



SUMMIT on OLDER ADULTS:
Behavioral Health Issues and the Coming Wave



Introduction

On October 30, 2014, the Massachusetts Executive Office of Elder Affairs (EOEA), the Massachusetts Departments of Mental Health (DMH) and Public Health (DPH) and the Massachusetts Association of Older Americans (MAOA) organized and sponsored an “invitation only” summit on the Boston University Campus. Over 100 Massachusetts state agency heads, policy makers, health and home care professionals, medical directors, health economists, providers, advocates and other leaders engaged in a day-long conversation on the challenges presented by the coming wave of older citizens with behavioral health needs. This report is a brief synopsis of the day’s proceedings and is not intended to provide a detailed overview.





General Background

It is projected that over the next fifteen years, adults age 65 years and older will constitute twenty percent of the United States' population. In Massachusetts, most of the population growth during that period will be among the 60 and over age group. This growing demographic shift will have profound and long term impact on health care, including our behavioral health infrastructure. For example, the prevalence and cost of depression for this population is high and the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) reported a 50% increase in emergency room visits by people over 65 for misuse of pharmaceuticals. While our aging population shares some similarities with previous generations, its size, diversity and range of behavioral health needs present unique challenges.

In October 2012, representatives from the Massachusetts Executive Office of Elder Affairs, Department of Mental Health, Department of Public Health, Bureau of Substance Abuse Services, (BSAS) and MassHealth (the Commonwealth's Medicaid Program) attended a Northeast Regional Policy Academy convened at SAMHSA Headquarters in Rockville, MD. SAMHSA officials, leaders from other federal agencies, including the Centers for Medicare & Medicaid Services, the Administration for Community Living, and officials from other states discussed potential strategies and issues. Each state represented at the Academy was asked to create an action plan, and the October 30th Summit, outlined herein, was part of the Massachusetts plan.

The Summit | Welcome and Overview



The Behavioral Needs of Older Adults: Demographics and Statistical Realities

Ann Hartstein, Secretary of the Executive Office of Elder Affairs, opened the summit by observing the unprecedented growth in the senior population. The aging of the “Baby Boomer” generation is bringing a tidal wave of primary care and behavioral health issues unlike any the Commonwealth has ever confronted. The Massachusetts senior population, which is currently slightly under 20% of the general population, will grow to greater than 26% by 2030. Secretary Hartstein suggested one of the goals of the summit must be to develop a strategy to debunk many of the myths that surround mental health and aging. They are as follows:

Myth

Depression is a normal consequence of aging.

Response

It is not a normal consequence, although the isolation that often accompanies aging can lead to feelings of hopelessness and despair. We need to be ready to address this as necessary.

Myth

Treatment does not work for older people.

Response

Treatment does work. The challenge is to get treatment to the seniors and the seniors to treatment. We need to address both the stigma associated with asking and participating in treatment, as well as access issues.

Myth

Post Traumatic Stress Disorder (PTSD) a/k/a Battle Fatigue is a new phenomenon.

Response

PTSD has always existed, but defining and categorizing it are the result of the Vietnam Era experience. Getting treatment for what we now call PTSD has been an ongoing concern since WWII. Veterans Administration data suggests 15-30% of Vietnam Era veterans suffer from some form of PTSD, which is often co-occurring with substance use disorders. A RAND Study concluded that 75% of those veterans also met the criteria for substance abuse or dependence. This is one of the most important behavioral and substance use issues of today.

Myth

Elders do not use illegal drugs and it does not matter if older people self-medicate to the point of being unproductive, since their age prevents them from being productive in any case.

Response

We know from studies and research that seniors do use illegal drugs and self-medicate using prescription medication – their own or others’. The “baby boomers” experimented with drugs when they were young, and many of them still do. Society is worse off for not having those individuals participating in community life to their fullest.





Elders can be active and productive members of society. One of the most significant and on-going barriers seniors confront when looking for help or being receptive to offers of help is the “ageism” they encounter from professionals. As attendees consider today, strategies to expand and extend behavioral health services to meet the cresting wave of seniors, one achievable goal is the elimination of “professional” ageism.

Kathy Sanders, M.D., Medical Director at the Department of Mental Health provided information on the behavioral health needs of the senior population. Approximately 20% of the over 65 population suffers from a mental health disorder, which is less than the prevalence rate for the general population (25%). Approximate percentages within this 20% are:

- 11.4% suffer from anxiety, including panic and obsessive compulsive disorder.
- 7% of the population suffer depression, compared to 10% for under 65.
- Less than 1% (approximate 0.6 %) suffer a serious mental illness such as schizophrenia.

Dr. Sanders also explained the fastest growing cohort of the senior population is those over 85. There is, Dr. Sanders noted, an over reliance on medications in general throughout the health care delivery system with regard to behavioral health issues, and this is particularly true with the senior population. This may be symptomatic of the ageism bias noted by Secretary Hartstein. Too often the first reaction to a senior in distress is to provide another medication as opposed to the more comprehensive evaluation and patient discussion we see when treating younger people.

The natural developmental issues in late life require a thoughtful and thorough formulation to best meet the individual’s need. Seniors may be negatively impacted by a fragmented system of care that relies too heavily on medication.



Madeleine Biondolillo, M.D., Associate Commissioner for the Department of Public Health noted that DPH has long been concerned with substance use disorders among the elder population. Current DPH initiatives include:

- Ongoing support for the Massachusetts Partnership on Substance Use in Older Adults since its beginnings in 1987.
- Sponsorship of the annual Aging with Dignity Conference for 19 years.
- The Healthy Aging and Prevention of Falls initiatives.

According to Tufts’ Foundation’s Healthy Aging Data Report, 9% of the 60+ older population engage in excessive drinking.

As with food and medication, metabolism changes during aging may require cutting back on alcohol use. Alcohol is processed more slowly and stays in the aging body longer. People who have been moderate or heavy drinkers all their lives may develop problems, especially when coupled with changing health and additional medications. Some people who have never used alcohol or drugs, or who have been in recovery for years, may start to use alcohol or drugs to cope with losses. And some, dependent on alcohol, but perhaps functional for years, may start to have more obvious problems.

To increase awareness of the problem, DPH through its Bureau of Substance Abuse Services (BSAS) has produced materials for health care providers on early identification of unhealthy alcohol use by older adults, along with materials for consumers on alcohol’s impact on aging bodies and on the interactions between medications and alcohol.



Substance use disorders among the aging population require our attention and diligence.

While most of the overdoses we hear about involve heroin, many problems with opioids start with prescription medications.

The Commonwealth's Prescription Monitoring Program data shows adults between ages 51 and 70 fill the most prescriptions for medications with abuse potential.

A national study of Medicare Part D claims found that 30% of people who filled prescriptions for opiates, had multiple prescriptions from 2 – 4 opiate prescribers.

Two years ago the National Survey on Drug Use and Health reported that over 19% of people over 65 had used an illegal drug in their lifetimes. That percentage jumped to almost 48% for people in the 60 – 64 age range.

It's critical that older adults be encouraged to tell every prescriber what medications they are already taking; to lock up medications with abuse potential; to check with their local police to learn how to dispose of unused prescription medications; and not drink alcohol while taking these medications. It is equally important that healthcare providers always ask about alcohol and any drug use before writing a prescription. They should stress the importance of not drinking while on certain medications, especially a prescription for opiates, benzodiazepines, or other sedative medications as the combinations can be dangerous.

Substance use may be a risk factor for suicide. A recent DPH publication *Suicide and Self Inflicted Injury in Massachusetts* reported:

51% of suicide victims had a documented current mental health problem such as depression; 37% were currently receiving some form of mental health treatment; and 27% had an alcohol and/or other substance use problem.

These risk factors spread across the age span. Those suicide victims who were ages 65 and older had more physical problems than those in other age groups. We also know that screening for depression and for substance use can also be an effective suicide prevention measure. Moreover, screenings should be encouraged rather than eliminated when treating the senior population.

Kurt Czarnowski, President of the Massachusetts Association of Older Americans (MAOA)

During 2015, the Massachusetts Association of Older Americans will enter its 46th year of policy advocacy, public education and professional training on behalf of Massachusetts elders. Mental health issues have been at the forefront of the MAOA's concerns throughout. As a co-founder of the Massachusetts Aging and Mental Health Coalition, MAOA is pleased to be a part of the Aging and Mental Health Collaborative, comprised of the Departments of Mental Health, Public Health, Executive Office of Elder Affairs, and the Aging and Mental Health Coalition. This Summit was a significant milestone in the Collaborative's work. It was, in many ways, a new beginning to build new partnerships to strengthen access to high quality services, knowledge about aging and mental health, consumer empowerment, and public awareness of approaches to promoting emotional wellness.

MAOA believes that it is more costly to our state, our families and our society not to treat mental health conditions when intervention is needed. We must be as clear and knowledgeable about the value of prevention and health promotion of mental health as we are about the prevention of cancers, heart disease, and other conditions. Massachusetts needs to build a comprehensive approach to mental health during later life that includes treatment, health promotion, prevention, knowledge-based consumer choices and public understanding. Why is this important?





Absent community treatment options, the presence of a mental health condition and related behaviors of an elder is a determining factor in a family caregiver's decision to seek a nursing facility admission for the elder, often leading to a premature and unwanted expensive placement. The intensity and duration of care for chronic and acute medical treatments can be significantly increased because of failure to provide intervention for comorbid depression, anxiety, or other mental health conditions, increasing the cost of medical care.

The Massachusetts Health Policy Commission estimates found in 2013 analyses that patients with comorbid behavioral health and chronic medical conditions incurred total medical expenditures at least 2.0 to 2.5 times higher than those with a chronic medical condition and no behavioral health conditions.

The demands and stress on family caregivers to provide care, often without significant support, to an elder with an untreated mental health condition frequently has been related to the need for mental health intervention for the caregiver.

The cost of not building a strong mental health network for Massachusetts elders is too high.



Stephen J. Bartels, M.D., M.S., Director, Dartmouth Centers for Health and Aging, Dartmouth College: *A conversation on the mental health needs of and substance use by older adults, with a focus on effective integrated treatment models, evidence-based approaches and the prevalence of suicide.*

By way of an overview to the conversation, Dr. Bartels noted mental health issues must be treated as part of the overall health care of older adults. There are plenty of evidence-based practices and models of care, which unfortunately have not been fully adopted or integrated into the health care delivery system for older adults. Dr. Bartels believes older adults are “victims” of the mental health and substance abuse “carve outs” that are prevalent in the health care system for the general population. Specialty care geriatric settings do not work. (“We built it, but they did not come...”). Instead, he emphasized mental health providers need to be in the primary care setting. Integrated care is cost effective, saves lives, but takes time to develop. Finally, Dr. Bartels noted, even if you are not concerned about extending lives of older adults with mental disorders, the economics of providing better integrated health care and intervention for this population compels change. Consider the following data:

Mental illness can double or triple the cost of care to Medicaid and Medicare for those who are dually eligible.

Middle aged adults (40 – 64) with schizophrenia are 3½ times more likely to be admitted to a nursing home.

Providers, insurers and policy makers, according to Dr. Bartels, “need to rediscover the neck,” that is, to understand and accept the deep connection between emotional disorders and injuries or illnesses to the body. Moreover, the connection will become even more important as the older adult population grows significantly over the next 15 years.

He outlined studies:

Depression kills older women 7 years after hip fracture.

Depression is linked to the greater likelihood of mortality after a heart attack.

Older men with depression have a higher rate of suicide.

We know treatment works and evidence-based practices exist such as:

- ✓ Integrated service delivery in primary care.
- ✓ Mental health outreach services.
- ✓ Mental health consultation and treatment teams in long-term care.
- ✓ Family/caregiver support interventions.
- ✓ Psychological and pharmacological treatment.
- ✓ SBIRT Model (Screening, Brief Intervention, Referral to Treatment). This is an evidence-based effective model for older adults misusing alcohol and psychoactive prescription medication.

In summary, Dr. Bartels observed, we know: (1) the head is connected to the body; (2), mental health in older adults is a health care problem; (3) effective treatment saves lives and pays for itself; and (4) treatment works and has lots of evidenced-based practices. He then added:

So what's the problem?

The problem, in Dr. Bartels' opinion, is the workforce. Physicians have a limited interest in geriatrics. He illustrated the large number of unfilled geriatric fellowships, observing, "We built it, but they did not come." There will never be enough specialty providers to meet the need.

The solution, Dr. Bartels believes, can be found in developing countries, and in India where individuals with little or no formal education are trained to provide care.

Through Reverse Innovation, Task Shifting, and health care reform we can train individuals with no formal education to do case management type work and brief interventions. Moreover, investments in technology can help older adults remain safely at home and make better decisions. Computers could allow seniors to engage in:

- ✓ Self-monitoring.
- ✓ Health data entry.
- ✓ Self-management education.
- ✓ Remote nurse monitoring.

Dr. Bartels outlined studies showing increased use of telehealth and Health Buddies have effectively improved outcomes for people with diabetes, hypertension and other illnesses. Other studies showed decreased hospitalizations among patients who had been trained in self-management.

Reverse Innovation is the smart use of people and technology. It requires:

- ✓ Community programs, research, education.
- ✓ Health coaches, self-management.
- ✓ Technology to monitor and deliver health care at home.





Thomas G. McGuire, Ph.D., Professor of Health Economics, Department of Health Care Policy, Harvard Medical School – *A conversation on the economics of behavioral health for older adults with a focus on parity in access and coverage and the division of financing between the private and public sectors.*

To provide a context for the economics of behavioral healthcare for the senior population, Professor McGuire noted the following:

- ✓ Nearly 20% of individuals in the U.S. age 65 and older have a mental health and/or substance use disorder. These older adults have greater disability, poorer health outcomes, and as much as 47% to 200% higher rates of hospitalization and emergency room usage than older adults with no mental health or substance use disorders.
- ✓ Less than 33% of older adults with mental illnesses utilize mental health services.

Professor McGuire provided a brief history of parity at the state and federal levels. He noted that parity never guaranteed access, but simply addressed discriminatory practices by those insurers and third party payers that placed limits or restrictions on behavioral health illnesses that were not placed on primary care illnesses covered under the same policy. In terms of real economics and the healthcare delivery system, it is the **payment** a provider will receive, not parity, which is critical to improving access.

Currently, public expenditures for behavioral health services far exceed the amount paid by private or commercial insurers. A July 2014 Massachusetts Health Policy Commission Cost Trends Report indicated the following:

ANNUAL CLAIMS EXPENSES (PER PERSON)	COMMERCIAL PAYERS	MEDICARE
Individuals without BH Needs	\$3,622	\$7,931
Individuals with BH Needs	\$7,313	\$19,609

Traditionally, health plans were reluctant to offer equal benefits for behavioral health services not simply because of stigma or lack of understanding about the illnesses, but rather because of adverse selection. If a plan offered very good mental health benefits, the people with the most serious behavioral health needs would gravitate towards that plan, thereby skewing the pool of covered beneficiaries.

If we want to increase private payer participation, thereby broadening the financing of these services, we need to create payments and incentives to encourage good coverage for behavioral health treatments. As a general rule, we have failed to properly pay and incentivize insurers for the cost of chronic illnesses, including mental illnesses. Our risk adjustment formulas need more work. The consequences of failing to properly finance or pay for behavioral health services are costly and devastating to the senior community:

- ✓ The number of nursing home residents with mental illnesses (exclusive of dementia) exceeds the number of people with mental illness in all other health care institutions combined.
- ✓ Untreated mental illness is often the decisive factor in predicting nursing home placement.

Some solutions to consider:

- ✓ Under the Affordable Care Act, payments can be tied to overall health outcomes for the individual, which includes behavioral health conditions. This could become an important incentive to fully integrate behavioral and primary health, but the critical issue is to ensure that the payment levels are sufficient to pay the costs of those services.
- ✓ Studies have shown mental health screenings at annual physicals will result in approximately one third of the patients requesting a referral for treatment.
- ✓ Germany has a long-term care insurance program that covers care delivered at home, and does not require admission to a nursing home type facility before coverage kicks in.

While the shifting of our health care system from a disease model, where it is an illness or injury that triggers coverage, to a preventative model has made some progress, it is slow. Nevertheless, it may represent the best long term approach to reducing health care costs (or at least lowering the rate of increase) and reducing the demand for behavioral health services, which today exceeds the availability of services.

A. Kathryn Power, M.Ed., Northeast Regional Administrator, U.S. Substance Abuse and Mental Health Services Administration – *A conversation on the opportunities offered by the Affordable Care Act to improve behavioral health services for older adults, action steps we can take and continuing the dialogue.*



Following up on Professor McGuire's discussion, Ms. Power explained the Affordable Care Act (ACA) builds upon federal parity laws by requiring coverage of mental health and substance use disorders services as one of the essential health benefits categories. However, she conceded the ACA does not have provisions specifically targeted at behavioral health care for older adults.

Again as follow up to Professor McGuire's discussion, Ms. Power pointed to the following models as representing "incentives" for delivering comprehensive and integrated care:

- ✓ Dually Eligible Demonstration Projects, including one in Massachusetts known as One Care.
- ✓ Community-based Health Homes.
- ✓ Accountable Care Organizations.

She acknowledged Dr. Bartels' lament that there are not enough physicians interested in geriatric care and noted the United States expects to need 52,000 more primary care physicians by 2025. Moreover, we need treatment breakthroughs in:

- ✓ Dementia.
- ✓ Depression.
- ✓ Anxiety.
- ✓ Medication challenges.

Lastly, as part of the challenge to keep the dialogue going, Ms. Power asked all Summit participants to answer the following questions:

- ✓ What is your role in addressing the Coming Wave?
- ✓ What barriers do you see as surmountable or insurmountable?
- ✓ What partners or collaborations need to be established or expanded?
- ✓ What policies need to change?
- ✓ What can you do tomorrow to ensure this population's needs are met?





Participants Respond | Appendix

The accompanying appendix to this Report contains the comments provided by Summit participants. We hope you will take time to read and reflect on them. We grouped them into the following categories:

- ✓ Responding to the Shortage of Physicians
- ✓ Stigma
- ✓ Training and Specific Populations within the Senior Community
- ✓ Advocacy and State Government
- ✓ Educational Outreach and Information on Available Services
- ✓ Topics for Future Summits or Meetings
- ✓ Other Comments

Acknowledgment

We want to acknowledge and express our appreciation for the outstanding participation from all the attendees. One of the goals of this event was to inspire a call to action and we hope that this day motivated you and other participants to continue the work on this important issue.

Planning Committee Members

Bernie Carey
Massachusetts Association for Mental Health

Lisa Colozzo
Massachusetts Department of Mental Health

Michelle Cormier Tallman
Massachusetts Department of Mental Health

Carol Girard
Massachusetts Department of Public Health

Ruth Grabel
Massachusetts Department of Public Health

Chet Jakubiak
Massachusetts Association of Older Americans

Lynn Kerner
Advocates, Inc.

Kathy Kuhn
Boston University

Tim O'Leary
Massachusetts Association for Mental Health

Eleanor Shea-Delaney
Massachusetts Department of Mental Health

Sue Temper
Massachusetts Executive Office of Elder Affairs

Those interested in obtaining copies of the presentations delivered by Summit speakers should send an email to the Massachusetts Association for Mental Health, using the following address: timoleary@mamh.org

Appendix | The Participants Respond

Throughout the Summit participants offered questions and comments to the presenters and other participants. In addition, participants were invited to submit additional comments for a three week period following the Summit. Rather than interspersing the comments made during or received after the Summit, we elected to include them in this separate section of the report. Three additional points:

1. With respect to comments either made at the Summit or brief written statements received later, we have attempted to organize them by subject matter or other appropriate category.
2. Other participants have submitted lengthy written comments covering a variety of topics. Those we have included under Other Comments. While edits were made to some of those comments, they did not change the substance of the letter, and we provided the names of the writers.
3. The Commissioner of the Massachusetts Commission for the Deaf and Hard of Hearing submitted a thoughtful response answering each of the questions posed by A. Kathryn Power. That response, in its entirety, is included at the end of this document.

Responding to the shortage of physicians today and as forecasted in the future:

- } There was significant support for Dr. Bartels' observation that in developing countries, people with little or no formal education are being trained to provide care. It was suggested by several people that we expand the Certified Peer Specialist (CPS) program used in mental health, whereby men and women with psychiatric disability (persons with lived experience) are trained to work with other persons with lived experience. A trained CPS can work both in the behavioral and primary care health setting. The program could be directed towards caring for seniors. It makes sense to develop programs to train older adults to work on health issues with their contemporaries. Whether called "health buddies," "health coaches," or whatever, the isolation of aging is reason enough to increase outreach efforts. ~
- } We need community-based geriatric outreach workers. The problem is, while they do not have to be social workers or a person with formal education to be effective, insurers with their credentialing processes, require certain educational standards before they will even consider reimbursing the costs of these workers. This needs to change in order to address the workforce issues. ~

Integration of Services

- } After hearing about the difficulties that have been demonstrated in integrating behavioral health with primary care settings, some participants commented about efforts to incorporate behavioral health into housing for older adults, which is being done in some places. There are a variety of models and we should explore the opportunities in this arena further. ~





Stigma

- } Today's emphasis on recovery, and recovery focused care is the most effective way to encourage those who need behavioral health services – no matter the age – to seek help. ~
- } We need more educational outreach to reduce the impact of the stigma surrounding mental illness. ~
- } We should resolve not to use the word “Stigma.” We need to talk about community conversations on mental health, accessing services, and you can go around the bias that exists. If you talk stigma, you go nowhere. ~

Training on Specific Populations within the Senior Community

- } We need programs targeted at seniors who have been victims of domestic and intimate partner violence and sexual assault, both in early life and later. ~
- } Need more “trauma-informed” care trainings for geriatric services. ~
- } We need to address the racial & ethnic disparities in mental health access. ~

Advocacy and State Government

- } We should establish an Office of Elder Mental Health which would develop policies and advocate for the elder population. We need it to collect Massachusetts based data on elder needs and distribute it to legislators and advocates. ~
- } Participants and others were invited to join the Massachusetts Aging and Mental Health Coalition, a statewide membership organization dedicated to improving awareness of the critical problems elders face when experiencing mental health and substance use conditions. The coalition provides education and advocacy on issues related to mental health, wellness and recovery. ~

(Note: the Coalition meets the second Friday of the month from 11 – 12 at the Chelsea room in the Lindemann Mental Health Center, 25 Staniford Street, Boston, MA 02114
For more information contact **Cassie Cramer**: ccramr@eldercare.org or
Rebecca Kessler: rkessler@chd.org)

Educational Outreach and Information on Available Services

- } There seems to be a general lack of awareness about the available services for older adults with behavioral health issues. PACE (Programs for All-inclusive Care to Elders) is a national program with a number of affiliates in Massachusetts. For example, Elder Service plan of Cambridge Health Alliance is a PACE program and is particularly equipped to serve this population. It seems critical that efforts be made to increase awareness of available services, such as PACE. ~

Topics for future summits or meetings

- } A future summit should include consumers and people on the direct care level (home health aides, personal care attendants, case managers, and protective services workers) present and involved in the dialogue. ~

- } Some topics for a future summit could include a look at ageism and its impact on well-being and decision-making; guardianship as it pertains to community first and best practice; and supporting Protective Services workers and those in crisis-intervention roles. ~
- } Some attendees were struck by the needs and the cost restraints inhibiting our ability to ensure a higher quality of life for older adults with mental illnesses, while we know that there is an enormous expense associated with the last month (s) of life. Increasing discussions around end of life options might free up some resources for helping people have an improved quality of life for many years. ~

Other Comments

- } It is certainly important to reinforce what Drs. Bartels and McGuire discussed in great length and that is that older adults are not exempt from behavioral health issues. It is certainly important to look at how these are addressed through the lens of physical and mental health challenges. Cognitive issues are prevalent in many older adults and per my career difficult to pick out and treat in the scheme of overall health issues. I am a believer in population management. My take away was that resources (mental and physical health) need to focus on the specific needs of older persons as a population. Resources need to be managed for this population as any other population and must also include housing and wellness based programs. ~
- } During the Older Adult Behavioral Health Summit, several members of the Massachusetts Aging and Mental Health Coalition (MAMHC) spoke about the work that several provider members have been undertaking to improve services to older adults. The job of building an innovative, integrated, cross-disciplinary system to respond to the needs of Massachusetts' older adults and their families is a challenging task. Massachusetts has a strong aging service network. Through this network, both expertise and creative potential can be drawn upon to develop the much needed system. MAMHC would like to see a fully-funded regional system of mental health and aging services that would build on the best practices that are already taking place in Massachusetts and include regional teams with local Aging Service Access Points as the hub. Other team members/services to include at minimum:
 - Mental health providers with capacity for home visits, including outreach, assessment, and treatment in the home
 - Capacity for linguistic services
 - Coordination of care which includes behavioral health focused care management and wraparound services
 - Peer support
 - Interdisciplinary, cross agency, coordinated training in aging and mental health to strengthen the skills and knowledge of current and new aging and mental health staff
 - Evaluation of program success ~

Currently some providers are offering an array of these services. There is little consistency through the state. Let's lift up what works and create a system that works to benefit older adults and their families across the Commonwealth.





Historical Perspective

In 1978, a group of sixteen individuals including the state mental health commissioner, the Secretary of Elder Affairs, advocates, and professional service providers convened to develop a document entitled; “Goals for Mental Health Services for the Elderly in Massachusetts” and provided a blueprint or plan for addressing many of the concerns expressed at the Summit. The Report listed the following five goals:

- ✓ Prevention
- ✓ Building a system of community-based services
- ✓ Residential Care
- ✓ Staff Development or Training
- ✓ Evaluation, monitoring and research

Editor’s Note: The January 3, 1979 document, noted above, is too lengthy to reproduce in this report. However, if any reader would like to obtain a pdf. copy of the report, please contact MAOA at cjakubiak@maoamass.org



Remarks from Heidi L. Reed, Commissioner, Massachusetts Commission for the Deaf and Hard of Hearing

1. What is your role in addressing the ‘Coming Wave’?

- } The Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH) serves a statewide population of people who are growing older, some have been deaf for all or most of their lives, and many more are increasingly becoming hard of hearing and late-deafened. This unique population may tend to experience isolation because of their inability to hear. For native American Sign Language (ASL) users, there are limited opportunities to interact and communicate freely among the hearing population who don’t sign. As this population ages, their isolation and risk of depression and illness increases even more. ~
- } MCDHH needs to address this coming wave in several ways. One is to enhance access to communication by increasing the pool of sign language interpreters as well as Communication Access Real time Translation (CART) providers. Another is to expand the workforce; especially the pool of workers with signing skills and expertise in the unique needs of the deaf and hard of hearing in all areas of the geriatric fields. Another is to develop/strengthen collaboration efforts with both private and public entities that are currently working on serving the aging populations. ~

2. What barriers do you see as surmountable/insurmountable?

- } Even though statistics from Johns Hopkins report that the population of deaf and hard of hearing people has grown to one of every five people, deaf and hard of hearing people are viewed as a low incidence population and easily overlooked by the majority hearing population of service providers, age cohorts, and even family members. ~
- } Individuals with hearing loss are often in denial and do not self-disclose making it difficult to support their needs prior to their hearing loss impacting their everyday life; work, home, and relationships. ~

- } Communication access policies and procedures and Americans with Disabilities Act (ADA) compliance procedures are not consistently and universally implemented throughout the field of behavioral health and substance abuse prevention and treatment. ~
- } Assistive technology such as visual alerting systems for safety and communication and assistive listening devices are underutilized by people who could benefit from them at home, in the workplace, in the community, and in the service/business environment. ~
- } Hearing aid affordability is a barrier. ~
- } For MCDHH, barriers to addressing the coming wave are limited funds and limited staffing with which to provide training and technical assistance targeted to the wave of older adults who are deaf, hard of hearing, and late-deafened. ~

3. What partners/collaborations need to be established/expanded?

- } Launch a model Community Health Worker for the Hard of Hearing (CHWHH) Program to focus on the aging hard of hearing population as well as young and middle aged adults. This requires a funding source. ~
- } Establish and leverage strong collaborations between MCDHH and Elder Affairs and Veterans Affairs as well as Council on Aging and other entities whose populations include growing numbers of people with hearing loss. This requires targeted staffing. ~
- } Other agencies have obtained grants and then successfully partnered with MCDHH to implement accessible service delivery. Grant applications should include provisions for communication access, so that the proposed services can be effectively made available to people who are deaf, hard of hearing, and late-deafened. ~

4. What policies need to change?

- } Agencies and organizations must recognize the requirements of deaf, hard of hearing, and late-deafened senior citizens along with their hearing counterparts while focusing on improving services and ensuring that all residents of Massachusetts have equal access to the various services. ~
- } Policies and procedures should be updated and consistently maintained to ensure provision of reasonable accommodations and compliance with the ADA. ~
- } Funding should be designated in EOHHS to support communication access and technology advancements for this population. ~
- } Mandate new employee orientation which should include training in effectively communicating with and serving the diversified population of people who are deaf, hard of hearing, and late-deafened. ~
- } Agencies and organizations should obtain training and technical assistance related to use of communication access technology such as captioning, remote CART, assistive listening systems, sign language interpreters, American Sign Language (ASL) fluent staff, video remote interpreting, and use of accessible telephone systems. With additional staff, MCDHH could provide this training and technical assistance. ~





- } Service delivery models should be available to serve elders who are deaf and use ASL within a linguistic and culturally accessible environment. Such an environment includes peers who are deaf and can communicate directly with each other in ASL, and staff who are themselves deaf and fluent in ASL, and use of communication access technology such as videophones, alerting systems, and captioning. ~

5. What can you do tomorrow to ensure this population's needs are met?

- } All service providing agencies can implement steps to reach out to and become accessible to deaf, hard of hearing and late-deafened older adults who are among their clients and employees. We can find out what other states do to identify and connect with hard of hearing, and late-deafened older adults within their client/constituent communities. ~
- } MCDHH can develop, strengthen, and expand on collaborations/partnerships with other entities that serve older people and make sure that deaf, hard of hearing, and late-deafened senior citizens are included in their policies. ~





