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

Regional Focus Group Results

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Background

An estimated 20 percent of adults age 55 and older suffer from a mental disorder, such as depression or anxiety (The John A. Hartford Foundation, 2011), and this number is expected to double to 15 million by 2030 (Jeste et al., 1999; National Council on Aging, 2014). Of the seven million older Americans affected by depression, many do not receive treatment (National Council on Aging, 2014). Symptoms of depression and anxiety are frequently overlooked and untreated in older adults because they coincide with other late life problems (American Psychological Association Office on Aging, 2005). In rural areas, an estimated 50 percent of older adults residing in the community meet the criteria for depressive disorders (Zanjani, Kruger, & Murray, 2012). The number of older adults with substance use problems is expected to double to five million by 2020 (National Council on Aging, 2014). Like depression, substance use problems have the potential to lead to poor health outcomes (Zanjani et al., 2012). Innovative strategies are needed to better understand behavioral health problems in older adults and to address a mental health delivery system that has historically been fragmented, underfunded, and substantially underserves older adults (Bartels & Smyer, 2002; Jeste et al., 1999).

Current preventative services for people with mental health and substance use issues are significantly limited and two-thirds of older adults with mental health problems do not receive the treatment they need (National Council on Aging, 2014). Older adults who access mental health services usually do so in primary health care settings because of their coexisting physical conditions, and as a result they are much less likely to receive mental or behavioral health services from a mental health specialist (Karel, Gatz, & Smyer, 2012). Without adequate and appropriate treatment, older adults with behavioral health problems are more likely to have increased health care utilization, greater potential for disability, limited quality of life, and increased mortality (Bartels, 2003).

To address unmet behavioral health needs for older adults and to support aging in place and home and community-based alternatives for assessment and recovery, asset mapping is an important tool to help uncover solutions. It enables communities to:

- Build on and expand existing community strengths
- Facilitate community involvement in research and action
- Generate a shared awareness and understanding of community assets
- Articulate and communicate knowledge to other agencies and organizations
- Manage resources, community development, and strategic planning
- Identify and potentially increase capacity within communities

Generating greater awareness and understanding of community assets, this collaborative process provides an opportunity to improve both understanding and management of behavioral health problems in older adults as community partners and organizations work together to identify:

- Assets and resources that can benefit older adults with behavioral health needs

- Gaps and barriers that impact the implementation of programs and services for older adults with behavioral health needs

- Potential opportunities for coordination and collaboration that would benefit older adults with behavioral health needs

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 ADRC Option Counseling Grant from the Administration for Community Living, the Older Adult Behavioral Health Work Group engaged UConn Health's Center on Aging (UConn COA) to assist with an Asset Mapping project. The project will create a map of the behavioral health resources available in Connecticut that serve behavioral health needs of older adults (defined for these purposes as age 55+,) including those with mental health and/or substance use needs. The project will also assist the Older Adult Behavioral Health Workgroup in achieving its mission and goals:

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

- Goals:

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

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

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

    4. Promote education and outreach to older adults with emphasis on prevention, early intervention, evidence-based treatment and services, and recovery.

The asset mapping process will focus on identifying strengths and needs by region and is projected to run for 15 months. In the first phase of the process, the UConn COA led 10 focus groups across the state with behavioral health professionals and other professionals who refer older adults to behavioral health services. Findings from the groups will guide development of a statewide survey to be administered to a broader group of behavioral health providers and those who make referrals to behavioral health services. The project will enhance the state's knowledge of community partners and organizations that address issues related to older adult behavioral health and inform future efforts of the Older Adult Behavioral Health Work Group.

Methodology and Analysis

Methodology

Focus Group Instrument

A semi-structured focus group guide (Appendix A) was developed by UConn COA researchers with input from the Older Adult Behavioral Health Workgroup. Fourteen guiding questions focused on various topics including:

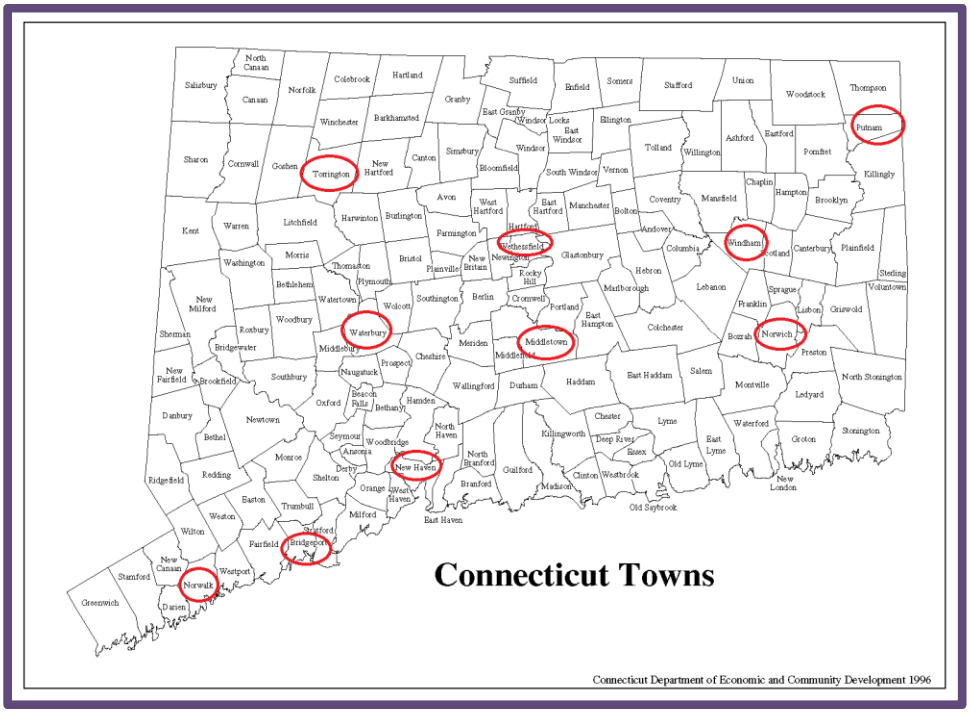
- the extent of available older adult behavioral health services
- the use of evidence-based behavioral services and interventions
- referrals (i.e., why they are made and where people needing services are referred to)
- the unique needs of older adults
- service barriers and gaps
- underserved subgroups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

Research Sample

The Older Adult Behavioral Workgroup requested that UConn COA conduct two focus groups in each of the five state regions as defined by Aging and Disability Resource Center catchment areas. The Work Group was primarily responsible for identifying potential focus group participants in each region, including both behavioral health providers and referral sources. Some individuals who were nominated for participation declined to participate for diverse reasons. Providers as a group were the least likely to accept the invitation due to their tightly-scheduled days, though many who declined expressed interest in the topic and willingness to assist in other ways. The remaining list of suggested contacts was supplemented by UConn COA researchers who called senior centers and other diverse organizations in an effort to broaden participation.

Two focus groups were held in each region, representing a broad geographic distribution (see Figure 1). Because the Eastern region is the largest geographically, one of the Eastern region focus group was held via videoconference and included participants in both Willimantic and Putnam. Both of the North Central region focus groups were held in Wethersfield.

Figure 1. Geographic distribution of focus groups



Recruitment

Potential informants were initially contacted by email and invited to participate in one of two focus groups scheduled for their region. The email invitation described the purpose of the project and encouraged potential participants to share the invitation with others who might be interested in participating. Participants were also given the option of several days and times, including morning, noon, afternoon and evening options, and asked to indicate which would be most convenient. Focus groups were scheduled at the date and time convenient for the most respondents. Locations were easily accessible with free parking. Prior to each focus group, persons who agreed to attend received a telephone call from a UConn COA researcher reminding them of the time, date, and location. All potential participants, regardless of whether they responded to the first invitation, were offered a second opportunity to respond.

A total of 63 people participated in the 10 focus groups. Norwich had the most participants (n=12) and in Norwalk only one of the several expected participants was able to take part (see Table 1), so that session may be more properly characterized as a key informant interview. One planned Western region focus group in Canaan had to be cancelled and rescheduled for a later date in Torrington. Despite the email and telephone reminders, several individuals who had agreed to participate were unable to take part on the designated days.

All focus groups were led by an experienced focus group moderator and an assistant. They were held between mid-July and mid-September of 2014 and lasted an average of 65 minutes. Attendees were asked to indicate whether they were a behavioral health provider, referral source, or both. Table 1 also contains their self-reported answers.

Table 1. Focus groups dates and location

Focus Group	FG Date	Region	Location	Number of participants	P[1]	R[2]	P/R[3]
1	Tues., 7/15/14	NC	Wethersfield	5			5
2	Thurs., 7/17/14	NC	Wethersfield	10	2	8	
3	Mon., 7/28/14	SW	Bridgeport	4			4
4	Tues., 7/29/14	SW	Norwalk	1	1		
5	Tues., 8/6/14	E	Norwich	12	3	9	
6	Tues., 8/12/14	W	Watertown	7		1	6
7	Tues., 8/19/14	SC	New Haven	7		7	
8	Thurs., 8/21/14	SC	Middletown	7	2	5	
9	Tues., 8/26/14	E	Willimantic and Putnam	7	2	5	
10	Tues., 9/16/14	W	Torrington	3		2	1
Total				63	10	37	16

[1]Provider; [2]Referral; [3]Provider/Referral

Participants represented a wide range of organizations and municipalities throughout the state (see Table 2 for a partial list).

Table 2. Organizations, and municipalities represented by focus group participants

Organizations, and municipalities represented by focus group participants	
Bridge House	Southeastern Mental Health Authority
Stratford Senior Center	Reliance House
Southwestern CT Agency on Aging	United Services, Columbia
Middlesex Hospital	Mansfield Senior and Wellness Center
Private Practice	CT Community Care, Inc.
Middletown Senior Center	Day Kimball Hospital
Home Instead Senior Care	Keys2Memory
Regional Mental Health Boards	Lawrence & Memorial Hospital
St. Luke's Community Services	Western Mental Health Authority
Fellowship Place	Waterbury Hospital
Clelian Adult Day Center	Western CT Mental Health Network
Elderly Services	Community Companions and Homemakers
Bethel Senior Health Center	Sullivan Senior Center
Senior Resources AAA	McCall Foundation, Inc.
Generations Family Health Center	Independence Northwest
Charlotte Hungerford Hospital	

Analysis

The ten focus groups were recorded and professionally transcribed. Transcripts were entered into ATLAS.ti 7.5.2. ATLAS software is designed for qualitative (open-ended responses) information. Content from each question was analyzed line by line in order to identify and interpret each individual's responses. Major concepts or areas of interest supported by direct quotations 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. Similar statements were explored and compared to refine each theme and ensure a more complete understanding of each theme.

Results

Focus group questions assessed the respondents' role in behavioral health services and whether they were providers or primarily made referrals. They also explored the extent of older adult behavioral health services, the use of evidence-based behavioral health services and interventions, why and where referrals are made, the unique needs of older adults, services barriers and gaps, under-served subgroups and resources agencies need to fulfill their goals. Two additional questions asked for suggestions regarding groups that should be included in the statewide survey distribution and questions that should be included when developing the survey. Results of the analyses fall into nine major themes as noted below, and are followed by conclusions and recommendations. Some aspects of the nine themes are closely interwoven.

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

Older adults in need of behavioral health services

At the beginning of each focus group, key informants were asked to describe the frequency with which they encounter older adults with behavioral health needs in the course of their professional employment, as well as the indicators observed and types of services that appear to be needed.

How often older adults with behavioral health needs are encountered

Key informants, regardless of background or profession, overwhelming agreed that they encounter older adults needing behavioral health services frequently: the most common answer was “every day,” and no answer was less frequent than “weekly.”

> *I would say that every day there is somebody in our office or in my direct practice that could benefit from those services and has those needs.* [Norwich]

Older adults encountered vary tremendously in the types of issues presented and duration of the need. Some have had long-standing issues with mental illness or substance use aggravated by age, while others have newly-acquired issues exacerbated by lack of services, co-morbidities with dementia, or the changes that come with aging.

> *With the cognitive impairment, what I’m seeing is a lot of comorbidities now, with long history of schizophrenia, long history of bipolar, Down syndrome, now having cognitive issues as well, so that’s another unique mix that is coming to light. And one of the big things that I do see is the depression with dementia is very, very different than depression that is situational, because it’s more of an apathy from the disease itself, low energy, negative symptoms. So that they won’t respond in the same way that a depressed person gets … an antidepressant, and boom, they’re better.* [Norwich]

> *We know that we have an issue here. People in later life, 55 on, who are encountering difficulties… and they have no programs. And that's one of the things I run into with people between 60 and 65 who come to our attention because we have no programs.* [Middletown]

> *What I noticed there with their psychiatric groups was difficulty to adjust to the changes, transitions and changes, the death of a spouse of many years or moving from a home they had brought their children up in into senior housing, a smaller space, and disorienting…these issues that I see as specific to seniors, and the changes that they're going through, I think are drastic changes and just as difficult to deal with as adolescent changes. It’s being called “elderescence.”* [Middletown]

Often, the behavioral health needs surface in the context of other issues, such as poor housekeeping, hygiene, or social issues related to poverty. One representative of a homemaker agency encounters older adults “at least weekly” with what appear to be obsessive behaviors or excessive hoarding.

> *But it’s usually in the context of some other issues they’re having, some type of social issues that’s affecting their healthcare, lack of food, lack of insurance, things like that. That’s usually the way we’re introduced to the older adults who may have mental health issues. So I’d say that’s the, again, that’s the door where we would see them, and if appropriate, we would try to refer them to our behavioral health.* [Willimantic/Putnam]

> *I’ve seen, a few times a week I’m at a senior center, but every day we see seniors, because they come in with, they need food, or they need help with insurance counseling, so we see them pretty much daily. And I see like a lot of depression, I see people grieving, I see all forms of behavior that I can’t diagnose, but I just know that they might need a referral.* [Willimantic/Putnam]

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

Informants observed a wide variety of behaviors and symptoms indicating that some type of behavioral health services would be useful. Very broadly, these include mental health issues (depression, anxiety, psychosis, hoarding, eating disorders, obsessive-compulsive and other problematic behaviors), as well as addictions and substance use (use of alcohol or drugs, gambling, and challenges of persons in recovery). In addition, informants observed many more general issues that could trigger a need for behavioral health services, such as domestic violence, inadequate coping skills, grief, loneliness, isolation, stress, hygiene issues, poor appetite, and anger management. In this age group, it can be difficult to disentangle symptoms of behavioral health issues from those of dementia. Moreover, a presenting issue may mask behavioral health issues because of stigma.

> *We do see people with some psychiatric history. We see people who are depressed... We are also seeing a younger group of people coming in with a background, having been served by groups like the Kennedy Center but they're now retired and they have no place to go and they have nothing to do. … And because I serve mostly older people and we serve a lot of people who are well into their 70s and 80s. I mean we see a lot of people with some type of a dementia or some type of memory impairment that maybe has not been diagnosed in which they're not getting any treatment at that time but behaviorally we're seeing situations where they might be unkempt, their personal hygiene is something that's being neglected or they're just making very poor decisions.* [Bridgeport]

> *They never come in saying they have a need for substances or mental health because of course it's a sensitive issue so when we go in we assess. Once we do the assessment, then we realize that this person doesn't just need medical help ... They also are having different issues that are going on. So we usually have to start pulling together … whatever we need to do to make sure that the appropriate services are in the home to accommodate not just their medical needs but their mental health issues as well*. [Bridgeport]

> *You usually get the sense that they're overwhelmed by whatever it is that's going on. Maybe they're a caretaker for a disabled child or a disabled grandchild. Maybe they never recovered from losing a particular job, or whatever, and it caused financial hardships, and things like that. So, it's usually life stressors, and then, as you talk to them, it comes out in their story, quote-unquote their "story", and you can see a need for mental health services.* [Willimantic/Putnam]

The types of supports that appear to be needed also vary widely. Some needed services can be met by the key informants or their agencies, some may be met through referrals to other agencies, and some are not easily met by any existing resource in a timely or cost-effective way. Certain social services, such as help with recreation, companionship, benefits or insurance counseling, as well as help with food or housing issues are more likely to be available through direct help or referral, while services that require licensed counselors or other providers are more difficult to obtain due to shortages, wait times, lack of in-home services, payment issues, or transportation difficulties. The state's network of senior centers, municipal agents, resident service coordinators and many social service agencies, while not able to identify and meet all

the existing needs, do have broad coverage. However, in addition to capacity restraints, many of these agencies struggle to find the right person or place to make referrals.

> *I'm always looking for referral sources and wanting to learn more about the right referral sources, because we have a lot of good providers in the area, but it would be helpful for us to have a little bit better understanding of the scope of services, and which is the best place to refer whom.* [Norwich]

> *I think there's just also a general lack of availability of services which is why we have the waiting lists in so many places … I think in our region we just have very little to choose from.* [New Haven]

More intensive behavioral health services can be harder to obtain than social services, because the services do not exist, or because the number of providers is inadequate.

> *You need a lot more intensive services. If you have an older adult that's at home and is having a mental-health or substance abuse problem, for them just to show up once a week for a once-a-week counseling session is not really going to be sufficient.* [Norwalk]

> *We need more partial hospitalization plans, day treatment for people. And there's people who need, they need intensive day treatment, they don't need to be hospitalized, they don't, and we all understand how expensive inpatient care is, so I understand the need to get people out of the hospitals and out of the mental health facilities as soon as possible, but they still need more structure to get through the day, until they're in a better place.* [Willimantic/Putnam]

> *They'll be waiting for an appointment. I can't tell how many times people have said, "Can't you have somebody come to the home and assess the patient?" And I said, "That's exactly right. You're exactly right ... We should be seeing you in your home where you're more comfortable. We should have a psychiatric professional assess you with a nurse practitioner who could prescribe meds right there in your home and then we should be coming back doing therapy."* [Watertown]

> *At Day Kimball we are lucky to have a geriatric psychiatrist who's in our inpatient and outpatient behavioral health program, but she's swamped, swamped.* [Norwich]

One provider noted in frustration:

> *I tell you, in my own practice, I'm feeling like I can't keep up with the caseload that I have, so I'm not getting out to see people, or be in contact with them as much, and I am personally seeing more people ending up in the ED. And that's really upsetting to me.* [Norwich]

Several participants observed that even persons with identified behavioral health needs who are receiving substantial case management and other services often need additional help.

> *The homecare program for elders in Connecticut is a model program … For people whose only problems are physical, that can be an adequate plan for an older adult. But we find with the clients with mental health issues the care management model that we use for older adults is not sufficient. They need more and what we find with legislators is that they say "well you got the homecare program that's a care management program,*

that's for elders" … but the older individual with mental illness needs more than the other older adults. [New Haven]

In addition to behavioral health services, people in the 55+ age group are likely to need physical health services related to aging, and these are often difficult to combine, especially for persons with longstanding mental health issues:

> *We have a large number of people over 55 that are using our services … particularly folks that are coming to our [behavioral health] social clubs, and many of them have been coming for years, and now they're older. They have physical problems - that's having an impact on their mental health, and we're very concerned about the fact that we have defined services that are going to accommodate both aspects, so that when you see one of our folks in a program, you don't just say, "well, he's an old man, he's schizophrenic" or whatever, but he has now all these physical problems and so what's the best place for him to get care? And does a general hospital, are they really able to take into account and deal with the psychiatric component of why he or she has been admitted, and, at the same time, you want the general practitioner who's taking care of him to be cognizant of the impact of the physical on the mental and the mental on the physical.* [Middletown]

> *One of the big ones that we are finding is drug interactions between the mental health drugs and the physical health drugs. The average older adult has 5 medications that they take that have nothing to do with mental health. And then you throw in a mental health drug along with that and you get kind of messy stuff.* [New Haven]

Participants also noted that the term "older adults" covers a broad age range, with Baby Boomers differing in many respects from their elders:

> *If the state got serious with the older population coming in and the baby boomers as this population gets older, and there's going to be more and more people through the 60s and whatnot. It's a different type of vibe from the generation ahead, which was more of World War II individuals, which were much more private. With the seniors that are coming up, there's going to be significantly more addiction issues. Number one is because it's a larger population and, of course, alcohol is still going to be the major part of the mix. So the need is so great to address this population that is coming forward.* [Torrington]

> *I wonder if this is really creating a generation that was comfortable with drug use starting with the harmless pot-smoking in the 60s, and then it just sort of evolved, and now we've got this whole generation that experienced recreational drugs as a socially accepted thing and how that's playing out now.* [Middletown]

While most of the focus group discussions concerned older adults who are observed in some way by participants as needing behavioral health services, there was also recognition that there are older adults in need who never come to anyone's attention, and concern that they are missed entirely by existing outreach efforts.

> *We do a lot of outreach … but those people see us all the time, so we know where they are. It's the trailer in the woods that we haven't seen ever, or know exists. We do have an older population out here. It's definitely aging.* [Willimantic/Putnam]

Medication and counseling support

Participants were asked whether older adults in need of behavioral health services asked for or received medication, counseling, or both. While answers were somewhat mixed, participants referred most often to medications as the first line of treatment, with counseling occurring less often because of stigma or unavailability.

> *A lot of them will say, I need something for anxiety, I need some Xanax, or I need this and that, I've been on it years ago, it helped. Mostly a lot of anxiety, and PTSD is in there*. [Norwich]

> *I think a lot of it … depending on where the person or the patient is in their illness, direct mental health counseling for them may not be always that beneficial … and then also sometimes just the psychiatric care. Sometimes medications can be helpful to manage depression, or some of the anxiety that people experience.* [Norwich]

Several participants expressed reservations, however, about physicians' readiness to prescribe medications in lieu of taking more time to explore the problem.

> *If the patient comes in and says, "I'm anxious, I'm not sleeping," it's often very quick and easy just to prescribe a benzo or a sleep aide. And in older adults, as you know, that's probably a very, very poor choice, because of the changes in cognition and fall risks, and so on. But I think that more physicians are getting more savvy about it, and they're really taking time to say, "is there a better medication, or should I have this person go and see somebody," but then the resources aren't always there, so then they get frustrated. If they make a referral to an outpatient behavioral health program, and it's going to be like a 3-month wait, and that patient's calling them every other day, they are probably going to finally say, "just take that Xanax, and I'll see you in a month …" I think the physicians are getting frustrated because there isn't a resource for them, either, at times.* [Norwich]

> *We just had somebody discontinue med management services, only sticking with us for therapy, because we wouldn't consistently renew the person's Xanax. And sure enough, they called to say, "I don't want you anymore, I just want therapy, I'm getting it from my primary." So my guess is, the person went to their primary, a 5- or 10-minute visit, fine, we'll give it to you.* [Norwich]

Stigma can apply to both medication and counseling:

> *Asking somebody at 55 to go see a psychiatrist or a psychologist, or making that recommendation can come, can be very contagious in an appointment, so, we're struggling as an agency, on how to ask the right questions and refer people out in the best way because saying, "hi, I'm [name], you've never met me, but I think you may need to go see a behavioral health specialist" really doesn't put me in a great position when I'm in a client meeting.* [Willimantic/Putnam]

> *There's almost a stigma, particularly in older adults, as "I'm not going to take any type of medication for my psychological problem." I see that as a big issue and I think maybe the best way they could go is if I say, "Have you talked to your doctor at all?" GPs – I don't think they would diagnose somebody or refer somebody maybe to some mental*

health help, particularly the older GPs, but I don't find that the older adults really want to take any type of medication for their issues. [Torrington]

Extent of behavioral health services provided

A portion of each focus group discussion was dedicated to learning about the range of behavioral health and ancillary services currently being provided to older adults by participants and their agencies. In answer to the question: "How do you assist people who appear to need behavioral health services?" participants described wide-ranging activities and supports. At one end, providers including physicians, counselors and persons from hospitals and treatment centers described customary behavioral health practices. At the other end, some participants' involvement consisted primarily of giving information and making referrals. Between the formal supports and referral services are a large variety of other services that are essential to linking referral sources to counseling and treatment, and that serve to integrate and coordinate the overall behavioral health system. While the services form a continuum, it is useful to describe the major categories.

"Traditional" behavioral health services

It is clear that all or most of the full spectrum of behavioral health services can be found in Connecticut, but often only in some places, at some times, for some people.

> *We provide a full range of services ranging from crisis services in our Emergency Room … an inpatient level of care or behavioral health unit. Now, the crisis and the behavioral health unit are not specifically for older adults; they serve all populations – which I think is important to kind of recognize where it might be a specialty for older adults and where it's not. Then we have an intensive outpatient program where a person comes 3 days a week, 10-2, receives medication evaluation and group therapy, and they can, depending on their insurance coverage and what they need, can stay anywhere from a month to 3 months. Then our agency has outpatient, an outpatient clinic, where a person can get individual therapy and medication management; as well as a group would be helpful for them, we have an outpatient group and marital therapy. So that's the range of services that we provide at our agency so it's a pretty full range of services available. And our intensive outpatient is specifically for older adults so that people can really address their issues rather than being in a group with someone who's like 18 or 20 and really doesn't understand that people in a group are able to feel that others really know what they're talking about; that they're not alone.* [Wethersfield]

The availability of age-appropriate behavioral health support groups can greatly enhance clinical treatment, and serve as a non-threatening entrée for those who deny that a problem exists.

> *I've had my moments where I'd be called in and they got tubes hanging out of them and possibly a broken bone on top of it and still look me in the eye and tell me that there isn't a problem. So … instead of telling them they're going to treatment, I tell them they're going to lunch. And so they'll come to our group, everyone's their own age, which it's important in the mental health field to have age-specific groups so everyone could benefit because if an older person goes in and they're in with a group with a bunch of 20-year-olds in treatment … generationally they just don't feel they fit in. So if you have a group tailored to their needs, they're more likely to respond to the more senior members of the group.* [Torrington]

Crisis services, while often available, may be less appropriate for older adults, cannot address the underlying or longer-term issues, and are less effective than prevention.

> *And we do have crisis services -- that's great -- but the crisis services are just to make sure that the person is stable to be left there or needs to go to the ER, not to … start looking at, "Gee, what are your medical issues? Where do you go for medical treatment? How are you taking your meds?"* [Watertown]

> *If you wait for that crisis to occur you have nowhere to go but the ER and they can't handle it either. Because the general ER is not a place to send these elderly people who can't be asking questions and they can't answer because they don't, they're not even aware of their day, the season, the who I am, who you are, where I am. All these questions, orientations and then they get discharged because they don't know what to do with them. And they go back home again.* [New Haven]

Despite some availability of most behavioral health services, there was wide agreement that they are not sufficient in number, accessibility, and timeliness. One behavioral health service was identified as lacking in Connecticut, with an example given of how a neighboring state has addressed the issue:

> *Now in the State of Massachusetts, they have been putting together some systems to help address people's problems related to hoarding, and also Medicare pays for it through an occupational therapist, but there's no occupational therapists, really, in Connecticut, that are skilled and trained and so on and so forth. So Connecticut lacks the resources to effectively support people who have hoarding issue, even though there's lots of research on it.* [Wethersfield]

Ancillary services

Collaboration/Network formation

One tool used effectively in some towns and regions of the state is the creation of a network with professionals in other fields that can share information and practices, identify persons in need, and get them to the right resources.

> *We work with our fire department, our health department, our police department and we actually a couple of years ago started a task force just on hoarding because it's so hard to get in and it's hard to identify the issue. So we've actually started to set up a protocol with our fire department so that we kind of have a checklist of Fire Code needs in homes to be able to say, "You minimally have to have this, this, and this" and if they see something black and white, it's not as easy to ignore. So we've had some positive success with that and we're trying to tweak that even more but we've talked … about trying to get some kind of statewide conference on it so we can do something.* [Wethersfield]

> *They also have something which is very, very valuable and what I call our provider meetings. So, in the Town of Greenwich, Stamford, Norwalk, Westport, and Bridgeport, they have provider meetings so that any professional that works with older adults is that they attend these provider meetings, which could be on a monthly. Half of them are like*

on a monthly basis and the other on an every-other-month. So it's basically any profession that works with older adults, they attend these meetings and they share information with each other, and they usually have a presentation on a certain topic. So, I presented information about older adults and substance abuse … and I've had people from DMHAS and the Crisis Unit come in and talk about their services for the mental-health needs, as well, too. So it's a great forum of collaborating with other people in the community that specialize in working with older adults. There's probably maybe, fortunately or unfortunately, there's a lot of home-healthcare agencies that attend that, always trying to promote their services, but it's an important thing to educate them as well. [Norwalk]

Such formal networking can alleviate to some extent the disadvantages of town-based services in this state.

I think it's also complicating that we don't have a county system – that we have 169 towns and municipalities dealing with this independently. [Wethersfield]

Outreach programs/Problem identification

Many participants described outreach programs that affirmatively seek out individuals who may not otherwise seek help or be identified as needing services. These workers, who may be municipal agents or senior center or other agency workers, take the time to sort out numerous presenting issues and determine where help is needed and what the best services might be.

But a lot of times, making my point, is that when someone talks about a housing issue or something, there usually is another issue or issues that they need assistance in and that's where we come in through probing or asking more information. [Torrington]

I also have an outreach program and my outreach worker responds to a lot of individuals where neighbors and friends are calling for someone who is living alone and is somewhat isolated. We're seeing a lot of hoarding issues and a lot of issues where people are not keeping up with their utilities so utilities are being turned off. … We get a lot of calls like that and they often are generated from EMS or the Health Department who goes in for some other call and then begins to see that there are multiple problems. [Bridgeport]

Well, then [the outreach worker is] sitting down. "Okay, let's figure out what your financial status is. Let's figure out what plans you are eligible for. Let's figure out which plan will cover the medicines that you need. Let's find doctors that will participate with that plan, and then also these are resources for you to seek help for addiction or mental health." She can't really go much further than that aside from making people aware of what services are out there … But you feel that somebody is at risk. So those calls are being made on the person's behalf. [Middletown]

So, a lot of what she deals with is sit down, let's hear the whole story because frequently she's only getting the tip of the iceberg to begin with. You think you're solving a problem, and you find out that it's really 4 miles longer than you initially thought. It can take 3-4 hours for her to sit down with the one client we thought was going to be a 5-minute "let's just make a phone call for you". People who are dealing with addiction issues – heroin, alcohol, what have you. [Middletown]

Outreach services can be provided not only by social service agencies, but also by volunteers, such as churches.

> *Part of what my outreach worker does is we have a list that is getting bigger of people she tries to just call or visit more often to check on their well-being. To see how they're doing. We try to see if we can hook up with family… We try to look at creative services like can we use volunteers in some way. Can we use the worship community in some way to help us with those volunteer efforts? People that need to be kind of checked in on periodically. There have been Friendly Visitor Programs and telephone reassurance programs in the past so it's a matter of seeing if we can resurrect some of those again. It's one avenue to go. It's not the solution, but it's helpful. It's one more support that could be available*. [Bridgeport]

Peer support

In addition to professionally provided behavioral health supports, peer-led groups and other types of peer support were described as serving a crucial role for persons in recovery.

> *We're losing a lot of our older seniors now but to have more of an outreach in this [senior] center, I think, would be important coming up in the future. Right now, the meetings that are here – they have a regular following. It's a good group that shows up but I think we might have to do more in the future.* [Torrington]

Warmlines, a peer-staffed telephone support service, was noted as a particularly effective service.

> *There's also warmlines across the state that they could call… It's run by people with mental illness… and they're trained to do active listening and talk with people who are having difficulty, and it's geared towards other people with psychiatric or substance abuse issues and it's open usually until around 10 in the evening … Their symptoms might be starting or maybe they're thinking about picking up and using so it's just a friendly place. And like I said, they're all people who are in recovery. Some people have both mental health and substance abuse issues so they can speak to both areas of experience and some have more mental health but we train them in all kinds of things.* [Watertown]

Education

Numerous education initiatives range from signs and symptoms of behavioral health issues to information for persons and family members about where to seek help. Education efforts also reach out to professionals likely to encounter persons with behavioral health needs, such as police officers.

> *There's a Safer Drinking Guidelines pamphlet, which we're going to begin distributing as part of our presentations publicly, and we understand that from talking to addictions counselors that that is a real door opener for people to start conversations, so we're hoping to get added there, but I think that's an under-addressed problem.* [Middletown]

> *I do education. People are asking me, now more than anything else, to go out and talk about these things and … make people aware that there's a need for this, and I think that is a paucity, as you probably realize, of treatment for seniors.* [Middletown]

> *The Fairfield Police Department is especially trained to work with people who have psychiatric disorders and they're very compassionate. It's like an embedded social worker who travels with them when they go to somebody who has a diagnosis.* [Bridgeport]

Screening

Screening protocols with standardized tools for persons with substance use disorders or those at risk of developing them were also described. Screening can be administered by health care or community workers of various types in a wide variety of settings.

> *SBIRT [screening, brief intervention and referral to treatment] which is…a way to find out if people are at risk for alcohol abuse or maybe they're already abusing alcohol, and then preventing them from getting addicted or getting them the treatment that they need if they are addicted.* [Middletown]

Socialization

Many participants noted that socialization opportunities, while not directly considered behavioral health treatment, can help alleviate symptoms and promote recovery. Therefore, general or targeted socialization opportunities provided in a variety of settings are important to those with behavioral health needs.

> *We get a lot of people coming in where it has been recommended that part of their home therapy is to socialize more, get out more, to try to become more integrated in the community and some of them will even come with their case workers… We have a lot going on so they're not just going to plop someone in the lobby and say okay have a fun day. You have to really help them figure out. Do they want to go to an exercise program, a painting class, a book discussion? Whatever it might be. Tai Chi. Do they just want to hang out with the guys downstairs and play billiards?* [Bridgeport]

Evidence-based behavioral health services/interventions and tools

Focus group participants identified a list of evidence based behavioral health services they currently provide to their older adult patients (Table 3). The most common form of evidence-based therapy mentioned was cognitive behavioral therapy.

Table 3. Evidence-based behavioral services/interventions and tools

Evidence-based service/intervention	Description
CBT	Cognitive Behavioral Therapy
DBT	Dialectical Behavior Therapy
IMPACT	Depression Care for Older Adults
Motivational Interviewing	Identification, examination, and resolution of ambivalence about changing behavior
PEARLS	Program for adults aged 60 and over to treat minor depression and dysthymic disorder
REACH Program	Intensive outpatient program, that provides intake assessments, medication management, group therapy, aftercare planning
Reminiscence Therapy	The use of life histories to improve psychological well-being
SBIRT	Screening, Brief Intervention and Referral to Treatment
TREM	Trauma Recovery and Empowerment Model

In addition to the evidence-based services mentioned, some informants indicated the need for evidence-based screening and assessment tool adoption (Table 4), a need to educate professionals regarding the current standards of assessment instruments, and the importance of integrating screening tools into accessible settings frequented by older adults.

> *I think as far as the evidence-based evaluation tools, it would be helpful to know which were more valued by certain -- without having to do clinical searches, which were more valuable? Which were the standards? We see a huge gap in the Folstein especially for education and certainly for language. There's a huge gap in that. And I've done it in Spanish, with a minimal understanding of Spanish, and still you can get it. But just which ones are the current standard?* [Watertown]

> *I think a lot of the evidence-based programs, screening tools that could be integrated naturally into settings in which older adults naturally gather or are found are just not well known. So I think when and if we get to the point of recommendations that would be one of mine.* [Wethersfield]

Table 4. Evidence-based behavioral health assessment and screening tools

Evidence-based service/intervention	Description
Bereavement Screening	No specific evaluation tool mentioned
Folstein/MMSE	Mini-Mental State Examination (Folstein)
Geriatric Depression Scale	Self-report measure of Depression in Older Adults
MoCA	Montreal Cognitive Assessment
SBIRT	Screening, Brief Intervention and Referral to Treatment

Many informants indicated that they did not use evidence-based behavioral health assessments and interventions due to barriers including staffing issues, lack of funding, and competing priorities, such as emergency treatment for behavioral and/or physical crises.

Referrals to behavioral health services

Key informants shared their experiences regarding why or at what point referrals are made and where people needing behavioral health services are typically referred. Participants who receive referrals also described the people or entities that typically refer people to them.

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

Focus group participants noted that there is a need to refer people when their behavior becomes disruptive or endangers themselves or other people in the community. They refer people who appear inordinately anxious or depressed to the point where it affects their ability to function and complete the activities of daily living. In some cases, participants state that when a person's behavior escalates to a crisis situation, they refer them to behavioral health services. In other cases, when people are being treated by an emergency room doctor or a primary care physician for an injury (i.e., diabetic coma, broken leg), they are also assessed for substance use problems and, if necessary, a referral is made to behavioral health services.

> *I would say when it becomes obvious that there's a disruption to their life or their health, endangerment to themselves or to the community.* [Wethersfield]
>
> *Depression, anxiety, from all sorts of losses, and losing their abilities to do their day-to-day things.* [Norwich]
>
> *Most of the time if people come to us, it's not for a behavioral health issue … by the time we get through, we find this underlying issue of depression, cognitive issues, or something like that. That's when we look for the referral.* [Norwich]

Where people needing behavioral health services are referred

Of the 63 focus group participants, the majority had experience in making referrals of older adults needing behavioral health services. Table 5 lists places for referrals reported by focus groups participants. While by no means exhaustive, the list likely represents a good cross-section of organizations that receive behavioral health referrals. It is noteworthy that various hospitals, including emergency departments, and local mental health authorities are common.

Table 5. Behavioral health referral places

Behavioral health referrals	
Physicians	Hospital for an acute psychiatric stay
Clinical services	The Hospital at Hebrew Health Care
Gero-psychiatrists	Local Mental Health Authorities
Rushford	Northwest Mental Health Authority
Various therapists	Crisis Dept. of the Greater Bridgeport Mental Health
Danbury Hospital	Charlotte Hungerford Hospital
Sharon Hospital	Bridgeport Rescue Mission
Masonic Hospital	Alcoholics Anonymous
Nursing homes	REACH program, Bridgeport Hospital
Emergency Rooms	Saint Vincent's - Intensive Outpatient Program
Recovery specialists	Greenwich Hospital
DMHAS TREM[1] group	DMHAS Crisis Unit
DMHAS WISE[2] program	Institute of Living
CARE[3] Program	Reliance House
High Watch	Adler Center (Yale New Haven Hospital)
Stonington Institute	St. Luke's Elder Care Services' Gatekeepers Program
Middlesex Hospital - Outpatient	Generations Family Health (Willimantic or Putnam)
Day Kimball Hospital	Protective Services for the Elderly
UConn Center on Aging	United Services
MCCA - Danbury	
CHCPE[4] waiver	

[1]TREM - Trauma Recovery and Empowerment Model
[2]WISE - Working for Integration Support and Empowerment (Mental Health Waiver)
[3]CARE - Center for Assessment, Respite, and Enrichment
[4]CHCPE - CT Home Care Program for Elders

Others mentioned that referrals are made to Connecticut Community Care, Inc. to coordinate support services for people needing behavioral health services or to a Visiting Nurse Association if that service is needed. Some also refer to Meals-on-Wheels or to a respite care program for additional support.

Some participants expressed confidence in the available referral sources in their area, however they would like to have a better understanding of the scope of services in determining what place would be the best for a particular referral.

People or entities that typically refer people for behavioral health services

Focus group participants who are providers reported that they receive referrals from numerous sources. These are listed in Table 6.

Table 6. People or entities that make referrals

People or entities that make referrals for behavioral health services	
Self	Municipal agents
Family members (i.e., adult children)	Police
Neighbors	Fire department
Close friends	Medical offices
Informal gatekeepers (i.e., volunteers)	Doctors or Primary Care offices
General public	StayWell
Elderly outreach workers	Community Health Centers
Case managers	Hospitals
Social workers	Ambulance Corps
Shelters	Pain management specialists
Housing case managers	St. Luke's Elder Care Services' Gatekeeper Program
Resident Services Coordinators	Area Agencies on Aging
Landlords	Visiting Nurse Associations
Assisted living facilities	Connecticut Community Care, Inc.
Long-term care facilities	Department of Social Services
Group homes	Probation
Senior centers	Legal services
Postal workers	Protective Services for the Elderly
Beauticians	Faith-based communities
Town officers	Meals-on-Wheels

Several participants reported that a major source of referrals come from people who in their everyday contact with others interact with people who may be demonstrating a need for behavioral health services.

> *Meals-on-Wheels…postal workers, beauticians, just anyone out in the general community. Other seniors because they're the ones who are in contact with seniors. That's why we make presentations continuously at senior centers and to AARP, it's because they know seniors, and they're a major source for referral. About 40 percent of our referrals come in that way.* [Middletown]

Unique needs of persons age 55 and older

Focus group participants reported a wide range of unique needs of individuals age 55 and older. The need for geriatric provider services was mentioned most frequently. Other prominent themes included older adults' reluctance to seek treatment, comorbidity, medication adherence, addictions and substance use, and adjustment disorders.

Geriatric provider services

With unprecedented numbers of Americans nearing older age, the need for geriatric providers trained to handle the population's increasing, and increasingly complex, needs is evident in the responses of participants. This includes: a scarcity of available providers and geriatric

psychiatrists, the length of time one has to wait for an appointment, insurance coverage and network issues.

> *I would like to emphasize the fact that we don't have geriatric psychiatrists in our area, and so we lack people with the expertise to assess and direct the care*. [Norwich]

> *Our challenge with in-home counseling was the number of providers, there's a turnover in the agencies that provide that kind of support.* [Norwich]

> *Waiting to see a provider … it can take a couple of weeks or a couple of months.* [Wethersfield]

> *You have to be in the network. So your physician has to refer you to a physician in the network and there may not be a participating mental health provider in your network that you can get to.* [Wethersfield]

Geriatric provider services also included other providers' need for consultation in order to improve their services to the older adult population.

> *Professionals need mental health consultation, maybe for themselves, but also for the people that they serve. So definitely referral sources and streamlining referrals but also availability of consultation, further discussion like this – solutions come from discussion – so having opportunities for round table discussions around these things.* [Wethersfield]

> *My experience with working with our medical providers in the Northeast Corner is that it's, as you say, there's very limited time that they have to spend with people. I think the physicians are getting frustrated because there isn't a resource for them, either, at times.* [Norwich]

Provider services for older people needing psychotropic medications

Older adults needing psychotropic medications may have difficulty getting the treatment they need from providers because reportedly many prescribers are reluctant to treat this unique population.

> *The most difficult patient for us in the elder population is the patient with a delusional psychotic process … some people are afraid to treat older people with powerful psychotropics, for lack of knowledge and the additional training, and so these patients do get better, but very, very slowly because of the reluctance of prescribers to treat those patients. As you know, APRNs now are doing more of the primary care and the psychiatric care. In fact, we probably had four psychiatric APRNs in the recent months, but even the ones who have been there awhile are reluctant to prescribe for the older adults, because of the fears of the drug sensitivities and side effects.* [Norwich]

Provider services for people aging out of DSS

Aging out of DSS and concerns about provider services for this particular group of people were also mentioned.

The other part of the problem that we're seeing is the aging out of people who already have identified mental-health issues, as they age out of DSS, and it's like, now what? We're seeing people turned over to Medicare and good luck and particularly if there are complicating factors. I'm thinking, because I have a couple of cases right now particularly of people with bipolar or hoarding tendencies that they begin to get in difficulty there because there's no direct case management until another crisis occurs. [Middletown]

Reluctance to seek behavioral health treatment

Focus group participants reported that many older adults are reluctant to seek behavioral health services. Some informants listed denial of need for behavioral health services and stigma as reasons for older adults being more reluctant to seek the services they appear to need.

Older adults don't come seeking [mental health services] primarily, but it's something we uncover in the assessment process. And because they don't come seeking it directly it's very difficult to then facilitate referrals to the appropriate place because their identified need is not, "I'm not looking for … I don't want to see a psychiatrist. Don't tell me I'm crazy." [New Haven]

Often times, they're very reluctant to get the treatment until there's a crisis – and that can be police or somebody threatening, a health crisis, whatever it is. It's usually a crisis that puts them into the situation – the hospital or whatever it is – to get the help. It's kind of enforced on them instead of them seeking it. [Wethersfield]

The 70, 80, 90-year-olds are not so willing, so even though they can be identified as having behavioral health issues, even though they may be getting some psychiatric medications from their PCP, they're not willing, even if there was services out there. [Norwich]

Denial of need for behavioral health services

Participants noted that although people with behavioral health problems need help, many tend to deny the need for such services. Some participants referred to it as a generational divide and noted it is more common in older adults than the baby boomer cohort.

We've encountered…people who are in desperate need of help, but they're just well enough so that they're not committed to hospital or what have you. They just manage to stay out of that sort of service and deny themselves what they need. It can be very frustrating. [Middletown]

They come in for a physical concern, because that's something that you go to the doctor for, but if your brain hurts, they're still this like, we're going to be fine, I'll-pull-myself-up-by-my-bootstraps-type mentality, which is why, when you're a provider … we really do fund things like food and fuel, it is challenging to have those conversations with 55 and older. [Willimantic/Putnam]

Again, for me, it's a generational different divide and the pre-baby boom era that they did not talk about their problems. They pulled themselves up by the boot strap attitude … [Torrington]

Stigma

Stigma or negative attitudes and belief toward people who have a behavioral health condition are common and difficult to overcome for many people struggling with behavioral health problems. Some of the harmful effects of stigma result in reluctance to seek help or treatment. Participants noted the difficulty that occurs in trying to help people who need help.

> *There's a huge problem with the stigma of mental health treatment, just even getting in the door and explaining why I'm there, how an intervention-like therapy could be effective.* [Wethersfield]

> *Well, probably the older the adult the higher or more significant the stigma. In today's society, it's almost cool if you have a mental health need and you get to go into rehab and all this, but with the older adults they really view that as a character weakness, that there's something wrong with them.* [Norwalk]

> *People who are developing mental health issues later in life … they're not used to going to a therapist or a psychiatrist. They're not used to taking psychotropic medications. So this is all new to them … there's the stigma they have to get past.* [Bridgeport]

> *I find that any type of talking openly about any type of help they may need in terms of maybe seeing a psychologist or anything for your mental health, that's almost an area that is very difficult to get into because there's a stigma, particularly in older adults … I see that as a big issue … They're also so very private and God forbid you ask them a question, "Me, of all people? You're asking a 70-year-old if I have an addiction problem?" You know what I mean? I could say, "Yeah, it's very common and it's okay to say yes or no," but they'll take offense to that.* [Torrington]

Comorbidity

Comorbidity and the potential interactions between illnesses that can worsen the course of both, was listed as a unique need of those age 55 and older because it is experienced more in that age group than any other. Besides the generational divide noted between older adults and baby boomers, differences in comorbidity were also underscored. Boomers have a greater prevalence of substance use disorders and dependence on illicit drugs than previous cohorts and this cohort's size alone is predicted to double the number of people needing care for substance use disorders (Substance Abuse and Mental Health Services Administration, 2012). Multiple risk factors associated with substance abuse among boomers include a number of psychosocial variables such as stress, isolation, loneliness, the onset of illnesses, and depression (Patterson & Jeste, 1999). According to the Centers for Disease Control and Prevention (2010), boomers are evidencing depressive disorders at significantly higher rates than older adults, and these disorders are more common among individuals with chronic conditions (Barry, Murphy, & Gill, 2011; Lin, Zhang, Leung, & Clark, 2011).

> *One thing that is pretty obvious is just the mix of medical issues – functional ADL-type issues – with mental health issues and that doesn't happen so much in any other age group.* [Wethersfield]

> *On my case load, I find that the people that are just entering the 65 and older, are where I'm seeing like, wow, now we've got like all these psych issues, plus health issues, and I*

see it more with the younger 65 to 75, they're just coming in, and now it's like, bam, we've got all this stuff. [Norwich]

I would say a big issue that we're noticing is that as people get older their medical needs increase and if they've been on psychiatric medications for years they develop obesity and diabetes … It creates more and more problems and their med list keeps growing and growing. [Bridgeport]

What happens to a lot of our people, unfortunately, is they'll go to the ER because they're having some kind of a medical situation, and as soon as they find out they're a psych patient, they're sent right over to the psych side and not even addressing the medical concerns, and it happens quite often … and we've had people sent back to our residential programs in renal failure because they're like, "Oh, it's just their mental health," and then we send them over to a different hospital and they're admitted that day with renal failure. So that's a huge concern for us. [Norwich]

The state has to recognize that you have to have specialized services for elders. You can't have a one-size-fits-all mental health system … it's understanding a lot of medical, comorbidities, and understanding how the medical affects the mental health first, and then you look at mental health. [Wethersfield]

Older adults with HIV/AIDS and Hepatitis C

Some participants expressed particular concern about patients who have a mental illness and HIV/AIDS and/or Hepatitis C. Nearly one-fourth of all people with HIV/AIDS in the United States are age 50 and older, but there may be more cases than that (U.S. Department of Health and Human Services, National Institute on Aging, 2014). Some participants expressed concern that because doctors don't always test older people for HIV/AIDS, some cases may be missed during routine checkups.

Another population that we've recently found a greater need in is the elderly with HIV/AIDS … they have been contacting us for services. They don't know what to do in terms of medication. What's appropriate, what interacts with the psych meds. [Bridgeport]

There's a higher rate now that have [HIV/ADIS] because they probably grew up in a more sexually permissive environment at that time, so then when they get older, they don't really think too much about it … There is no or minimum HIV support … and that's something that needs to be. I mean, that creates a lot of anxiety. [Norwalk]

Medication adherence

Nearly 20 percent of community-dwelling people age 65 and older take 10 or more medications (Wick, 2011). Participants noted that as the use of multiple medications increase, older adults frequently find medication adherence progressively challenging.

One of the big areas that we have been trying to do something about is medication adherence with mental health drugs because we find that the adherence is just problematic … Just getting them filled can be embarrassing for people. A big problem is

drug interactions between the mental health drugs and the physical health drugs… more often than not they'll opt out of the mental health one and continue to take the physical one. [New Haven]

A lot of my cases, older adults have a phobia against taking any type of drug for mental health issues … [Torrington]

They'll go to the pharmacy, or they'll go to the doctor, they'll have a new prescription, a couple weeks later you'll hear, oh, yeah, I was supposed to start it but I didn't get to the pharmacy. So it's a major issue, this medication management issue. [Norwich]

Addictions and substance use

Addiction, particularly the use of alcohol and prescription drugs among older adults, is one of the fastest growing health problems facing Americans (Bogunovic, 2012). Addictions also include hoarding, which increases the risk of falls, has the potential to exacerbate chronic conditions, and may increase social isolation (National Association of Professional Geriatric Care Managers, 2010). Participants shared their concerns about how addictions present unique issues among older adults.

With the seniors that are coming up, there's going to be significantly more addiction issues. Number one is because it's a larger population and, of course, alcohol is still going to be the major part of the mix. So the need is so great to address this population that is coming forward and there should be more state resources to fund what has started now. [Torrington]

Well, when they were in their 40s, they could take the cocktails, but as they get older, they can't metabolize the alcohol as well, and, so, it turns into a behavioral problem, and then they become dependent on it. So what you're trying to do, I think, which is excellent, is circumvent it morphing into dependency that they then lose control of, right? [Middletown]

[Many] baby boomers have experienced multiple drug use, and they've ended up usually with alcohol dependency. [Middletown]

Two percent of adults over age 50 are using illegal drugs, primarily marijuana … This is why we're very concerned about what's going to happen with legalization of medicalization of marijuana. [Middletown]

Well I think we need to think about the evolution of the further understanding of hoarding, because at one point we had about 6 hoarders. [Wethersfield]

We recently had a hoarding forum in our town that was open to the public and we also had professionals come during the day so they could get excess information and resources and tools. We had about 100 people show up and we weren't sure if people who hoarded were going to show or if it was just going to be people who were concerned about people. And we didn't really know until the end when he offered a free clinical trial, 3 people jumped up and said, "I'm a hoarder. I want to sign up." And that was unbelievable. [Wethersfield]

Age-specific groups

In helping older adults who seek support for addictions and substance use problems, participants underscored the need to do so within peer treatment groups because their needs are different from other cohorts.

> *And one of the things I have to emphasize is that when we started the senior group … for addictions, they were so happy. They were so happy when they got there. Nothing existed at all before that. They were just dropping out of treatment. They could not engage with the groups … One of the people I have now said that she was in a treatment program, but they were all very young people, and she couldn't relate to them, and she's only in her 50s. She's not like an old, old adult. So I think it's very important that the emphasis be put on peer treatment groups and not put in with the general population because it really doesn't work.* [Middletown]

> *And so they'll come to our group, everyone's their own age, which it's important in the mental health field to have age-specific groups so everyone could benefit because if an older person goes in and they're in with a group with a bunch of 20-year-olds in treatment and they're all talking about heroin and et cetera, and being on the street, and rap music, for example, that might not be comfortable generationally – So if you have a group tailored to their needs, they're more likely to respond than the more senior members of the group, and many of them are sober for years.* [Torrington]

Adjustment Disorders

Difficulty adjusting or adapting to changes in life were reported to be another unique need of individuals 55 and older. Adjustment disorders typically involve struggling with some kind of loss and subsequent anxiety and depression.

> *A lot of our clients face anxiety and depression. That's one of things that we always see with the 65 and over population…we do have social workers that we refer them to but they want to be able to associate with other people that are going through and having the losses that they've been through. We do have adult day care that they can go to, but it's not the same as trying to help them go through the losses and the grief that they have.* [New Haven]

> *For me, it's loss. I mean, their loss of health, loss of family, loss of friends, they're retired, and then there is a loss of 'What's my purpose in life?" And as far as I'm concerned, that's my biggest thing that I try to address because if they don't see a purpose in their life, then these complications get worse.* [Torrington]

Loneliness

Lack of engagement with others, isolation, and loneliness were reported in association with adjustment disorders and as unique needs of people 55 and older. Understanding why people in later life are affected by loneliness is important because it is associated with adverse outcomes that may be avoidable or at least modifiable (Kamiya, Doyle, Henretta, & Timonen, 2014).

> *I come across people who are isolated and encounter loneliness and isolation from family, from friends, maybe family had moved away or whatever reason, they have no*

contact with their family. I see that as a big issue. [Torrington]

Whenever I meet an older adult, I try to find out where they're connected … because if they're not connected with anyone, that's a danger, and if they don't feel like they have a purpose or a connection, then that's another major problem. [Norwalk]

There are people out in this area that are, we're talking a lot about the Willimantic area, but there's people, and in your area, too, that are out in the country, that are very, very isolated. [Willimantic/Putnam]

Barriers and gaps

Focus group participants reported numerous barriers to older adults' access to behavioral health services and gaps in the services themselves. Barriers are the limitations that cause gaps in access (i.e., lack of transportation). Barriers that were most frequently mentioned were regulatory and systems barriers (e.g., Medicare/Medicaid, including high deductibles), housing, transportation, language, and other resources.

Barriers

Regulatory and systems barriers

Participants' frustration with state regulatory and systems barriers include the restrictive reimbursement policies of the Medicaid and Medicare programs and private insurers. This significant barrier was also addressed in the Trust for America's Health *Healthier America 2013* report that recommended the Centers for Medicare and Medicaid Services clarify states' ability to reimburse a wider range of health providers and pay for additional covered services under Medicaid (Levi, Segal, Fuchs Miller, & Lang, 2013). Other systems barriers included access to DSS and post sequester allocations for Title V. [Senior community service employment program.]

A third of our patients are 55, 60, and older … Medicare does not recognize IOP [Intensive Outpatient] elder care. So billing is really complicated, and patients and families have difficulty dealing with the billing aspect of it because some charges aren't covered. [Norwich]

Age 55 to 64 is kind of a subgroup because at that point they're not qualifying for Medicare, and so sometimes they can't access the same services that someone that is 65 and over. Usually when you think of Medicare you think of hospital-based services. So if somebody is 55 to 64, then their insurances may not be being covered by hospital-based services, and often times that's what they need. [Norwalk]

Medicare covers LCSWs and psychologists but not licensed professional counselors or marriage and family counselors. So that is a big problem because there's a huge amount of providers out there that cannot accept older adults on Medicare. That's a big issue. [Wethersfield]

Any inpatient service to address addiction is not covered through the insurance care that they have, which is another huge issue. [Torrington]

The other issue is that things have changed so fast so hard with insurance that the persons that are in the system, knowledgeable, sometimes they don't have a clue what's going on. They're trying to figure it out and with all the Access Health Connecticut, etc. and with the Affordable Care Act, it's just that everybody's trying to figure their way around at this point. So there are some systemic things that are happening there -- it's a whole new landscape. [Torrington]

Rather than having programs that meet the unique needs of individuals, we have boxes that we try to figure out, which box do you fit in the best, because we don't have, we can't create in fact what you need because of the silos in our waivers and the barriers that we have created with our policies that determine which program you belong to and how you get there. We can't overlap. [Norwich]

Because of behavioral health, the reimbursement is poor, and when you put Title XIX on top of that, it's really, really poor. [Norwich]

People who are dealing with addiction issues – heroin, alcohol, and people who are attempting to self-medicate because the medicines that they need are not covered by their insurance plans or they don't know another resource to get the medicines that they need, and then it kind of spirals down from there. [Middletown]

Prescription costs, depending on what their coverage is, can be exorbitant. And they're picking and choosing and we've had situations where people aren't taking their heart medication or getting their insulin because they have to pay what they deem a more important bill and so then things fall apart medically or mentally for them because they're going without their medication. [Wethersfield]

I know some of my coworkers were talking about how if there are any kind of entitlements, how nowadays it's almost impossible to get through to DSS … If you're on the phone for hours and if the person has a cell phone, all their minutes get used up because it could be hours. They have to go and wait in line for hours. [Watertown]

So if I have a senior now applying for Title V, their name on the list won't come up until close to, now, a year and a half later. So there's almost no point in applying if it's that long of a wait … prior to the sequester, I was able to refer to Title V, within a couple of months, their name would come up and be respond and I would have them working within a 4-month period. And for me, we're talking recovery, so that's a huge thing to enhance their recovery efforts ... You lose that year and a half of not having a purpose in life and it's huge at the end. [Torrington]

The Community Mental Health Center always did and I think they still do have like these SWAT teams that for emergency things in the community. It's really quite impressive and they're immediately responsive but they never would provide those services for older adults and I think it's related to a funding issue that they don't take Medicare clients and the older adults are on Medicare. That kind of model is something that we always wished was in place because when there's a need and it's right that minute … With older adults, the immediacy is really quite critical. [New Haven]

Housing

Supportive housing is a particularly critical resource and source of stability for people with behavioral health issues. Many focus group participants expressed concern about the housing barrier and associated issues including difficulties in finding housing for people with a criminal record, long waiting lists, appropriate environments, and feeling safe in a particular setting.

> *We are continually looking for the virtually nonexistent resource of supportive housing. There is so little. If there was just one resource that I could see increased to help individuals with mental illness it would be supportive housing. Ending the hospitals was great, but there's a big difference between hospitalization and fully independent in the community.* [New Haven]
>
> *We're seeing a greater need [in] a lot of housing instability and homelessness, due to some behaviors and being unable to maintain their residence at a board and care, or in subsidized senior housing in the community …* [Norwich]
>
> *Housing is always a challenge because again, for somebody with a history of mental health or substance abuse issues, along with it sometimes comes prior criminal record, poor credit history, etc. So trying to secure housing can be extraordinarily challenging.* [Wethersfield]
>
> *We have started to see that some of the population with behavioral health issues are also involved with the Department of Corrections and that creates even bigger issues with regards to housing and getting them support.* [Norwich]
>
> *The state does have a couple of pilot programs where like in Tower One, they pay for assisted living but the number of apartments available for that in the state are so few and the need so great … if they could work out something with the assisted living facilities, the private ones, some kind of a rate that would be acceptable, I think it would be a very good solution.* [New Haven]
>
> *What I've been seeing is people who have been in the workforce their whole life and maybe they have one chronic medical condition and now there's a terrible lack of senior housing, affordable senior housing. So these are people who have owned their homes most of their lives but now their retirement income is not enough to help them pay their taxes, keep the yard work, pay the bills. Now they apply for senior housing but there's a wait list. In our area, we've been told 4-6 years at some of these senior housings and then they finally get to the list …* [Watertown]
>
> *We have multiple clients that are living in housing that's literally falling down around them. Some won't leave; some can't leave. They've had reverse mortgages … We worked with the town social workers or the resources because we don't have a funding. We have independent living funds but it's minimal, but we've actually paid, just recently -- we can't do this all the time but we pay a bill here or a bill there to head off. It's a Band-Aid – housing. And that's a big thing because where's the housing going to go?* [Watertown]
>
> *Some things that my clients encounter issues with are housing situations because once they leave the nursing home it's really hard to find an appropriate place for them*

because they might not be able to go home because they need more supports than that. Then a residential care home or group home is great but they might not qualify for that. They might need a little bit more intensive services than that. It's difficult to find something that's very appropriate for them. [Bridgeport]

A lot of our clients who live in Stamford or Greenwich, it's very difficult. We have to see are you willing to move more north. If they do happen to have family or doctors or supports that are in the Stamford more south area that they might not have any choice and they might have to go north because that's where more of the services are at least. [Bridgeport]

Transportation

Transportation was viewed by participants as both a barrier and gap. In more rural areas, participants reported that it is a barrier because often there is no available transportation and people without a car cannot access services.

I really want to lean on the transportation piece of that. That is such a barrier throughout Connecticut. [Middletown]

There is no transportation, in Putnam, at least … If you don't have a car, you can't get anywhere. [Willimantic/Putnam]

I just saw a woman actually from Torrington the other day and it's, like, so complicated just to get a ride there. And she needs more intensive treatment and it's just a huge barrier. I mean, just in terms of getting to the appointments. [Watertown]

Transportation access to the outlying areas like Kent and Salisbury, and those are people out there who are so isolated that I know people out there with mental health and behavioral issues, they just can't access getting assistance. [Torrington]

Enfield finally got a bus, which had taken 6, 7 years, but there are a lot of outlying communities that don't have transportation systems. [Wethersfield]

So there is no medical transport unless you're dual eligible, Medicaid and Medicare. [Willimantic/Putnam]

Transportation, that's huge -- getting the person to the transportation because if they're Medicaid eligible, they can go on LogistiCare. If they're state-funded…they don't have that so now we have to try to get someone to bring them. But now if they have a medical issue that they're not safe on their feet, how are they going to get there? Families can't, won't, or they're not existent. So there's so many of these issues that are compounded on top of everything. [Watertown]

I've been in the field for 35 years and [transportation has] been an issue for 35 years and I'm still not seeing a lot of improvement, but I also think expectations are sometimes very unrealistic and I think we're seeing a generation now, a younger generation, where the expectations are even higher. I mean in Stratford for example for our residents we do provide a door-to-door service. But you still have to call a week ahead of time to get an appointment. It's not set up where we can do anything on the last minute basis or an

emergency basis so people are annoyed. We try to refer them to other resources. The Metro Taxi program, through the Kennedy Center, Greater Bridgeport Transit but unless they can have what I call a little "driving Miss Daisy" kind of thing they're still not going to be happy but I also understand that … There's still not enough transportation. They're not going where they need to go, when they need to go so there are all sorts of issues around that. [Bridgeport]

And then we haven't even discussed the people who live alone in the community, who have no resources, a lot of times no transportation. [Norwich]

So you may get [medications] prescribed, but folks don't either have adequate insurance to cover them, or they just can't access a pharmacy to fill the script. For us, sometimes it's a matter of transportation out here. [Willimantic/Putnam]

I too transport clients to their appointments because they don't know how to arrange them, they get lost, they get in the My Ride that's even kind of overbearing for them… Waiting for that service could be hours. If you're waiting a long time to see your doctor, then you miss your bus pickup time. And then you have to call for another bus to come. It could be two hours from that time. It's scary. I think about if we would go out there ourselves and put blind folds on our eyes and ears and see if we could navigate around the city. We wouldn't do it either. So it's scary. [New Haven]

Language and culture

Participants shared concerns about language barriers and cultural competence that may be more pronounced for older adults. Language appropriateness and cultural competence are important in improving access to health care and the quality of care and enable organizations to work effectively with the individuals of diverse cultures they serve (National Medicare Advocates Alliance, 2010). While the Spanish-speaking Latino population was most often mentioned, participants noted a large variety of other languages and cultures in Connecticut that may not be optimally served at present, including Albanian, Asian, Chinese, Laotian, Liberian, Portuguese, Russian, and Vietnamese.

I would like to talk about the language barriers because in Bridgeport we see a lot of Spanish-speaking clients that we serve. We do have Spanish-speaking care managers but not a lot and also for providers out there. So I think that's one of the other biggest barriers. [There's] not a lot of Spanish-speaking social workers to provide the services to the client even nurses, which is very, very difficult to find a nurse that will match up with that person to be able to provide them with the services that they need. [Bridgeport]

There is the Hispanic population. I've had some people that have not been connected, have no idea of the services that are out in the community. Even though they've had needs for a very long time, they haven't been caught yet. We have the people with substance-abuse issues, mental-health issues that are not connecting with services out in the community if they're homebound. [Middletown]

And in Willimantic, what we see a lot of is, because of the huge farm that's out here, there's a lot of migrant farm workers. So that, they're coming from these developing

countries with all kinds of issues that people have in developing nations, and we have a hard time getting them services again, because we don't have Spanish-speaking clinicians … It just makes it, makes it difficult. [Willimantic/Putnam]

There is a big gap in language and in service availability to elderly immigrants. [Wethersfield]

There's a great need for Chinese-speaking caregivers and translators. It's just a barrier. [Norwich]

I went crazy last week trying to find a therapist for a person who was willing to go into treatment, and could not get a Spanish-speaking person who could provide services to the person in Southern Connecticut. I had to send her up to Norwalk to an outpatient treatment facility. And we have Hispanic Clinica in New Haven but they had a waiting list and they couldn't provide services. [New Haven]

We've seen an increase in African immigrants … a lot of Liberians and some folks from Ghana who have come recently for services. I'd say like less than 10, but to us, that's an influx. [Willimantic/Putnam]

For 3 years, we've done almost nothing with the Hispanic population even though we're responsible for New Haven County, and that's what has a very large Hispanic population. We're very aware of that. [Middletown]

Well, it's not part of Spanish culture to discuss family problems with strangers. And, then, you have the same issue with African-American families in talking about AIDS, for example, in the black community. It's like kind of a no-no. It's a big barrier to cross. So, language and you also have to think also culture. What are our cultural understandings of behavioral-health problems could very different from what we think. [Middletown]

Other resources

Participants noted lack of other resources as additional barriers. For some situations, such as helping elderly hoarders deal with clutter in their living space, there are no available resources. Funding directed towards developing and supporting the health care workforce is also lacking. In addition, participants mentioned resources that exist but aren't being used in furthering communication and coordinating behavioral health services.

There's the hoarding and there's no resources for that and that certainly gets blown out. But there's also people who are just stuck and they say, "I got to clean out my house. I can't do anything until I clean out my house." And there's no resource, no family. You work with them and say, "Okay, take one spot a day." They don't have the ability to do that. There's nobody that can help. [Watertown]

I'm going to speak about DMHAS … and there's relatively no dedicated resources for older adults. We now have one person – one person in our whole system – dedicated to older adults and that's not right. [Wethersfield]

I think there's a lot of workforce development that needs to happen for all of the levels of care that people get. [Wethersfield]

Well, I can speak a little bit for the nonprofit sector, is that we haven't had a cost-of-living raise in 5 years, 6 years, so it's really difficult a lot of times to…we can't give raises, so it's hard to get good qualified staff to come in… [Norwich]

There has to be a communication and a coordination with the industry and the providers, to let them know how to train the individuals. Every provider that I've worked with for 17 years has said, we'd love to have our staff get more training. Where do we get it? Who does it? ... And then looking at who isn't at this table today. Housing's not here today. The resident service coordinators, are usually some level of social service training, and they're seeing this whole problem from a different perspective. The police and the fire department, there's some training that's happened for the police for mental health. Firefighters, they're the first ones in there. And so we're not using the many resources that we have effectively. We've got fragmented people who are all seeing this problem, everybody's doing a piece, we haven't got a vehicle to create a unified effort among us, and that would certainly improve things, and I think everyone I've talked to over time says, we'd like to make that happen. [Norwich]

Gaps

The gap mentioned most frequently by participants was provider services, followed by gaps in education, referrals, family support, and transportation.

Provider services

Gaps in provider services included services that aren't available where needed or can't be accessed by consumers because their insurance is not accepted. In some cases, there simply aren't enough doctors, such as psychologists or geriatric psychiatrists, to meet the specific needs of the aging population. Long wait lists and a dearth of wraparound services further widens gaps in provider services.

Shortage of providers, shortage of accessible providers – both physically and distance, and in what they have for coverage or what they can afford. [Wethersfield]

And there's the issue of a lot of providers not wanting to work with older adults … [Wethersfield]

So the other little gap is Visiting Nurses' Agencies. They're great and they can provide a lot of support in the home but they have a lot of rules too based on physical abilities and this home-bound status -- that there needs to be a physical need -- which as the population gets older, that obviously happens. But they have short term coverage, they can only provide services for a short period of time in the home until CCCI gets involved and they can provide a different funding source for more chronic care. But the visiting nurse agencies and their coverage through Medicare still hasn't quite caught up to the needs of the older population. [Watertown]

So from a systems perspective, there's a clear delineation between health and behavioral health and we are all whole human beings and we aren't separated like that in our own bodies. They're connected but yet the expertise – geriatric expertise, health and behavioral integration is just -- It's emerging, and that's good, but we have a long way to go. [Wethersfield]

What becomes an obstacle is the primary care physicians who are prescribing the psychotropic meds and then to get your person to seek additional assistance, "Well, why do I need that? I've gone to Doc Jones for 20 years. He knows me and he's given me medicine and I'm okay." Sometimes I'm not sure that the primary care physicians are totally up to their game on what's available and what's the best treatment … [Wethersfield]

I have to admit that access, Southeast Connecticut is very inadequate access because providers are there, but they either are private practice with private pay, or they're not accepting Medicare patients, or even for, like L&M, they have got a great psychiatric service, but they use intensive outpatient therapy a lot, and my seniors can't really adapt to that. [Norwich]

I had a conversation with a psychologist in early spring and he was saying that as the baby boomers are aging and getting older, there just aren't enough psychologists skilled in working with older adults and that's kind of a growing problem because … the older adults are far outweighing the psychologists who have the expertise in adult issues, particularly for behavioral health. [Torrington]

For behavioral services there's a long waiting list for that as well. For my program, for the mental health waiver and the nursing home diversion transition program they need to have a psychiatric appointment within 2 weeks from when they're discharged and if you call places like Southwest Greater Bridgeport you have a 2-3 month waiting list and we can't discharge them because they're only discharged with 2 weeks' worth of meds from the nursing home. So they have to wait 2-3 months. We can't safely discharge them. That's another issue we encounter. [Bridgeport]

We used to have a time when we would have the ability to meet with a couple of other geropsychiatrists – there was one in Glastonbury, the Adler Center -- and we either had a conference or sometimes they used to be able to have, when there were drugs coming out that were beneficial to elderly, we actually would have some education around the drug but also be able to liaison those other people and talk to them and say, "What are you doing?" But they just don't have -- nobody has time to take out of their day for the non-billable stuff. [Watertown]

There used to be a lot more daycare options for people, too. We used to have at least a couple of different programs up in Torrington … There is a gap that is a good alternate daytime option for people if they're willing to go in. [Watertown]

Some of those facilities like Hebrew Home and Masonicare actually do have delirium units now, which is better. [Patients] are actually seen and worked up more on a medical side. They'll treat the UTIs, they'll treat other organic causes to why there's a behavioral change. But that becomes a big dilemma too for facilities and the ER. So there seems to be like a huge gap. [Watertown]

Just calling primary care docs, just calling docs in general – they don't call back. I mean, not everybody but it's hard to connect. They're in with people, I'm in with people. It is hard. We'd lucked into some people that do some neuropsych testing that are pretty easy to get in - a group here in Waterbury - which is a Godsend because that has always been difficult. Just having that level of evaluation that accepts the insurances… [Watertown]

While the WISE program permits Connecticut to provide a broad range of home and community-based services to people with serious mental illness, gaps in the level of services and supports needed for many consumers were mentioned. Gaps in services also occur when there aren't providers with specific expertise in an area of behavioral health or when staff call out and replacement people are unavailable.

[WISE], a mental health waiver for people to divert them from the nursing home situation, is not a 24/7 program. So they offer maybe 6 hours a day, which is wonderful, but a lot of the folks we work with really need a 24-hour support, and need more supports than what we can … So we're kind of stuck. We're finding some people are falling through the cracks, and we're not really sure, a lot of them will end up in nursing homes when they really could be in a lesser level of care, but we just don't have it. [Norwich]

So one thing that we haven't mentioned at the table here today is obsessive compulsive behavior and eating disorders, and there are a lot of people who are struggling with those issues, and to try to find anybody who can address that is huge, to try to find a practitioner, someone, who when we have someone who has got everybody up in a stir because there are safety concerns that we're trying to figure out. Should this person be conserved or not? We don't have a good resource that can go into the home even, because sometimes getting people to come out is a challenge, who will be willing, who have the skills to go in and figure out, is it dementia, is it mental illness, and with the mixes of problems that they have, do they have the capacity to manage their own affairs, or, in fact, should we be seeking conservatorship for them, and the judges today want clear, convincing evidence. So the language that's been used in the past is not sufficient and we have people who are engaging in activities and behaviors that the rest of us looking on say are really risky and dangerous to themselves and others, and we have a hard time trying to sort through that. [Norwich]

People calling out, and so there's nobody to fill the shift that day, so someone's left alone for a full day, and that happens quite often. [Norwich]

Education

The need for education was underscored by participants and includes the importance of raising awareness about mental health issues among providers, families, volunteers, and the general public.

You need to have specially trained staff who understand older adults, the cultural issues, the generational issues, the medical issues, and you can't fit everyone into the same box as adults, young adults, children. There really has to be a specially trained workforce to

address the needs of older adults, and we have a whole population of severely persistent mentally ill folks who are aging very rapidly, and we have their parents, who are taking care of them, who are aging even faster, and are older, and what I see in the crisis field is that we're coming to this double-headed monster. [Wethersfield]

I'd say education. I don't think that I'm aware of many of them that must be out there and maybe the referrals I could be making that would be very effective but I don't even know about. Some kind of newsletter or speakers program to go out and let case managers and doctors who serve the Husky population … know what's available. [Bridgeport]

I think that the other piece that I would bring up is training in terms of elderly issues … introducing that training-wise to everyone who comes through is probably a good idea. It should be a mandatory piece, because most of us, again, don't know what's available, and really don't know how to work with the population. [Willimantic/Putnam]

The providers are not trained to provide those who understand working with older adults, and who engage older adults, and understanding their medical comorbidities, and I don't think there's enough specially trained people. [Wethersfield]

So educating the folks who are doing the assessments, to separate out the aging issues, the mental health issues, would be very helpful, because oftentimes we try to stay ahead of it. [Wethersfield]

[Mental health] education needs to apply to their families as well. Particularly adult children or grandchildren who are involved with that person connected with them and starting to see the changes and I'm looking at things like the depression, the anxiety. Not knowing how to help this older person because this is all so new for the family. It's not something they have a history of living with. So they haven't had years to learn and adjust. And it can often be traumatic for them as well. [Bridgeport]

I mean I see a huge gap in education here just even in terms for families as we're saying about how families understand. They have someone who has an elderly father and once he started to actually do research on what dementia is he's like oh he keeps mumbling these particular words or laughing because that's a part of dementia and he was thinking he was losing it. So how do you educate people to understand what's normal in the aging brain, like you were saying, and what behavior that needs attention? [New Haven]

We're trying to develop a trained Volunteer Corps that's trained both in the mental health and the physical safety components of addressing hoarding, so that's our dream vision but yeah, that's the gap – education a huge cost factor, and liability issues, "Who's going to finance that?" [Wethersfield]

Referrals

Participants shared concern about limited knowledge of where to refer to and the need for training to expand knowledge regarding referral options. There was also concern that SBIRT, a public health approach to the delivery of early intervention and referral to treatment for individuals with substance use disorders, does not include a mental health component.

There's not a lot available around here … but I think that the elderly that I have worked with, I'm at a complete loss as to, for referring them to different services and things like that, because I think that there's, for what is available, there's not any knowledge about what's out there. I don't know what's available to them. [Willimantic/Putnam]

We get a lot, in primary care, about patients coming in, who say, you know, I'm trying to take care of my children, I'm now taking care of my parents, and I'm at my wits' end, what do I do? But there's no place that you can even say, call here for some services. [Willimantic/Putnam]

There are a few geriatric psychiatrist referrals. Competency certainly is an area in which there's a lot of evaluation that's done but for individuals who are experiencing depression/anxiety or some new situation, it's difficult because the go-to referral sources or the go-to agencies and providers -- I think we're too limited in what we know about the go-to. I think there's definitely an expansion and growth in this area that is untapped and we generally tend to go to the same providers over and over and over again and we're not looking -- We haven't developed strong networks with providers we're not accustomed to such as local mental health authorities or other outpatient -- The resources that have been available for years, I don't know that we have the strongest relationship to make the referrals more seamless so it doesn't feel like it's a barrier, like a system issue, a bureaucracy that is kind of getting in the way. Sometimes it's just not having the relationships. [Wethersfield]

Unfortunately, a lot of the programs, more structured volunteer programs that use to exist, funding has dried up for that. It would just be nice if there could be more funding so that some of those programs could come back to being in existence once again. We try to connect them with families if they do have them. We also have a part time family care counselor who will try to work on bringing families together to sometimes look at their way to share some of the responsibility of helping out this person. We don't have a lot of other resources that we refer them to. [Bridgeport]

A lot of our clients face anxiety and depression. That's one of the things that we always see with the 65 and over population but there's not a lot of, we do have social workers that we refer them to but they want to be able to associate with other people that are going through and having the losses that they've been through. I haven't seen any of those that I would be able to refer them to. [Bridgeport]

Referral services like she had mentioned earlier. I worked in both the Hartford region and now the New Haven region and I could not tell you where the services are for [referrals]. [New Haven]

One of my biggest concerns, though, about the SBIRT is that there's no mental-health component to it. It's all substance abuse. [Norwalk]

Family support

Understanding that informed and engaged families can lead to better mental health outcomes for people with behavioral health issues (National Alliance on Mental Illness, 2013), participants underscored the need to support families.

Being able to offer the family support so they in turn can continue to be supportive of that individual. I think that's a huge gap that we encounter a lot. And I know with my family caregiver a lot of the education she does one-on-one with families is helping to explain the hows and whys of certain things. We'll talk about their medications, if they're on them. Or if they're in one of the early stages of some type of a dementia and they've been given medication for that. So a lot of the education is needed for the family as well as the older adult. [Bridgeport]

We see a lot that family members are rather burnt out on their relative. Maybe their relationship wasn't the Waltons, and they're a little contentious, and there's resentment, or I'm just tired of dealing with that person's shenanigans. I can't do it anymore. I have my own life. I have my own family I have to raise and take care of, and I'm tired of having this person be combative with me all the time when I'm trying to help, they don't let me help, now I'm done. And they just kind of wash their hands and walk away. And, as hard as that is, I sort of get it. You can only put yourself out there so much and not have the professional background or resources and try to deal and cope and understand. [Middletown]

But we do have a lot of caregivers who call us who are concerned that they're having trouble managing. They're concerned about their health, their stress level because of caring for someone who has some mental health issues … the adult children and the grandchildren that are all affected by this one individual within the family unit or sometimes there's more that have been inflicted with mental illness. So, I'm hoping that strategically we can all come up with a better way to service our people in the community. [New Haven]

So, I mean, there is the respite program through Western Connecticut but, you know, there's an application process, there's financial requirements, a doctor has to fill out a form … So I know it's been helpful for some families to get funds for respite stays or to have people help in the home but it's quite the process and if you're exhausted, you're not going [to follow through]. [Watertown]

Transportation

Transportation was viewed by participants as both a barrier and gap. In more urban areas, participants reported gaps in transportation are common, but this was suggested for rural areas as well. Cost of transportation was underscored as an associated issue.

So there's like a huge gap -- in the transportation and getting people to outpatient appointments and… It's just our Torrington is just so rural. [Torrington]

Even if they have transportation, it's just that some can't even afford it. So they're just getting by and I'm sure that that adds to their disparity, depression. [Torrington]

The transportation piece is extremely important. We have a couple of residents who need to go to East Hartford for their treatment, and that's quite a jaunt from New Britain. It's 2 bus services, and then there's the cost that's involved. So, it's problematic. And the other thing is, when they have local transportation, they can stay within New Britain, but if they have to go out of town, it's like it ends right there. [Wethersfield]

As long as they're a DMHAS client, Monday through Friday, from 9-4, arrangements can be made for transportation. When you get out to Canaan and Salisbury and those type areas, then it's extremely complicated and some of them don't have transportation. [Torrington]

Also, we all mentioned transportation is a big thing because there is LogistiCare. There is My Ride. There is the bus but not everybody is high functioned enough to be able to use those services or they might not be by a bus route or sometimes LogistiCare takes an hour or 2 longer so then they might miss their appointment because of that. Those are some of the issues that we encounter for our clients. [Bridgeport]

Barriers and gaps throughout the state and in rural areas

Differentiation between barriers and gaps throughout the state and in rural areas were reported less frequently.

Statewide

Statewide barriers and gaps focused on the lack of or limited services and resources and the need for statewide coordination of services and training.

The long wait at the VA Medical Center – a lot of my elderly male clients only use the VA as their total healthcare and to get counseling there is a very long wait. [Wethersfield]

Inpatient substance abuse treatment – like a 30-day program rather than just detox for older adults. I think that's not available in Connecticut at all. [Wethersfield]

I called 211 and they're telling me they'll get back to me in 24 hours if I leave my name and number and I'm saying to myself yeah, no. I mean I needed something right then and there. And I didn't want to call the police and I didn't want to call 911. That was not appropriate. But it was trying to find resources. [Bridgeport]

My experience with 211 is often similar. It's a waiting game at best. [Bridgeport]

Part of it is to also make sure that we are looking at our emergency services and the larger organizations around the state, to make sure there's a certain level of competency and education related to elders and mental health, and how they blend together … being able to have some kind of curricula that would say, this is what you need to know, this is the standard in Connecticut … that would be a good foundation. [Wethersfield]

Just in general, referring people to mental health services aren't really clear in the state of Connecticut, as far as statewide coordinated services, so I think it would be helpful if there was more education around how to do that … Even with the local mental health authority in their region, I think that's a huge need. [Willimantic/Putnam]

Rural areas

Barriers and gaps in rural areas focused on not having enough or specialized services and programs. Reimbursement for in home services is reportedly an issue for people needing those services in rural areas and the lack of tax relief programs is also burdensome for low-income older adults.

> *As a behavioral health manager, we do get a lot of referrals. However, we only have so many clinicians, so our difficulty is trying to see them all. A lot of it is not dementia, it's other causes, but it's frustrating trying to find resources for them in this neck of the woods, to be honest with you … even at our resource centers for seniors, or the senior centers themselves, I think a lot of them are placed there in hopes of getting some kind of service, but they don't. And so I think that's our struggle on, in this neck of the woods there's just not enough services around.* [Willimantic/Putnam]

> *That services aren't there, that transportation isn't there, that even if we had the best program, the best system in the world in place, there's nowhere to refer anybody… the fact that we're hearing that getting those mental health evaluations done … for dementia and for behavioral health issues, and then not having services available in the area to refer to. I think it's a key gap, and key piece of information.* [Willimantic/Putnam]

> *So we coordinate with all of you to try to get the services in but, as I said earlier, we've got good services but not all of them are the specialized services needed. In one of the communities that I manage, which is in the Torrington community, we're more rural. So some of the areas that are rural versus urban, there's not as many resources.* [Watertown]

> *And then we'll go from there and possibly talk with them about maybe getting some referrals for counseling, that are contractive counselors, agencies -- which is a gap and would be good if we had more, especially again in the rural areas -- more access to counselors that will come to the individuals.* [Watertown]

> *The Gatekeeper model, I think that's really a beautiful model to follow. However, it's located in the southern part of the state and they're expected to do our region, which is impossible. So the Gatekeeper program is really absolutely useless for Northwest Connecticut.* [Torrington]

> *Out in our rural section, many of our residents are land rich and cash poor and they want to stay home, they can stay home, they can't pay their taxes and have a co-pay for CCCI, they can pay their taxes but they can't get their car fixed or pay all their medications. And there are very few tax relief programs geared towards seniors. There's the state one but our municipality does not offer an additional tax credit for low-income seniors.* [Wethersfield]

> *A huge problem the state has to address is reimbursement for services in the home for elders who live in outlying areas of North Central Connecticut, where there's no transportation and people cannot get in to get services, and they are languishing in their homes because the state does not pay for in-home services for mental health treatment… so even if someone wanted it, they cannot get it.* [Wethersfield]

Underserved subgroups

When asked if they see any subgroups within the older population that are underserved, participants mentioned the age 55-64 group most frequently. Other subgroups noted include:

- racial and ethnic groups
- older adults with disabilities
- deaf and hearing impaired
- persons with cognitive impairment
- persons with substance use disorders
- persons who are retiring
- older HIV/AIDs population
- homeless
- low income elders
- veterans
- grandparents caring for grandchildren

Age 55-64

Persons age 55-64 were reported by participants to be a subgroup primarily because of the issues people in that age group have related to lack of eligibility for Medicare and coverage for other services.

> *The age 55 to 64 is kind of a subgroup because at that point they're not qualifying for Medicare, and so sometimes they can't access the same services that someone that is 65 and over. Usually when you think of Medicare you think of hospital-based services. So if somebody is 55 to 64, then their insurances may not be being covered by a hospital-based services, often times is what it is which they need.* [Norwalk]

> *I had a resident who was, he was like 63 and he couldn't get certain services because he was 63. He wasn't 65. He was 63, disabled and I couldn't get him Meals on Wheels. I could not get him anything in my area. Nothing. And it was a huge challenge for me. We literally counted the days until his 65th birthday. So that was huge.* [New Haven]

> *Well, I have found it difficult for people from 55-64 where they just fall short of a lot of services. I mean, I see some early-onset dementia patients, which is really heartbreaking. I mean, so they're 55, 56; it's a lot more progressive; families really struggle because there really is very little for that particular age group.* [Watertown]

Racial and ethnic groups

Racial and ethnic groups may encounter additional difficulties in accessing mental health treatment. Accessing services is a complex issue for underserved groups and may be due to poor interactions with providers, transportation, homelessness, not meeting eligibility criteria,

and difficulty understanding how to navigate the mental health systems (Lamb, Bower, Rogers, Dowrick & Gask, 2011). Additional difficulties may include personal, cultural, and social beliefs surrounding mental health concerns and the stigma associated with care and treatment options (Lamb et al., 2011).

> *And then we have a lot of, we're seeing a lot more Asian people coming in so and that can be a challenge.* [Bridgeport]
>
> *And a lot of more the Hmong population is very big in Eastern Connecticut.… Croatian, Bosnian, Serbian – we're seeing a growing population in Hartford and the surrounding area. East Asian.* [Wethersfield]
>
> *I can tell you what I see in Waterbury… we've seen a growing number -- of mostly Hispanic families who are bringing their elders over from Puerto Rico, who have never been here before, and now they're presenting to us in the Emergency Room or in our program. So now we have somebody who's probably their whole life been with a diagnosis of a chronic mental health issue, like schizophrenia or bipolar disorder. The majority that I've been seeing also seem to have some developmental delays probably -- I mean, average education is 1st or 3rd grade, is what I've been seeing. They're illiterate, cannot read or write, and now we have the aging issues on top of that.* [Watertown]
>]
>
> *There's a Chinese church in Norwich, and I reached out to them and said, hey, I need some Chinese-speaking people who are willing to like be a companion or be a homemaker.* [Norwich]

Adults with disabilities

Participants expressed concern about the paucity of services for adults with co-occurring physical disabilities. This population is increasing and as they reach older adulthood will likely continue to need additional services.

> *We have one client [who] has mental health issues but she also has MS and we find that it's very difficult to find services for someone who has MS especially if she needs support… there are very few residential services in Connecticut that can cater to people with not only MS but also mental health issues.* [Bridgeport]
>
> *A lot of the folks that we work with are having severe medical complications, and they're not even 55 yet. A lot of them are in their middle to late 40s, and they're having a lot of medical issues that maybe 50, 60, 70-year-olds have, but because of their long-term psychiatric illness, lack of care, lack of being able to take care of themselves, the medications they're on, they're getting sicker and showing symptoms in their 40s…* [Norwich]
>
> *Sometimes the young-disabled – which fits into the 55 and older still – they have been living at home and the parents can no longer care for them or they've died. So we've also had more of an increase in that population coming into the housing authority and therefore the incidences increased.* [Wethersfield]

Deaf and hearing impaired

The deaf and hearing impaired community is diverse and as such has a broad range of support and service needs that need to be expanded and strengthened.

> *I would also say those who are deaf and hearing impaired, there's a significant gap in support and services for that population as well.* [Wethersfield]

Adults with cognitive impairment

Participants mentioned concerns about cognitive impairment that can range from trouble remembering, learning new things, to concentrating or making everyday decisions that impact their life.

> *It's not so much age in terms of a subgroup but it is that population that is starting to become very forgetful, making poor judgments and they are often still living in their own homes. So they might come to the senior center, but yet I also see them somewhat isolated. They'll tell you they don't have a lot of family support. They may not even have any family at all left, but we're starting to see changes in their behavior. We're starting to see, and they may even talk about the fact that they're not eating that well. They're trying to stretch their meds so they're taking them every other day instead of every day or they're cutting them in half or whatever they're doing. But it's all about saving money and sometimes they're in rather large homes … we very often see people who are clearly not living lives that are very healthy or very safe. But they don't perceive themselves as having a problem … And we try to look at creative ways to offer them support… Whatever it might be to offer them that little support they need to still stay on their own to still feel independent and yet we know that there is some capability that they are losing at this point. I think it's sort of that gap. They're not ready for the homecare services per se but they need something and there's no one around to give them that something so what can we do as a community to offer them that kind of support?* [Bridgeport]

Other underserved subgroups

Other underserved subgroups mentioned less frequently include:

Adults with substance use disorders

> *We have an outpatient substance abuse program at our facility but they deal a lot with the young population and sometimes it's hard to imagine like somebody at 62 or 65 where you have really young people – 20, 30 …* [Watertown]

Adults who are retiring

> *I think that there is kind of a lack of focus for people who are exiting the workforce, who are going into a transition that is going to be surprisingly disruptive to them.* [Watertown]

Older HIV/AIDS population

> *Another population that we've recently found that there's been a greater need is the elderly population with HIV/AIDS. Recently, they have been contacting us for services. There's not that many support groups out there for them. They don't know what to do in terms of medication. What's appropriate? What interacts with their psych meds? So that's an [underserved] population as well.* [Bridgeport]

Homeless

> *We see quite a few homeless people come in because during the day they can stay at the center… We have one gentleman now he's living in the back of a truck. There's another gentleman I'm aware of who is living on someone's property in a tent … These are people I see practically every day. And then from time to time drifting in people will come in and just say I have no place to go so they park it for the day. They don't bother anyone. I mean they're fine to be in the center but when the doors close I don't know what happens to them. This time of year again not a major issue but come winter it's a real concern.* [Bridgeport]

> *The homeless… the shelters are not really being accessed and evaluated. I mean, you figure that really somebody should have the role of at least once a month going into a shelter and, again coming up with the outcomes and the monitoring is going in once a month, say to the Norwalk … to every shelter and seeing who's new that's 55 and over and doing that SBIRT and mental-health assessment or whatever and then documenting that and tracking that and having the outcomes based on that. So I don't see that that's necessarily happening.* [Norwalk]

Low income elders

> *More lower class people who don't have the insurance to cover [care].* [Wethersfield]

Veterans

> *A lot of PTSD coming into the picture, and … there's a lot of veterans out there that are underserved and misunderstood.* [Norwich]

Grandparents

> *Grandparents who are caregivers of grandchildren…I think it's huge. Out here we have a lot of grandparents taking care of grandkids, and they're putting obviously kids' needs first, and they're maybe not servicing their own needs.* [Willimantic]

Reasons for underserved subgroups

It appears that more is known about the disparities than the reasons behind them. Participants provided only a few reasons for the existence of certain underserved subgroups. These include not coming under the auspices of Protective Services, a gap in provider services and associated issues with completing medication evaluations, and difficulty diagnosing behavioral health problems when there is a lack of cultural competence.

Because they don't fall under Protective Services and that gets very difficult when you have a really difficult situation. And you don't have an agency that's going to protect them, so to speak, against themselves. [Wethersfield]

Because of the lack of therapists available and psychiatrists … to do the medication evaluations. [New Haven]

I think when there is a problem with bilingual, it's very hard to diagnose whether or not that person has a mental health issue, whether or not they're going through a depression, or even confusion or dementia. [Willimantic]

Resources needed to fulfill agency goals

The question: "What resources do you currently need to fulfill your agency goals for older adults with behavioral health needs?" generated answers in three broad categories including additional trained professionals, training and technical assistance at all levels, and community outreach and engagement.

Additional behavioral health professionals

The resource question generated responses consistent with those in other areas, particularly in reinforcing the need for additional trained professionals to provide behavioral health services. Many respondents cited that shortage as the reason some people could not be served, or had to endure long waits for treatment. There were also warnings that aging baby boomers will stress the system without additional resources.

Nurse clinicians, more of those; more of psych nurses; less restrictions on services so that they can go in and do what they need to do to keep them out of the hospital. [Watertown]

And we also need more crisis workers … because their lists are getting longer and they can't get out as soon, as fast as we need them. We have to wait 5 days or sometimes even a week to get to a client who is decompensated. [Bridgeport]

I just recently heard the statistic of 10,000 folks turning 65 each day … for the next, what, 10, 15 years, and looking at how strapped the healthcare community is, the social service community is, how we do more with less, less, less, and it's like, what is wrong with this picture? It seems so obvious, it's like global warming, but it seems so obvious that our workforce needs to increase, the services, the money, it's like, why isn't there any kind of like huge uprising? [Norwich]

Training and technical assistance

Training needs discussed were extensive, ranging from community members, families and volunteers to social service agencies, to trained professionals in the field. Behavioral health professionals were often cited as needing additional training in issues specific to older adults, while those serving older adults in many capacities need training in how to identify and deal with behavioral issues, and how to refer for further services. Behavioral health professionals were also identified as needing training in the physical health needs of their patients.

As a supportive health provider, I wish we had more training experience on to how to deal with the health need. It's difficult to understand when you're dealing with [this] population that you usually come in contact with the mental health versus [the physical] … when you get older your body changes and stuff like that. We don't know as providers all the time especially even mental health providers like clinicians and stuff. [New Haven]

Conversely, some general medical practitioners need training in appropriate approaches to behavioral health needs.

Our primary care docs really, I don't think they really grasp the issues out there, the treatment appropriateness, because I have PCPs who will order antipsychotics for clearly mild dementia, that they don't need, yet I have referrals because the PCP says, "I don't feel comfortable ordering this, or taking care of this type of client." [Norwich]

Every level of contact could benefit from further training.

Training for my staff. I'm very blessed now that I have quite a few staff members with master's level preparation. Several of them are MSWs. But not all of them and yet I think all of them, particularly the ones that are more directly interacting with our clients like even my drivers, could use some training to understand some of the behaviors, to understand what to look for and when to then make a referral. They would be making the referral to my outreach worker, but then she in turn needs some help. [Bridgeport]

I think there's a need for education on the community level. I run a senior center … we don't deal on the same level of behavioral issues that other people do, but we're the place that we start seeing them. And how we identify them is usually the person is ostracized by the rest of the seniors at the senior center. All of a sudden we'll find there's one person sitting at the lunch table by themselves every day. [Norwich]

The need for guidance on where to refer persons for evaluation or treatment is widespread.

Where should we be referring this person? How should we be going about making that referral? When do you bring in the family and try to engage them? Because right now if things are really bad again we just call 911 because that is our only resource. [Bridgeport]

We could use more training and information about how to make the best match as far as referrals. [Norwich]

Just in general, referring people to mental health services aren't really clear in the state of Connecticut, as far as statewide coordinated services, so I think it would be helpful if there was more education around how to do that … So I think that's a huge need. [Willimantic/Putnam]

Family members and volunteers of all types need training to effectively identify persons in need of help and refer them appropriately.

Better training of family. So that's, if they do have a family network, maybe it's a better training of … family members of the younger generation than my generation, about who to call and what to do if mom or dad is starting to act … [Willimantic/Putnam]

There are so many churches and synagogues that have their own…outreach programs, not necessarily people that are trained with any background. They're just caring people who want to help their fellow parishioners if you will but very often we get a lot of referrals through the churches … They see stuff that they just get worried about. They can't define it. They can't label it. Nor should they need to. That's not their profession. But they just see things that worry them. It might be going into a house and seeing how unkempt it is and this is a house where someone is living that they know used to be like a great housekeeper and now it's falling apart at the seams if you will. Or the personal hygiene that's being neglected. Or the garbage sits around. The hoarding that's around. But these are volunteers doing something good and they have no idea what to do with that. Like "I see this but how do I help this person? How do I try to help someone who may not be asking for help but I'm certainly seeing the need?" [Bridgeport]

Several participants noted that a centralized statewide informational and referral resource such as 2-1-1 could be a crucial step to helping person, families and agencies make appropriate referrals. At present, however, that system appears to lack the depth and currency to fill that gap.

I think for those of us that work in this field, we skip the 2-1-1. A lot of times the reality is, it's outdated, they give you misinformation. For those of us that do this, and know these systems very well … I can't even waste my time. You know what I mean? Because usually you get somebody, and you hear them clicking, and they're reading information, and you have to be the one to say to them, "yeah, that program no longer exists, the funding was cut off, that was a 2 year grant." It's just so outdated that it's not useful for those of us that are the providers. It may be useful to residents or people, but it's not useful to providers, in my personal opinion. [Wethersfield]

Training for peer supporters, who can be some of the most effective resources, was also recommended.

What you do is that you train people that have been in recovery, and you train them to become like a peer counselor. They call them recovery coaches … Because they've been there and they've done that. They've got substance abuse or mental-health problems or whatever, but then they've been trained as like a peer counselor … So instead of having a home-health aid 7 days a week, you put in a recovery coach there twice a week and they can try to engage them in the community. They can take them to an AA meeting or they can make sure that they go keep their mental-health appointment with their treatment program. [Norwalk]

One suggestion for training that can help to meet the resource gap is to foster networks of professionals who can train each other or participate in joint training on a variety of topics.

It makes me wonder if we need some kind of network of providers that work for the towns and providers that work for different community action agencies, or whatever. If there's a way of being able to tie people together in some kind of communication, with an ongoing series of trainings. [Wethersfield]

I mean, we don't even know about each other's agencies. How does the person out there who's older find resources? If they don't contact us … they're not going to get services and I think we have to have better awareness to the isolated or the disabled population who are aging on what's out there for them. [Torrington]

I know that 20 years ago, I attended the interdisciplinary teams and whatnot, and at [name of agency] we're a community mental health clinic, so we were in lots of different community teams, and then as the grants tightened up and tightened up and tightened up, there's no way that I can meet productivity, get my job done, and go to the community ... It's a huge gap in my services at this point. [Norwich]

Community outreach and engagement

As problematic as it is to find help for persons with identified needs, participants also noted that some older adults with unidentified behavioral health needs never come to anyone's attention, and may need to be found and screened by community outreach to persons themselves, to their families, or to others such as homemakers and companions who are in a position to observe the problems.

Well, I've always said that with the older adults and with mental-health problems, it's a hidden epidemic, and it's not really talked about. It's not really screened enough. And a lot of the symptoms are masked by aging issues, and there just needs to be a lot more resources than there are. [Norwalk]

I think there's a need to educate just the general senior population as to what is not normal. Because they have this feeling that everything is normal. [Norwich]

But the people who are at risk need people who care for them to notice what's happening and so on and partner with the individual to help the individual get what they want. [New Haven]

And if we could only find ways to put some money on the front end of this, and we had adequate resources, and that workforce that we were talking about, because it's those homemakers and those companions, let me tell you, that are keeping those people well in the community. [Norwich]

Suggestions for the statewide survey

Focus group leaders described the plans of the Older Adult Behavioral Health Workgroup to field a statewide survey to assist in the asset mapping project, and solicited advice from participants for names and groups to be added to the survey contact list as well as questions to be considered for the statewide survey. Participants recommended an extensive list of medical and community professionals and organizations to participate in the statewide survey (Table 7). For convenience, these are listed in the domains of medical, community, aging services, and first responders.

Table 7. Survey participant suggestion list

Medical	Community	Aging Services	First Responders
Community health Centers	Centers for Independent Living	Adult Day Centers	EMS
Dialysis Centers	Churches, synagogues and other places of worship	Assisted Living Staff	Fire Departments
Emergency Room Doctors	Community-Based Agencies	Congregate Housing	Mental Health Emergency Services
Geriatric Assessment Centers	Connecticut Local Administrators of Social Services	Laurel House	Police
Geriatricians	Corporation for Supportive Housing	Masonicare	
Hospice Care Facilities	Elected Officials	Meals on Wheels	
Hospital Care Coordinators	Health Departments	Municipal Agents for the Elderly	
Local Mental Health Agencies	Healthcare Advocates	Nursing Home Staff	
Primary Care Doctors	Homeless Shelters	Resident Services Coordinators	
Social Workers	Housing Authorities	Seniors Blue Book Staff	
Substance Abuse Counselors	Housing Authority Department of Agriculture (hoarding)	Senior Center Directors	
Visiting Nurse Agencies	Leadership Organizations	Senior Disabled Centers	
Walk-in Clinics	Librarians		
	Protection and Advocacy		
	Shelter Providers		
	Soup Kitchens		
	State Agencies		
	Veterans Administration		

Focus group participants were asked to provide suggestions for questions to include in the statewide survey. A broad range of topics were mentioned and are listed in Table 8, along with a description that explains the intent of the topic.

Table 8. Suggested topics for statewide survey questionnaire

Question Topics	Description
Addiction	How to integrate SBIRT
Adjustment disorders treatment availability	Depression and anxiety triggered by death of a significant other, retirement, loss of housing and income
Areas for improvement	General open-ended question
Barriers to services for the unidentified and unrecognized residents, particularly those older adults living in rural areas of the state	Stigma of mental health, long wait lists, lack of transportation solutions
Behavioral health crisis treatment	Location of services
Community education	Methods to inform the community about older adult behavioral health
Evidence based programs	Best programs and why
Family and caregiver needs	Services needed to support them
Funding issues	Prioritizing needed services, potential sources for funding
Gaps in services	Location and type of gaps
Gatekeeper Program	What communities use this program
Location of actual services	Obtain address, phone, email
Provider experience	Number of older adults served and in what capacity
Socialization and isolation issues	Services that address these issues
Types of needed services that are underfunded	Include evidence based assessment, screening, and programs

Conclusions, Recommendations and Next Steps

Conclusions

Focus group participants from all five regions of the state contributed a wealth of information that will be useful in developing the statewide survey. Although some providers were represented in most focus groups, it would be beneficial to identify a greater number of providers for participation in the statewide survey. Clearly, existing behavioral health services are striving to meet the needs of people who seek them and some evidence-based behavioral health services, interventions, and tools are currently being implemented. However, stigma, lack of insurance coverage for mental illnesses, housing, transportation, and other support and rehabilitation services are desperately needed and are often not available. In addition, a lack of community mental health care has led to widespread, inappropriate use of emergency departments, crisis stabilization units, and institutional and residential care, including prisons.

While many focus group participants expressed confidence in many of the referral sources currently available, there was also frustration in not having enough resources, particularly specialized resources (i.e., geriatricians) to refer to, and in some areas of the state resources

are not available at all. In many cases, participants would like to have a better understanding of the scope of available services so they could make more informed decisions when making referrals.

Participants stated that some of the unique needs of adults age 55 and older make it more difficult to serve them. These include: reluctance in many older adults to seek treatment; the increasing rates of comorbidity, especially among the boomer cohort; problems with medication adherence; addictions and substance use disorders, again more common among the boomer cohort; and adjustment disorders, often more common in the older adults.

The wide range of identified barriers and gaps in services were not surprising. These barriers and gaps have historically been problematic and include: lack of insurance; housing; transportation; cultural competence; resources, such as geriatric providers and appropriate services and programs to refer people to; education, and family support. In rural areas of the state, barriers and gaps in services were noted to be greater.

Although there are many barriers and gaps in behavioral health services throughout the state, there are numerous existing strengths to build and expand on, and for those invested in the process to improve access to service and enhance the infrastructure, there are opportunities for facilitating community involvement and action. Although funding is a barrier for many of the changes, it is still possible to promote a shared awareness and understanding of community assets and begin to strategically plan a collective commitment to change.

Participant recommendations

A number of detailed recommendations were made by focus group participants for the consideration of the Older Adult Behavioral Health Workgroup, including the following:

Develop provider/referral partnerships

> *We have a lot of requests for finding primary care providers who are geriatric or geri-psych – that's another area where we need to have something. The people that refer and the people that provide, it would be great to have like a big workshop for everybody to get together…get psych and medical together so we could share…or create a directory.* [Norwich]

Develop crisis services

> *And we also need more crisis workers other than just Greater Bridgeport Mental Health because their lists are getting longer and they can't get out as soon, as fast as we need them. We have to wait 5 days or sometimes even a week to get to a client who is decompensated which is not really good for us because there we are sending in homemaker companions or aides that are not even…their level of…their training is not there to do that.* [Bridgeport]

Promote mental health first aid curriculum

> *We're seeing a lot more requests for the mental health first aid curriculum in the communities, especially our faith communities, our churches, and we've been partnering*

with the Eastern Regional Health Board too on doing some of these training, so there are a lot of those informal gatekeepers that are out there that are really looking for that information. How do I know is something's going on with someone's mental health? What are some of the symptoms? What are the resources out there?...Churches and other community groups are seeing a lot of these folks and are reaching out now for help. They're saying, "How can we help? How can we partner with you?" [Norwich]

Promote warmlines across the state

There's also warmlines across the state that they could call. We used to have one in Waterbury – we don't anymore – but they have it in Danbury and Torrington. It's run by people with mental illness - and I used to run it here - and they're trained to do active listening and talk with people who are having difficulty and it's geared towards other people with psychiatric or substance abuse issues and it's open usually until around 10 in the evening. [Watertown]

Expand substance use education and awareness for consumers

There's a Safer Drinking Guidelines pamphlet, which we're going to begin distributing as part of our presentations publicly, and we understand that from talking to addictions counselors that that is a real door opener for people to start conversations, so we're hoping to get added there, but I think that's an under-addressed problem. [Middletown]

Increase provider education

Some providers would like more education to better understand how the body and mind age and how best to provide programs and services that would enrich the lives of people struggling with behavioral health problems.

As a supportive health provider, I wish I had more training experience on how to deal with the health need. It's difficult to understand when you come in contact with the mental health versus when you get older your body changes…we don't know as providers all the time especially even mental health providers. [New Haven]

Expand the Gatekeeper Program

The Gatekeeper Program, once again I wish that could be expanded, because essentially with the Gatekeeper Program, if anybody, the postman, or the banker, or somebody sees an older person that they have a concern about, then they can report to the Gatekeeper Program, and that person will go out and see them. So, because you have people who do make connections, sometimes it's the postman, or the banker is big one, the bankers really see the person who has the same teller for 20 years, and they see them aging and becoming more confused, or whatever. So I think that is a good program, but probably just not big enough. [Willimantic]

Older adult sober houses

I can't think of another word, but I'll just say older adult sober houses. So that if you have older adults that have an ongoing problem with substance abuse or mental-health issues

that there's a… that there's a house there, so that they're all supporting each other and maybe receive other services within that… They do have sober houses for the younger people or whatever, but there really is none that are just targeted for just older adults. [Norwalk]

Next steps

Next steps in this collaborative process to improve the understanding and management of behavioral health problems in older adults throughout the state should include:

- Identify a broad range of providers throughout the state for inclusion in the statewide survey
    - Includes provider key informant interviews during the next few months to gain additional provider insights
- Develop and implement the statewide survey
    - Includes the possibility of establishing a subcommittee to focus on survey development
- Further stakeholder involvement
    - Includes consumer input through community forums or focus groups

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Appendix A: Older Adult Behavioral Health Focus Group Guide

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

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

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

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

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

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

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

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

   a. If yes, please identify them.

   b. If no, why not?

6. [**ASK ONLY IF THERE ARE ANY PHYSICIANS OR APRNs IN THE GROUP**]
   Do you use Evidence Based Practice (EBP) screening tools for depression (i.e., Geriatric Depression Scale, Beck Depression Inventory, or PHQ-9, etc.) and alcohol abuse (i.e., CAGE or AUDIT)?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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