refuse assistance or believe they don't need assistance in this area.

[Services/resources are] few and far between.

Unsure of the service availability.

➤ Lack of awareness and education about services

I am not educated about what services are available.

I am not aware of the specific things that the Agency on Aging or DMHAS offer the elderly so I can't speak to this one directly.

➤ Behavioral health system

I didn't know there is a system.

I do not know that much about it overall.

'System' implies an organized entity. I am not sure there's is any system related to actual clinical practice. I worked for DMHAS for decades and I am painfully aware how narrowly focused that agency is. The private sector is a free for all which is at risk for being destroyed as the hospitals continue to take over community practices. Sorry, but similar systems destroy practice with bureaucracy.

The system is not strong. Not well-known.

I don't think there are many strengths. I think overall CT is severely lacking even though comparable to other states it is one of the best. We can do better.

Eastern: Suggestions for improving behavioral health services

Overall, suggestions for improving behavioral health services in Connecticut were similar to those from other regions but with some variations in frequency.

➤ Increase funding

Funding resources available to low to moderate income individuals. Funding could be used for services and/or transportation to get to service providers.

Increase funding and staffing within the state Behavioral Health systems.

We are short staffed; that needs to change.

*Continue to fund enhancements to mental health care versus cutting services.
Allocating more funds to behavioral health services.*

➤ Education

We need to make sure that schools that are training people to be psychotherapists are giving enough decent training about chronic and serious mental illnesses.

More training for all providers on managing the medical and psychiatric challenges facing people as they age.

Increase training among home health providers and others about behavior health.

Educate hospitals, rehab centers and nursing facilities about what long-term care services are available in the community.

More enhanced education for providers for addressing older adult needs.

➤ Outreach

Provide a public health approach to get the word out about treatment of MH and SA conditions the same way we see smoking commercials etc. This is the only way we will be able to truly get services to all people.

Advertise resources to families besides expensive assisted living.

Increase outreach to and advocacy for addressing stigma and increasing awareness of mental health and substance abuse challenges specifically for older adults.

Make resources more known – advertise; more training specific to older adults.

A referral network to help find providers.

Provide incentives for outpatient clinics to market to older adults.

➤ Integration of services

That all providers communicate and are on the same page to avoid pts that doctor/med seek.

Create a system where professionals can talk to each other.

We also have to look at putting more behavioral health services within primary care to reduce the fear of seeking mental health services.

Involve primary care for referrals onsite [to] behavioral health care with medical practice [and] attention to costs of prescribed medications to encourage use.

Combine them with medical services.

➤ Insurance coverage

Improve reimbursement rates.

Get Medicare to cover psychotherapy by Licensed Marital and Family Therapists. In-home social work services [are] reimbursable through Medicare to private practice social workers.

Fix the Medicare system as it is driving providers away.

For Medicare to include Licensed Professional Counselors among the providers who can provide covered behavioral health services for CT's older adult population whose insurance is limited to Medicare.

Expand the Medicare scope of practice, decrease out of pocket cost to clients.

➤ In-home services

Make more home visits and allow more flexibility in providing services.

Provide behavioral health services in the home for older adults and their caregivers who are home-bound, have limited mobility, lack transportation or the older adult can't be left home alone.

If someone is homebound it should be easy to agree to do a home visit without red tape. Home services should be available to those older adults with depression and mental health issues so that they are seen.

For community providers there should be the availability of in-home counseling and psychotherapy.

➤ Transportation

Develop a statewide plan to insure the availability of transportation for older adults seeking behavioral health treatment.

Transportation services without the 30+ minute wait on hold for Logisticare.

Improvement to the very poorly run cab transportation system for the older adults and all residential care clients.

➤ Increase providers

Recruitment and training of geriatric culturally diverse and competent providers in all areas of service from the professional psychiatrist to the direct care workforce.

Need for more specialized providers.

More experienced providers.

Need for Geriatric Psych services in New London County x3.

Western: Best practices

Providing behavioral health services to older adults

Best practices suggested by Western respondents included integrating services between behavioral health professionals and primary care physicians, implementing outreach programs at senior centers, providing geriatric specific behavioral health services as a part of outpatient services for older adults, and evidence-based therapy and medication management. Specific therapy methods mentioned included: Cognitive Behavioral Therapy (CBT); Dialectical Behavioral Therapy (DBT); motivational interviewing, Integrated Dual Disorder Treatment (IDDT); Trauma Recovery and Empowerment Model (TREM); Target Affect Regulation: Guide for Educations and Therapy (TARGET); and Eye Desensitization and Reprocessing Therapy (EMDR).

Multi-disciplinary approach including behavioral health and physical health.

A coordinated effort on behalf of client with their primary care physician, psychiatrist and even pain management doctor. A team approach.

As a solo practitioner, I provide services for individuals, couples and families. My clients are referred to me by primary care physicians, other doctors and clinicians, insurance companies, the internet and word-of-mouth. Whether someone is acting as an advocate or the prospective client self-advocates, I am there to help them with therapy as well as direct them to community resources.

As a Registered Nurse prior to gaining my LMFT, I think the coordination of services with physicians and medical knowledge are of utmost importance when working with older adults.

*Public service announcements that help chip away at stigma for people seeking help.
Visiting Nurses Association outreach via senior centers.*

Geriatric specific behavioral health services as a component of outpatient psychiatric care at a local community hospital.

Treatment: Motivational Enhancement Therapies, Cognitive Behavioral Therapy, Medicated Assisted Treatments for Opioid Use Disorders, Co-Occurring Treatment via Integrated Care Planning.

Full assessment and screening, evidenced based therapy and Medication Management.

Mental Health First Aid training for members and staff. Utilizing crisis intervention, city police department, and the state of CT.

*Offer age appropriate activities to include only older population.
Building trust and validating concerns of older adults.*

Working with family members and having family members be and feel a part of the team.

Use of the Area Agency on Aging professional services and knowledgeable staff.

Public safety awareness campaigns that help chip away at stigma for people seeking help.

Collaboration across numerous disciplines.

In-home services reimbursed would be best practice.

We are nonclinical and provide community-based support. Many older adults come for the socialization piece, lunch, and to use our food pantry.

Not focusing on diagnosis but focusing on functioning levels and coping and adapting to assist in living with fewer problems.

Family involvement.

Enabling referrals to behavioral health services

Western respondents mentioned different methods to enable referrals to behavioral health services including: immediate referral if medical issue could impact mental status, implementing clinical team meetings between collaborators on a regular basis, combating stigma related to mental health, and information regarding availability of current services in a specific region.

Refer to primary care physician or other physician whenever a medical issue arises or is suspected impacting mental status.

Education, Inter-Agency Networking and Collaboration; Outreach via Education and Client/Patient Word of Mouth (when they feel open enough to share).

In some of our programs we have clinical team meetings on a regular basis with the Local Mental Health Authority [LMHA] to collaborate services for each individual served and quickly change plans to accommodate individuals' needs. We work closely with the LMHA-WCMHN [Local Mental Health Authority-Western CT Mental Health Network] to talk about referrals that best meet the needs of the individuals and are appropriate for the milieu.

Being aware of agencies to meet their needs, but many of them refuse to access due to fear, unknown and lack of trust and Yankee attitude of doing it myself.

Able to access up-to date information to show what is available in the area being served.

Educating the public about behavioral health services

Western suggestions for educating the public about behavioral health issues include presentations for the public and area agencies, organizing workshops, investing in outreach programs to inform local residents about services in their area, providing pamphlets in Spanish, and utilizing organizations to reach older adult populations via advertising.

Many families are caregivers for the elderly in their household, and they do not know of the services available. It is not a user-friendly system, especially for older adults who may not know how to apply online to DSS services or how to set up visiting nurse services, etc. There needs to be a 'jump-start' almost hand-holding approach to get older adults initially involved in treatment.

Need for understanding of specific services and cost.

Mental Health First Aid Certification.

Groups on aging, family supports.

Educating families and other providers about addictions, mental health, and the aging population.

Workshops, pamphlets in Spanish.

Town of West Hartford had a good outreach program through Human Services Department; they would visit clients in their home and get them connected to services. Additionally, when I was there for my social work internship, we hosted events and educational sessions at the two local senior centers to inform the residents.

Utilize grass roots to educate stakeholders about services.

Western: Strengths of Connecticut's behavioral health system

Strengths underscored by Western respondents focused on access to care, such as qualified providers and clinicians, availability of low-cost treatment centers, provider referral services, and inter-agency communication. Respondents mentioned specific programs, such as CT Home Care Program for Elders (CHCPE), DMHAS wraparound supports, Senior Grant from DMHAS, and the CT Behavioral Health Partnership (CTBHP). In addition, respondents provided

suggestions to improve existing programs. One respondent mentioned creating an intensive case management level for impaired adults within the CHCPE, and another mentioned more wraparound services and outreach.

➤ Qualified providers and clinicians

Qualified therapists to provide counseling.

They try their best to provide professional help to people working with challenged individuals.

Dedicated staff that educate and guide.

Qualified providers and clinicians.

Home to large integrated health systems as well as multitude of solo practitioners offering consumers wide choices to receive services.

We are fortunate that we have many doctors and specialists in CT.

Availability of low cost treatment centers. Wide range of therapies used. Competent, committed staff.

Acknowledgement in the state that individuals at different stages of their life may need different types and levels of support.

➤ Referral services

Provider referral services.

Easy to use once in place.

Inter-agency communication.

➤ Programs and services

Free problem gambling services.

Grants given to non-profits to serve our older adults.

➤ Specific programs and services

We have the CT Home Care Program for Elders designed to meet their needs.

The Senior Grant through DMHAS provides services for clients who would not otherwise have access to these services. The clients and families of clients who receive services then become ambassadors for encouraging other older adult to seek services.

If the client meets DMHAS services they get wrap around supports.

CTBHP – We have the flexibility to continue working with the client despite it being duplication of services. I think CT is starting to expand these services as the older adult population expands provides coverage and contracted providers until 65 years old and Medicare eligible.

Line Staffing from WCAAA [Western Connecticut Area Agency on Aging].

Elder Protective Services are a good resource in CT ... also 2-1-1.

Senior Grant for intensive residential treatment.

Western: Weaknesses of Connecticut's behavioral health system

Similar to respondents in other regions, Western respondents reported concerns about weaknesses of the behavioral health system in Connecticut focusing mostly on lack of resources and services for older adults and concerns about insurance coverage.

➤ Lack of resources and services

There is a dearth of psychiatric services available. Existing services are inadequate, and not patient centered.

Lack of resources for older adults.

Sorry to say in Region 5 I don't see any strengths. Services are spotty at best.

Don't think there is any ... even medically ...

CT is behind as there is very little initiative to have in-home services for the elderly.

I am honestly disappointed in the system for older adults when it comes to mental health. There is lack of referral sources for 55 and up.

It is a weak system.

I am not sure there are any particular strengths other than some of the Universities like UCONN have begun to make behavioral health services for older adults available. As the population ages and the volume of age 55 + increases the system will have no choice other than to respond to and address this rapidly growing need.

➤ Insurance coverage

Here at [agency], we do not yet accept Medicare, which I find is a weakness at my agency; because we must turn away those whose primary insurance is Medicare.

I really have not had any specific difficulties treating adults 55+, as I am an older counselor myself. However, the biggest problem would be that I do not take Medicare, which rules out a number of older folks that call asking for Addiction specific treatment.

We serve up to age 65, there is very little appropriate Geri-psych services available in CT unless you have private insurance. Often there is no distinction between Adult Psych and Geri-psych and they are really two different patient treatment populations CT Home Care Program for Elders is a great service, as well as CCCI [Connecticut Community Care, Inc.], but clients need to meet certain, sometimes limiting criteria, as well as income/financial standards.

Western: Suggestions for improving behavioral health services

Western respondents had numerous suggestions on a broad range of topics. The top three suggestions for improving older adult behavioral health services included increasing awareness and education (i.e., for providers, the public, and students), improving access to services and improving healthcare insurance options. Other suggestions focused on in-home supports, funding, providers, outreach, transportation, housing, and the need to address the stigma associated with seeking behavioral health services.

- Awareness and education (Providers, the general public, students)

Providers

Increase awareness to providers at all levels of treatment.

Our area is in need of more providers in general but also training is needed to educate all providers on how to assess mental health issues that impact older clients.

More training in geri-psych services which requires the attention of a psych specialty.

Train primary care physicians to medicate elderly patients properly.

Staff at homes trained in dealing with people with mental health and addictions diagnoses.

The supervisors and director need training and commitment to their job and making client a priority.

Get word out to hospitals, clinics, etc.

Very little specifically designed for older adults – need more education re: approaches to this specific demographic.

Host a best practice forum for addiction service providers.

General public

Knowledge is power ... The general population needs to know and learn about the services that this state provides and what each service entails.

Provide educational forums to increase public knowledge about available coverage options.

Information and educational enhancement, community projects regarding the specific cultural, social, physical and psychological dynamics, and inherent value of an aging population.

Better education about working with older adults' transportation and payment help.

Getting older adults more involved. Ask THEM what they feel they need.

Need to incorporate the Senior Centers as venues for education and possibly treatment.

*Increase public education on the behavioral health needs of the elderly.
Advocate for their needs and help to link them up to existing resources.*

Students

Add this focus to the teaching programs at all the CT Universities. Develop student internships/placements. Age 55 + services in behavioral health require special training and not enough training of this type is available and the need for this specialty has been ignored not only by the educational institutions but also by the professionals who offer such treatment and are poorly prepared and poorly educated to do so.

Growing awareness of the need as the peak of the Baby Boom generation emerges both in terms of their political/social influence and own needs, and education via institutions of higher education and professional organizations (e.g., CT NASW).

➤ Access to Services

Increase the number of mid-morning to mid-afternoon programs, including lunch and socialization for Intensive Outpatient Programs and Partial Hospitalization Programs.

Older adult clients need access to Intensive Outpatient Program level of treatment.

Day programming specific to those who can't function in mainstream population.

A wider range of treatment hours would allow working adults to access treatment.

Elderly Protective Services is the only agency I have ever had experience with, and they were great. Other than that, I feel there needs to be more wrap around services offered and certainly more outreach to the population. Many older adults are sitting in their homes right now, in desperate need of services that they do not know how to access.

In general, the Home Care Program for the Elders available to qualified individuals is helpful to enhance home health services. It would be even better if there was an intensive case management level for more impaired adults.

Access to psychiatrists for inpatient skilled nursing facility services.

Assisted living centers need behavioral providers for their residents.

Improve screening and communication/referral from primary care physicians and hospital to substance abuse agencies.

Case management (not restricted by assets) needs development.

Fund core services including outpatient, case management and community support services.

Improve coordination of care and follow up/aftercare with all other providers.

Peer support and empowerment programs.

Translation.

We only have one (very) limited program in area. Programs need to be developed/funded, including age specific medical co-morbidities, and multi-lingual.

Older adults do not want to go to groups with 'younger' population; intimidated; attempted to locate substance abuse services for 72 year old female and unable to in 06708 area.

Better integration of mental health and physical health services.

Providing free services and a way for the client to get to the services offered.

Develop specialized residential treatment for seniors with substance use disorders.

Increase number of Skilled Nursing Facilities that will tolerate the behaviors of the older adult behavioral health population.

More age appropriate activities/programs.

Develop support groups for their needs, mentoring opportunities, and help ease them into senior opportunities as a positive and appropriate process as they get older.

➤ Insurance

Make it more affordable; they usually have limited means and insurance.

Issues of large deductibles.

Medicare reimbursements are too low after all the deductions.

From what I have heard from my clients, there are some barriers to accepting Medicaid since the advent of Obamacare, so that the clients have to travel outside of Fairfield County to New Haven for providers for some of their medications. This may be an effect of the takeover by Danbury Hospital of the entire region, and setting policy for doctors region-wide.

Remove co-insurance, co-pays.

Address reimbursement rates so that individuals are funded for the services they need throughout their life span.

Spend a little to save a lot-medical cost offset.

That Medicare recognize LADC [Licensed Alcohol and Drug Counselor], LPC [Licensed Professional Counselor], LMFT [Licensed Marriage and Family Therapist].

Include routine behavioral health assessment as part of Medicare/Medicaid coverage.

Creating action plan so clients who complete residential treatment are able to go into Intensive Outpatient Program treatment despite their insurance carriers.

Broader range of providers accepting Medicaid.

➤ **In-home supports**

Increasing home-based services such as availability of psych APRN to assess and treat clients that have significant difficulty getting to appointments for a variety of reasons.

Increase availability of in-home mental health counseling.

Make it easier for private behavioral therapists to do home visits.

Increased number of in-home services and providers who perform home visits. In-home or residential placement reimbursement.

Provide better in-home support to families.

Include family/supports.

Increased availability of respite for families that are challenged by caregiving through Elderly Protective Services or Access Agencies.

➤ **Funding**

Many times funding is for finding/referring new cases but there is no new funding to expand the services that these referrals go to.

Fund services specifically for over age 55. Similar to how Young Adult Services have separate State funding.

More funding ... It is a time in life where loss is everywhere. Loss of family, spouse, children ... some people do not even have family and they are sitting in their houses alone, every day.

Allocate more funding to existing programs which would be more cost effective so they can hire more qualified staff to provide outreach and care for this population wherever they reside.

Funds to support staffing for local Family Education Groups.

Increase in funding for different organizations so they can specifically address and work with older adults.

Improve funding for inpatient staffing.

Due to its growing numbers due to baby boomers reaching that age that the need to expand and put monies into that area of health services is vital.

Make available grants to those BH providers who want to develop and train staff to expand services in this area.

➤ Providers

More qualified therapists.

Need more practitioners who specialize in treating seniors.

Most seniors receiving behavioral health services are being treated by their general practitioners.

Would be great to see a 'mobile geriatric psychiatrist' who would, by Region, visit each senior center once a month to meet & talk with seniors. Would be a way to reduce fear/stigma/mistrust.

Bring behavioral health service providers into senior centers.

Increase number of providers who accept Medicaid.

Spanish speaking providers.

Social workers in the medical office ... incorporate this into regular medical check-ups as routine. It should go hand in hand and is a way to get older adults more open to mental health treatment. Sometimes, the only human contact an older adult has is through their PCP provider. Why not make this a door to connect with them?

Connect town social workers for the elderly with private and public behavioral providers.

Primary care physicians who refer to behavioral health clinicians.

➤ Outreach

Need more outreach to make seniors aware of services.

Professional staff available to visit senior centers monthly to meet with individuals and families.

They need outreach services AS MUCH as young adult services.

Enhancement of cross-generational integration and outreach to combat potential isolation and stereotyping.

Need to have more in-home/community outreach instead of having clients come to the office.

➤ Transportation

Better transportation.

Have transportation to/from services.

Transportation unconditional of physical ability to take public transportation.

Transportation is a major barrier if they do not qualify for a med cab.

➤ Housing and facilities

Concentration on needs for older adults that would include memory loss and physical accessibility needs as individuals age and development of housing to accommodate.

More affordable housing.

Facilities that are user-friendly for those requiring additional equipment to assist them with physical limitations.

➤ Stigma/discrimination

*Work on changing the attitudes/stigma of getting behavioral health services.
Increased collaboration between DMHAS and DSS and more education regarding programs that can be provided across agencies.*

Eliminate the stigma.

Find a way to get rid of the behavioral health 'stigma' is important for people. Many are ashamed of having/needing these types of services.

Southwestern: Best practices

Providing behavioral health services to older adults

Some specific organizations in the Southwestern region were mentioned by respondents as modeling best practices for older adult behavioral health including: Bridgeport Hospital, Connecticut Geriatric Society, Greenwich Hospital's Center for Healthy Aging and Masonicare. A few of the most notable best practices included coordinating care with medical providers, using evidence-based practices and other tools for treatment, use of providers who specialize in the older age group, public education regarding stigma and barriers, outreach and advocacy, and home-based services.

Other services mentioned as best practices included: providing transportation and meals for seniors, using motivational interviewing, Cognitive Behavioral Therapy (CBT), and Dialectical Behavioral Therapy (DBT) along with Trauma Informed Care, a treatment framework involving understanding, recognizing, and responding to the effects of all types of trauma. The

coordination of services among providers, culturally competent care, and specialists, such as geriatric psychiatrists, were also mentioned.

Our agency has always provided transportation and meals for seniors in our care. When we had the staff we would do educational programs at local senior centers and senior housing.

Motivational Interviewing has been one of the best practices used in our facility. We also use Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, and Trauma Informed Care.

Home-based services, coordinating care with medical providers and working with elderly services at both the municipal and state levels. Older adults are likely to develop depression as a result of multiple losses, medical problems, family issues and a combination of factors. Then there are people who have had a behavioral health diagnosis throughout their lives and need specialized care in their older years, such as closer monitoring of medications as these may need to be adjusted.

Culturally competent care which includes client's language, background and cultural beliefs.

Greenwich Hospital has a specific program, Center for Healthy Aging, that is designed to meet the mental health needs of older adults and their families. We have geriatric psychiatrists and two clinical social workers with expertise in working with older adults.

Through community provider groups in Greenwich and Stamford, professionals can stay apprised of clinical services. Additionally the Connecticut Geriatric Society provides advocacy and training.

Describing mental health treatment as 'something to help them get through this time' as someone to 'just bounce things off of to get another perspective or resources.'

Coordinating with other service providers to provide holistic care to improve behavioral health, working to eliminate stigma and providing intensive case management to link consumers with community services.

Enabling referrals to behavioral health services

Several respondents mentioned specific places to which they typically make referrals. These were the WISE program, Area Agencies on Aging, hospital-based programs, and the state crisis management program. Also mentioned were building working relationships with the professionals providing services and keeping informed about the many services available.

Our staff routinely volunteer on a number of local, regional and state committees and task forces, which allows us to develop a working relationship directly with the professionals who are providing services. It's a lot easier to make an appropriate referral when you are personally familiar with the providers and their agency services.

I have made direct referrals to geriatric psychiatrists and hospital-based behavioral health and substance abuse programs for indigent patients. I have also referred patients to in-patient emergency and psychiatric facilities. I have referred patients to the local state-funded crisis management program which is excellent for emergency assessment and follow-up referrals to their outpatient program.

Referral to Area Agency on Aging.

Referral base education use of senior centers for support.

Educating the public about behavioral health services

Many respondents stated that performing a variety of education, outreach and advocacy efforts was best practice. Specifically mentioned was bringing older adults together for seminars, presentations and discussion groups in an effort to raise awareness. Coordinating with the WISE program in addition to other agencies and the community senior provider network were also mentioned.

Groups and outreach for substance abuse.

Letters to facilities about services.

Education regarding stigma and barriers. Creating opportunities for community lectures/presentations.

SBIRT for Older Adults Community trainings

Working with WISE program and collaborating with other agencies to bring a critical mass of older adults together for seminars and discussion groups.

Southwestern: Strengths of Connecticut's behavioral health system

Southwestern respondents shared specific programs and strengths including the WISE services, Area Agencies on Aging, DMHAS staff training, care management services and education provided to consumers. Some participants listed commitment to providing services as a definite strength. Other respondents noted general strengths (i.e., multiple services available, collaboration, senior center programs).

➤ Specific programs with strengths

The training that the DMHAS has provided for its staff, and the education provided to our consumers. Knowledge is power and it brings about change.

Husky reimburses LPCs [licensed professional counselors]. I have a senior client right now and it is an excellent fit.

Area Agency on Aging.

The Mental Health Waiver [WISE] for those on Medicaid.

- Commitment to providing behavioral health services for older adults

Connecticut has implemented many mental health services across the board and seems committed to addressing the mental health needs of its citizens overall.

Willingness to improve services, especially for the undocumented population.

Awareness that more outreach and psycho-education is needed.

- General strengths

Qualified, caring professionals.

There are many services available in Connecticut.

Transportation to medical and other appointments.

Teamwork with area providers trying to take care of people in the greater Norwalk area in the best way possible.

The inpatient units provide excellent care to elderly persons diagnosed with mental illness, especially those with co-occurring chronic physical illnesses and/or disabilities. The infrastructure is there.

Offering programs at local senior centers, etc.

More and more practices are accepting Medicaid/Medicare.

The small number of agencies in Lower Fairfield County which provide care management services to indigent populations provide significant assistance, but they are understaffed and do not follow through with complex cases.

Southwestern: Weaknesses of Connecticut's behavioral health system

Like respondents in other regions, Southwestern participants noted system weaknesses.

The system is getting worse. It is much more difficult to access necessary services to maintain people in the community and out of institutions." Another added, "Applying for services can be overwhelming as the same questions are asked by different entities causing older residents to give up and not follow through to get the services they need.

I don't think CT's mental health services are adequate for any age group. SWCAA [Southwestern Connecticut Area on Aging] is the agency that I think provides the best all round care for seniors but they have to meet the criteria for access to services.

I do not see any strengths in the public sector – our severely ill clients get older, develop medical issues and eventually end up in nursing homes or pass away.

The most challenging aspect is providing holistic care in one location as transportation and accessing resources are two important barriers.

Southwestern: Suggestions for improving older adult behavioral health services

Southwestern respondents listed education and awareness, access to services (i.e., age group specific services, in-home services, family services, counseling), and service coordination as the top three suggestions for improving older adult behavioral health services. Additionally, participants suggested the need for reliable transportation, more visiting nurse services and home care, funding, insurance, collection of data, decreasing stigma, provider training and increased staffing.

➤ Education and Awareness

More community education. Disseminating information continuously and consistently, in order to reach the older adults is most important.

Conduct outreach through places of worship, housing complexes, and shopping centers (not just senior centers). People who go to senior centers are usually getting the services they need.

Cultural Diversity training as it specifically applies [to] seniors.

Targeting education/marketing of services to older population.

Education and training, raising awareness of specific issues, addressing the gap between the ages of 55-65 when many services begin.

Educate providers regarding the resources.

Consumer education on behavioral health issues to reduce the stigma of mental woes. Destigmatizing mental health concerns by normalizing symptoms relating to life experiences, genetics and environments. Early on in schools we turn learning disabilities and disciplinary issues into diseases not issues that education, behavioral techniques and stress management skills can handle ... especially where anxiety is present-too much medication to the developing brain – not enough skill training.

Educate to remove the stigma regarding seeking help.

Increase capacity of trained providers including more culturally and language skilled.

Increased training of psychiatrists and social workers and other ancillary professionals in psychotherapy with older adults.

The elderly population needs are specific and very different than the ones of a younger population. Professionals need to be educated on how to medicate and provide appropriate treatment for this population.

Medical Doctors need to get on board and make referrals.

Create a certification for providers.

➤ Access to services

Homes that provide for physical health needs as well as psychiatric. Follow the waiver program similar to services provided by DDS.

Provide services and support systems for the families caring for the elderly.

Provide counselors in nursing homes/assisted living.

Develop more assisted living homes specifically for the elderly with co-occurring disorders.

Targeted specific older adult groups in every major town with a qualified provider facilitator.

More services are needed that are geared toward the 55-65/70 year olds. From my experience this group sometimes does not feel connected to the under 40 year old population nor to the 70 and older group.

Designated elder behavioral health specialists.

Difficult question. I think CT can do better in this area in program development for the elderly. CT is strong in providing Home Care services for Primary Care but we need more Visiting Nurse services and Home Care for the elderly as they bring multiple medical issues and lack of transportation or family involvement.

Increase Intensive Outpatient Programs for older adults.

Home-based services including outreach workers as well as CNAs, Homemaker services and visiting nurses to help individuals remain in the community and reduce the need for hospitalization due to termination of benefits and lack of medication.

Issues regarding individuals with the onset of dementia. Nursing homes resist taking older clients with psychiatric issues. Little to no resources for the mentally ill with dementia.

Continued/Ongoing Case Management once their service needs have been met, not leaving it to other agencies.

Have more iCare-managed facilities spread throughout the state.

Increasing the number of home care agencies especially profit-making which will expand the parameters of interventions medical social workers can provide mental health and substance abuse patients beyond one visit case management, assessment, and referral.

I believe that Medicare will pay for very limited extra visits for more case management, referral, and crisis management.

Need the equivalent of a nursing home with appropriate clinical staff to deal with both the issues of aging and behavioral health; few places for clients to move on to for increased care.

➤ Coordination of services

Healthcare providers who make referrals to a provider with the patient present in the room.

Physicians and other healthcare providers who follow up with their patients re: the referral and treatment progress.

Although we have some quality facilities in the state, I think the system is still too fragmented and needs more coordinated efforts.

Have centralized services with one stop shopping, so application for benefits (such as food stamps and medical insurance) can be done at one time.

Have specialized teams in mental health that focus on older adults and people with physical disabilities. Many times these clients require much case management as well as therapy to address their needs. And the team needs to include a medical doctor with a specialty in geriatrics.

Coordination of services, hospital, emergency rooms, nursing homes, SWCAA , Gatekeeper, and community outreach to conduct SBIRT, and mental health evaluations.

Consistent use of screening tools by physicians and other healthcare providers.

Development of a care plan with case management provided.

Easy procedures to information share between medical and behavioral health providers.

Improve partnering with Health Fairs and Senior events.

➤ Transportation

Better senior transportation – the service the state uses for people that have transportation is abysmal – an insult to taxpayers that they retain the contract. They disrespect their customers – customers are at their mercy. Providers and clients schedules become disrupted routinely when that service is used.

Improve escorted transportation services for those with physical disabilities and/or cognitive impairments so they can get to necessary appointments, such as doctor visits, and social/recreational activities to prevent depression and enhance their mental health functioning.

Improved access to, vouchers for transportation.

➤ Funding

How to help private clinicians cover costs.

Compensate practitioners at a higher level, make it easier/better for them to see these adults.

Free services especially for poverty level seniors.

More funding to help create advocacy and spread the word about abuse/neglect and exploitation of elders, which CT has done a poor job with.

Fund geriatric specialists and imbed in agencies who provide behavioral health services.

➤ Insurance

We need more providers able to provide services under Medicare/Medicaid.

Subsidized co-pay.

No co-pays – many cannot afford therapy or medications (when they only have Medicare).

Increase rates of reimbursement for providers so that more providers are willing to accept insurance, Medicaid & Medicare.

➤ Increase Staffing

Under staffing of care management services for indigent and low income populations especially for complex cases. Also lack of providers for indigent populations especially for those requiring free services long-term. Improving this situation is important for all ages including patients over 55.

Few private-practice psychiatrists do this, although there are excellent local psychiatrists specializing in the geriatric population accessible to patients with Medicare and Supplemental Insurances and private-pay patients.

Have more geriatric specialists.

Increase the number of psychiatric nurses in home care agencies.

➤ Other Suggestions

Just one – someone in charge to push for a Geriatric Adult Program initiative, akin to Young Adult Services, that seeks funding/training/staffing, etc.

Surveys to collect data directly from seniors.

I work as an outpatient LCSW in a DMHAS state run facility that also has three floors of inpatient beds on which I occasionally do overtime. We all have outpatient caseloads of 40+ which leaves us VERY little time to do the level of wrap-around connection that are needed for our aging population. In addition caseloads need to be lower--since older people require more of our time--they need us to speak and act at a pace they can handle--not the pace required to care for 40+ caseload on a 35 hours per week.

We do not have easy connections for caregivers--and that is also needed.

Inpatient units are not all equipped to handle an aging population--they do not even have the SHOWER CHAIRS that are the correct height for women--so I have been asked to use regular CHAIRS to shower patients. This is DANGEROUS. A full review needs to be made of adapting these inpatient units to be safe for our aging population.

Follow up on medication compliance.

Maintain a list of such [certified] providers.

South Central: Best practices

Providing behavioral health services to older adults

Best practices suggested by South Central respondents included: self-sustaining support groups, advocacy (e.g., social workers using resources to link older adults with services), providing transportation, fostering empowerment, and the use of motivational interviewing. Also mentioned were different approaches to therapy including Cognitive Behavioral Therapy (CBT), and Eye Movement Desensitization and Reprocessing (EMDR) therapy, an integrative psychotherapy approach that is effective in relieving many types of psychological stress.

Support group once provided by Cornerstone for older adults, with depression, living in senior housing. Support group developed into a naturally occurring group that maintained itself after the funding for the project ended.

Provide psychiatric/Rx/individual counseling/case management/community outreach/VNA/mobile crisis/peer support services.

Collaborative healthcare team--good communication.

Collaboration with referral to elder service agencies. Collaboration with conservators. Social workers exhausting every possible option and including all parties involved.

Linking consumers to transportation programs and/or providing transportation as part of services offered.

Having a one-one support staff member attend for introductions to new services, etc.

Well trained APRNs and MSWs.

Team approach to care for the elderly.

Motivational Interviewing model.

Day groups/services; focused group (i.e., Health and Wellness).

Supportive psychotherapy; family therapy; CBT; Palliative and End-of-Life Care.

We have a predominantly bilingual staff for a predominantly bilingual/monolingual Spanish-English speaking population and this really helps.

Integrated services (behavioral health and medicine).

[Provider] uses an outside provider to provide the services – Cognitive Behavioral Therapy. The provider now offers services in our facility so our referrals are made directly to the provider. [We] participate in the Greater New Haven Collaborative which informs the community about the services that we offer.

Integrated treatment for co-occurring disorders; network of community services; inclusion of families.

Specific groups to deal with issues of aging, medical, financial, loss, family placement.

Groups for older adult substance abusers whose issues are unique and different from younger people.

Grey AA [Alcoholics Anonymous].

Enabling referrals to behavioral health services

South Central respondents mentioned different methods utilized to enable referrals to behavioral health services including integrating primary and mental health care to increase referrals for older adults and educating providers about best time to refer.

The integration of primary and mental health care in our facility has greatly enhanced the number of referrals to geriatric psychiatry because patients are more comfortable seeing providers in co-located clinics.

I am in the process of establishing a geriatric psychiatry clinic at my place of employment. I have tried to start to educate internal medicine providers about when might be good time to refer patients for behavioral health treatment and also educate them on inappropriate medications in this age group.

Refer to agencies for mental health care/VNA/Primary care/residential supported housing.

[We] rely on CMHC [Connecticut Mental Health Center—a collaboration between DMHAS and Yale University Department of Psychiatry] for referral advice within our region. [We have] had success in being able to provide and/or refer our residents/tenants to the appropriate providers in the community.

Educating the public about behavioral health services

South Central respondents suggested distributing information through pamphlets, brochures, and the Internet for consumers and their caregivers. Topics participants suggested should be emphasized included mental health stigma, palliative care, and end-of-life care.

Public education and outreach by a number of different organizations in both the addiction and mental health areas: SBIRT.

Information pamphlets and good resources for patients and family members/caregivers to utilize.

Internet and brochures.

Interagency information and training for professionals and clients.

I try to market to relevant doctors and agencies to let them know of my services.

South Central: Strengths of Connecticut's behavioral health system

South Central respondents mentioned the following strengths of Connecticut's behavioral health system: providers (e.g., geriatric psychiatrists, counseling resources), other statewide services for behavioral health, and the contributions made by medical schools and academic institutions.

➤ Providers

Even though there are few geriatric psychiatrists in the state, most of the providers we do have are excellent ones.

There are some good, caring people working in the field.

The number of agencies available.

There are some good programs out there (i.e., Agency on Aging).

There is an abundance of counseling resources available.

There are a number of trained geriatricians and geropsychiatrists. The issue is that not enough people know they are out there.

➤ Statewide services

State and federal benefits seem to meet the many needs of majority elderly consumers.

Statewide services to mentally ill.

➤ Medical schools and academic institutions

Yale and UConn Medical Schools and academic departments.

South Central: Weaknesses of Connecticut's behavioral health system

Respondents in the South Central region, like participants from other regions, mentioned a number of weaknesses of Connecticut's behavioral health system including: insufficient resources/services, lack of awareness and education, insurance, and insufficient housing.

➤ Insufficient resources/services

I can think of no strengths. The 55+ clients are an underserved population in the state of Connecticut. Tragically underserved!

Lack of staff is greatest barrier to day groups/services.

There is no time to take on any additional responsibilities such as marketing programs; we cannot handle more clients. Our wait lists are long. Our provider's schedules are booked full. We are shoving everyone into group therapy because individual time is not available.

Poorly trained behavioral health providers for this aging population; problems with access to quality health and behavioral health care.

I personally have worked with older adults for some twelve years. Many are quite frail with limited ambulation and mobility. I cannot report on strengths. There is a huge difference between someone who is 55 and someone who is 85.

➤ Lack of awareness and education

Lack of public education regarding aging, palliative and end-of-life care; stigma associated with mental health; lack of qualified and well trained geriatrician (medical and psychiatry) for the aging population which is growing exponentially. Note: Everyday 10,000 Americans turn 65 years old and we are not prepared as a country to provide adequate/quality services they deserve.

Believe older adults are faced with ageism--are the largest growing population given the least focus.

➤ Insurance

Not good. The Medicare reimbursement is not very much and most seniors who need assistance are unable to afford the co pay that comes with Medicare.

Behavioral health systems are minimal for the population over 55 and Medicare credentialing does not cover for Licensed Professional Counselor providers.

➤ Insufficient housing

Few--we need more housing, nursing homes, assisted living arrangements.

South Central: Suggestions for improving older adult behavioral health services

The three most frequently mentioned suggestions for improving older adult behavioral health services by South Central respondents were developing more services and/or programs (e.g., in-home services, affordable services, and more prevention services), access to more providers, and increasing awareness and education of behavioral health in general. Additional suggestions focused on the following familiar themes: access to services, funding, insurance, transportation, housing, and outreach.

➤ Services/programs

Make more affordable services available.

Increase availability for those on T-19.

Services closer to home rather than regionalized or only hospital based.

As the intellectually disabled population ages as gracefully as the non-disabled population, we need more services that are skilled and feel comfortable in serving this subset of the aging population.

Need MORE Prevention Services.

Services and programs specifically geared to this population equivalent to Young Adult Services.

Allow tele benefits, including telephone without visual accompaniment if disabled and ill, too many appointments cancelled, which leads to being dropped by provider. This increases depression of older adult.

*Increasing holistic service options to address symptoms and stressors faced
Case Management having more services available and accessible.*

Add additional available services on the weekends.

Have providers offer services at the agency for residents who are unable to leave the facility.

Increase the number of multi-language behavioral services.

You said 'dementia' was not part of this survey - which is kind of funny. Great majorities of the elderly who are referred for psychiatric services here also have some dementia - trying to refer them to a comprehensive dementia clinic providing diagnosis, treatment and social service counseling in a timely manner is almost impossible! As a director of a behavioral health service with no social workers or case managers, we cannot handle demented clients – they require a huge amount of services that our behavioral health department is not trained or equipped to handle.

In-home services for persons that are homebound with limited mobility.

Sensitive programming for older adults that integrates aging process in treatment. For instance a healthy 55 year old is different from an 85 year old with multiple health issues.

Free in-home assessments.

We have child guidance clinics why not senior clinics?

A central office that handles elderly-demented clients' social service needs is really needed.

Develop a council on aging and mental health.

➤ Providers

Access to more providers.

*Incentives to bring more geriatric psychiatrists into the state.
Increase providers' ability to credential with Medicare.*

More psychiatrists/APRNs [advanced practice registered nurses], who specialize in geriatrics.

Have psychiatrists accept Medicare as a condition of their license renewal require CME [Continuing Medical Education] in geriatric psych for MDs and APRNs [advanced practice registered nurses], allow FQHC [federally qualified health centers], and CMHCs [community mental health centers] to see geriatric patients.

Continue to allow all professions (LMFT, LCSW, PhD, etc.) to see Medicaid patients.

Have an on-line directory of mental health providers and resources – more staff.

More staff. We have been on a hiring freeze FOR YEARS! As our staff capacity dwindles, so does the capacity of the number of clients we can treat.

Create centralized database with contact information for trained clinicians who are open to seeing older adults.

Increase number of mental health care providers in primary care practices.

➤ Awareness and education

Incentivize mental health professionals to pursue specialty training in geriatrics by offering loan forgiveness programs or enhanced salaries with specialty training – we have 4 fellows graduating annually from the Yale Geriatric Psychiatry program.

Education of health and behavioral health providers regarding access to existing resources.

Increased awareness of the need for services in this population.

More education for the aging in place population.

Train healthcare providers to provide geriatric care.

Increasing studying older adults' illness trajectories to identify potential early interventions to offset some issues older adults face.

Spread information about related resources for those unaware such as transportation supports to maintain appointments and independence in the community.

Available state supported behavioral health representatives within Towns/Cities.

Representatives who visit the Senior Centers & Community Centers to share challenges. These [state supported behavioral health representatives within towns/cities] – state trained behavioral reps – would educate the government/municipal workers who directly work with the older adult population on available services.

Awareness of late life development seems lacking in professionals in our region.

Get providers together to talk about the issues.

Constantly assessing the level of cultural competence of staff that serve clients. I believe if people feel valued they will be more 'tolerant' of other shortcomings.

➤ Access to services

Focus on generativity and legacy building opportunities could make mental health services more acceptable to seniors and more positively focused.

I believe the AAAs have been a wonderful component of our state services for the older population. I believe they should be included as a referral and information resource for any aging services in the state.

Create a more streamlined process for handling major/basic needs of elderly clients.

Explain each step to the elderly client so that they understand what to expect.

Keep the elderly client informed of all changes and movement in the process of helping them meet their needs.

The system needs to integrate more with primary care – where the older adults gravitate when in need. Also, there are many older adults who are fragile in the community and in need of more support to prevent them from going into nursing homes. The chronic psych/older adults are falling in the cracks.

Cultural and linguistic accessible behavioral health services for older adults population.

Improve access to vocational training.

The Agency on Aging is a mess; I have tried to refer elderly clients there to get assistance of various kinds and it is very hard for me (as an MD) to negotiate their fragmented system.

Create database with list of resources available to older adults that could be shared with physicians and other providers providing care to older adults.

Longer treatment stays.

Increased number of organizations/programs for patients to be discharged after their hospital stay.

Community-based mental health/ VNA / case management.

➤ Funding

Greater funding for area agencies on aging.

Fund providers who are not state agencies.

Fund senior only programs.

Less cuts to programs such as intensive outpatient programs for older adults.

Funding to support the needs of the growing population of 55+ clients.

Improved reimbursement through Husky/title 19 with limited red tape.

➤ Insurance

The integrated care model falls apart because co-pays are an issue. The patient cannot afford to pay the co-pay to the doctor and then see the behavioral health consultant on the same day with often a higher co-pay (if we want to do a warm handshake handoff in the same location). This only applies to those who have co-pays. Behavioral health in integrated care should integrate payments with medical care. It is very hard as a private practitioner to work within the current model for primary care.

Eliminate co-pays for Medicare recipients on minimal, fixed incomes.

Work on improving reimbursement for Medicare patients.

Medicare patients should be eligible for group therapy and visiting nurse services.

➤ Transportation

Improved transportation services.

Look at transportation services to assist people in getting to these appointments consistently and punctually.

➤ Housing

Affordable housing in good condition within neighborhoods in which people can feel safe, part of a community and have access to necessary resources (i.e., housing, transportation, food, churches/synagogues; health care; hospitals; behavioral health care) .

Housing for elderly.

Provide assistive living home for the deaf/hard-of-hearing/deaf.

➤ Outreach

Improved access through outreach.

Outreach to this population with names/locations/services offered in their communities.

Agencies that specialize in those services should make the effort to contact agencies like this one.

Conclusions

In considering the results of the statewide survey, it is important to note several limitations. First, the survey was not random, but rather a snowball or chain sample not necessarily representative of the entire population of providers and referral sources regarding older adult behavioral health. Many providers and referral sources may not have had an opportunity to participate. As noted, physicians were likely an underrepresented group. Persons who did respond appeared to have trouble answering certain questions, particularly the question concerning “service categories” for the 18+ and 55+ population.

Nevertheless, the responses of over 850 statewide participants, with good representation from all five regions and from a variety of organizations, paint an interesting picture. Over half provide services regionally, with fewer having either statewide or only local coverage. The most common services offered, as expected, were information and referral, diagnostic screening and assessment, and various forms of individual and group counseling. While services provided to the 18+ population may include older adults, there are many fewer services of any type that are designed specifically for older adults.

Perceptions of barriers in accessing behavioral health services and challenges faced in providing or referring to services did not differ substantially by type of provider. Top barriers included lack of knowledge about services, lack of transportation to access them, cost of services and providers that don’t accept certain insurance, and lack of qualified providers. Top challenges named reflect the same themes: lack of services to which consumers can be referred, limited staff and funding, and lack of affordability of services that do exist.

Analysis of regional results reflects very few differences on any measure. It may be that the behavioral health system for older adults is similar statewide, or that differences occur on some other measure, such as urban/suburban/rural. See the main report for an integrated analysis of information from all four phases of data collection.

References

- Archer, T. M. (2003). Web-based surveys. *Journal of Extension* [Online], 41 Article 4TOT6. Retrieved from <http://www.joe.org/joe/2003august/tt6.php>
- Bonevski, B., Randell, M., Paul, C., Chapman, K., Twyman, L., Bryant, J., Brozek, I., & Hughes, C. (2014). Reaching the hard-to-reach: A systematic review of strategies for improving health and medical research with socially disadvantaged groups. *BioMed Central Research Methodology*, 14. Retrieved from <http://www.biomedcentral.com/content/pdf/1471-2288-14-42.pdf>
- Cummings, S. M, Savitz, L. A., & Konrad, T. R. (2001). Reported response rates to mailed physician questionnaires. *Health Service Research*, 35, 1347-1355.
- Dillman, D. A., Smyth, J. D., & Christian, L. M. (2009). *Mail and Internet Surveys: The Tailored Design Method, Third edition*. New York: John Wiley and Sons.
- Glaser, B., & Strauss, A. (1967). *The discovery of Grounded Theory: Strategies for qualitative research*. Chicago: Aldine Publishing Company.
- Harris, P. A., Taylor, R., Thielke, R., Payne, J., Gonzalez, N., & Conde, J. G. (2009, April). A metadata-driven methodology and workflow process for providing translational research informatics support. *Journal of Biomedical Informatics*, 42, 377-381.
- Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., & Hess, S. A. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology*, 52, 196-205. Retrieved from <http://dx.doi.org/10.1037/0022-0167.52.2.196>
- Hsieh, H., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15, 1277-1288. Retrieved from <http://qhr.sagepub.com/content/15/9/1277>
- Israel, G. D. (2011). Strategies for obtaining survey responses for Extension clients: Exploring the role of e-mail requests. *Journal of Extension* [Online], 49(3) Article 3FEA7. Retrieved from <http://www.joe.org/joe/2011june/a7.php>
- Kaplowitz, M. D., Hadlock, T. D., & Levine, R. (2004). A comparison of web and mail survey response rates. *Public Opinion Quarterly*, 68, 94-101.
- Montauk, L. (2000). Medical junk mail. *The Lancet*, 356, 344.
- Petchenik, J. & Watermolen, D. J. (2011). A cautionary note on using the Internet to survey recent hunter education graduates. *Human Dimensions of Wildlife* 16, 216-218. Retrieved from <http://www.tandfonline.com/doi/pdf/10.1080/10871209.2011.542554>
- Teddlie, C., & Yu, F. (2007). Mixed methods sampling: A typology with examples. *Journal of Mixed Methods Research*, 1, 77. Retrieved from <http://www.sagepub.com/bjohnsonstudy/articles/Teddlie.pdf>

- VanGeest, J. B., Johnson, T. P., & Welch, V. L. (2007, December). Methodologies for improving response rates in surveys of physicians: A systematic review. *Evaluation and the Health Professions*, 30, 303-321.
- Wright, K. B. (2005), Researching Internet-Based Populations: Advantages and Disadvantages of Online Survey Research, Online Questionnaire Authoring Software Packages, and Web Survey Services. *Journal of Computer-Mediated Communication*, 10.
doi: 10.1111/j.1083-6101.2005.tb00259.x

Appendix A: Older Adult Behavioral Health Asset Mapping Survey

Older Adult Behavioral Health Asset Mapping Survey

ABOUT THIS SURVEY

- The survey should take about 10 minutes to complete.
- The purpose of this survey is to determine how well the State of Connecticut and your community in particular are prepared to deal with the behavioral health and substance use needs/addictions of older adults. The survey will identify the strengths and needs of the behavioral health system by region and statewide.
- Results of the survey will enhance the state's knowledge of community partners and organizations that address issues related to older adult behavioral health by identifying: regional assets that support older adults with behavioral health needs; resource issues including gaps and barriers that impact the implementation of programs and services; and potential areas of coordination and collaboration.
- For purposes of this survey
 - The term “older adults” means individuals age 55+.
 - “Behavioral health” refers to services for older adults affected by or at risk of a psychiatric disorder, mental illness, substance use disorder, and/or other addictions. For the purposes of this survey, “behavioral health” does not include cognitive issues, such as dementia.
- All surveys will be kept strictly confidential; your answers will be reported in the aggregate so that no individual can be identified. The report will be shared with state agencies and be available from the team administering the survey.
- The survey is funded by a grant from the U.S. Administration for Community Living, and administered by a research team from The Center on Aging at UConn Health, on behalf of the State of Connecticut Department on Aging and Department of Mental Health and Addiction Services.

INSTRUCTIONS

- Answer the questions as completely as you can.
- You may choose not to answer a question if you prefer.
- After you have completed the survey and are satisfied with your responses, please enter “submit”.
- For questions about the survey, please contact either of the following:

Kate Kellett, PhD
kkellett@uchc.edu
Ph: 860-679-4281

Noreen Shugrue JD, MBA, MA
nshugrue@uchc.edu
Ph: 860-679-1689

1. Please choose the type of organization that most accurately represents where you work?
(Select one)

Type of Organization	Select one
Advocacy/Policy Organization	<input type="checkbox"/>
Community-Based Aging Organization	<input type="checkbox"/>
Community-Based Disability Organization	<input type="checkbox"/>
Community-Based Behavioral Health Organization	<input type="checkbox"/>
Community-Based Aging Disability Organization	<input type="checkbox"/>
Hospital Based Organization	<input type="checkbox"/>
Primary Care/Specialty Care Medical	<input type="checkbox"/>
Home Care Direct Service Agency	<input type="checkbox"/>
Institutional/Nursing Facility	<input type="checkbox"/>
Municipal Government (town, city)	<input type="checkbox"/>
State Government	<input type="checkbox"/>
Other (Please specify)	<input type="checkbox"/>

2. What is the zip code of the location where you work? _____

3. Which best describes your service area? (Select one)

Service Area	Select one
Town/City Only	<input type="checkbox"/>
Region/County	<input type="checkbox"/>
Statewide	<input type="checkbox"/>

4. Does your organization provide any of the following services related to behavioral health?
(Please check all that apply and indicate the target populations covered)

Service Categories	Provide to Ages 18 + (Addiction Specific)	Designed Specifically for older adults Age 55+ (Addiction Specific)	Provide to Ages 18 + (Mental Health Only)	Designed Specifically for older adults Age 55+ (Mental Health Only)
Advocacy/Policy Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information & Referral via Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information & Referral via Internet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Health Outreach (brochures, PSAs, ads etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Health Education (presentations, classes, workshops)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual Counseling Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Group Counseling/Support Group Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Federally Recognized Evidence Based Interventions (i.e. PEARLS, IMPACT, CBT...)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In-Home Counseling Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic Screening and Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services to Non-English Speaking Populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peer - to - Peer Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peer - to - Peer Support Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tele-Counseling (use of telephone/video for consultation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integrated Teams of Behavioral Health and Primary Care Providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Co-location of Behavioral Health and Primary Care Providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supports for Family Caregivers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In-Patient Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing for Consumers w/ Co- Occurring Physical & Mental Health Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Services (Please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. In your opinion, what are the **THREE** most significant barriers older adults (55+) face when trying to access behavioral health services?

Barriers	Select top THREE barriers
Lack of Qualified Providers	<input type="checkbox"/>
Lack of Transportation	<input type="checkbox"/>
Lack of Knowledge About Available Services	<input type="checkbox"/>
Limited Hours of Operation	<input type="checkbox"/>
Cost/Limited or No Health Insurance Coverage	<input type="checkbox"/>
Lack of Providers that Accept Insurance	<input type="checkbox"/>
Fear/Distrust	<input type="checkbox"/>
Stigma	<input type="checkbox"/>
Language or Cultural Differences	<input type="checkbox"/>
Limited Physical Mobility	<input type="checkbox"/>
Citizen/Immigration Status	<input type="checkbox"/>
Other (Please specify)	<input type="checkbox"/>

6. Please indicate which methods of payment your organization will accept for services.
(Select all that apply)

Payment Method	Select all that apply
N/A - Services are Free of Charge	<input type="checkbox"/>
Medicare	<input type="checkbox"/>
Medicaid	<input type="checkbox"/>
Private Insurance	<input type="checkbox"/>
Other (Please specify)	<input type="checkbox"/>

7. What are the **THREE** most significant challenges faced by your agency regarding the provision of or making referrals to Behavioral Health services for older adults (age 55+)?

Agency Challenges	Select top THREE challenges
Limited Number of Staff	<input type="checkbox"/>
Limited Space, Tools	<input type="checkbox"/>
Limited Knowledge of Available Resources	<input type="checkbox"/>
Lack of Training	<input type="checkbox"/>
Lack of Services to Refer Consumers to	<input type="checkbox"/>
Consumer Inability to Afford Services	<input type="checkbox"/>
Consumer Non-Adherence to Treatment	<input type="checkbox"/>
Consumer Refusal of Service	<input type="checkbox"/>
Proscribed Parameters of Services, Regulations and/or Internal Agency Scope Limitations	<input type="checkbox"/>
Limited Funding and/or Funding Restrictions	<input type="checkbox"/>
Meeting Needs of Minority Populations	<input type="checkbox"/>
Other (Please specify)	<input type="checkbox"/>

8. Please share any best practices you have used or seen in (1) providing behavioral health services to older adults; (2) enabling referrals to such services; and/or (3) educating the public about such services.

9. What do you think are the strengths of Connecticut's behavioral health system for older adults?

10. What are your top **THREE** suggestions for improving behavioral health services for Connecticut's older adult population?
