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
  - 10 Focus Groups/2 per AAA region.
  - 10 Key Informant Interviews.
  - 5 Community Forums/1 per AAA region.
  - 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:
  - Traditional BH services (inpt/outpt facilities; counseling).
  - Education (pamphlets; therapeutic practices)
  - Use of screening tools (SBIRT; CAGE; AUDIT)
  - 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
  - No Wrong Door efforts
  - Develop partnerships
  - Expand membership of OA BH Workgroup
  - Educate OAs & Caregivers: Treatment Works!
- Integrate BH, Physical Health & Aging Services
  - Physician education: screenings & referrals
  - Healthy IDEAS
  - Professional Development: e.g., CADAR training; person-centered counseling training

Next Steps: The Action Plan

- Develop Geriatric Workforce
  - Training curriculums for senior center staff & HCBS waiver programs
  - Learning Collaboratives
- Support & Strengthen Existing Programs such as……
  - DMHAS SWELL Proposal (NHDTP, Senior Outreach, & Gatekeeper; link with LMHAs/BHHs & CCTs)
  - SBIRT
  - CHOICES
  - MFP
  - Care management services; community senior centers
- Continue Data Gathering & Analysis

THANK YOU!

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