Meeting the Needs of Older Adults with Behavioral Health and Substance Abuse Disorders: A Statewide Asset Mapping Evaluation in Connecticut

Long Term Care Planning Committee

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Introduction

• CT is 7th oldest state in U.S.; By 2025, in CT, older adults will make up 20% of population in most cities & towns.
• Living longer; more chronic illness.
• Chronic illness as risk factor for BH & vice versa.
• Population quite diverse.
• Older adults usually seek care from PCPs who may not identify & treat.
• Lack of workforce with geriatric expertise.
Workgroup & Project Background

• 2012 – Policy Academy Regional meeting at SAMHSA headquarters to explore challenges & costs of promoting behavioral health care for older adults.
• Primary Focus – anxiety, depression, prescription meds & alcohol misuse/abuse, & suicide prevention.
• Charged state teams to address state-specific priority issues.
• 2012 – established Older Adult Behavioral Health Workgroup to raise awareness in CT of OA BH needs & address implementation of EBPs.
Workgroup & Project Background

• Workgroup comprised of public & private entities with DMHAS & SDA co-chairs.
• Little state data on issues; Explored statewide asset mapping idea.
• Funding obtained by SDA through an Administration for Community Living Aging and Disability Resource grant.
• UConn Center on Aging engaged for study.
Timeframe & Methods

• July 2014 – September 2015
  o 10 Focus Groups/2 per AAA region.
  o 10 Key Informant Interviews.
  o 5 Community Forums/1 per AAA region.
  o Statewide Electronic Survey

• October 2015 - Final Report

• March 2016 - Official release of report
Study Conclusions: Assets

• Community assets exist, but not in all areas of state.

• Assets include:
  o Traditional BH services (inpt/outpt facilities; counseling).
  o Education (pamphlets; therapeutic practices)
  o Use of screening tools (SBIRT; CAGE; AUDIT)
  o Ancillary services (health; police & fire dept; support groups; peer support; warmlines)
Study Conclusions: Resource Issues

- Underservice
- Uneven quality of care
- Lack of integration of BH, physical health & aging services
- Inadequate workforce
- Obstacles to remaining in or returning to community
- Silo mentality
- Financial barriers
Potential Areas of Coordination & Collaboration

• Recognized care models (IMPACT; SBIRT)
• Regular provider meetings.
• Consistent formal networking with professionals in various fields to share information and practices – particularly around referrals.
Recommendations

• Education & Awareness – identifying the need & where to go.
• Integration of BH, physical health & aging services
• Workforce development – at all levels
• Link & strengthen existing assets
• Policy – billing reform; increase reimbursement
• Research – collect & analyze more data
Next Steps: The Action Plan

• Increase Education, Awareness & Access
  o No Wrong Door efforts
  o Develop partnerships
  o Expand membership of OA BH Workgroup
  o Educate OAs & Caregivers: Treatment Works!

• Integrate BH, Physical Health & Aging Services
  o Physician education: screenings & referrals
  o Healthy IDEAS
  o Professional Development: e.g., CADAR training; person-centered counseling training
Next Steps: The Action Plan

• Develop Geriatric Workforce
  o Training curriculums for senior center staff & HCBS waiver programs
  o Learning Collaboratives

• Support & Strengthen Existing Programs such as......
  o DMHAS SWELL Proposal (NHDTCP, Senior Outreach, & Gatekeeper; link with LMHAs/BHHs & CCTs)
  o SBIRT
  o CHOICES
  o MFP
  o Care management services; community senior centers

• Continue Data Gathering & Analysis
THANK YOU!

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