National Coalition on Mental Health and Aging
Draft Meeting Minutes
October 10, 2018

Welcome and Update

Joel E. Miller, NCMHA Chair and the American Mental Health Counselors Association representative, called the meeting to order and welcomed 13 members present onsite and 14 joining via conference call. The meeting was conducted at the American Psychological Association, 750 First Street, NE, 9th floor Conference Room, Washington DC. Joel Miller reviewed the agenda.

Joel Miller asked for any changes needed in the minutes of the June 5, 2018 meeting. Hearing none, Jake Jackson, National Board for Certified Counselors (NBCC) made a motion to approve the minutes as circulated; Kathleen Cameron, National Council on Aging (NCOA), seconded the motion; and the motion passed.

NCMHA Bylaws

The Executive Committee recommended revisions to the NCMHA Bylaws. The revised bylaws were circulated at the October 10, 2018 meeting and are Attachment 1 to these minutes. Chris Herman, National Association of Social Workers (NASW), moved the adoption of the revised bylaws, Jake Jackson, NBCC, seconded the motion. The motion passed and the revised bylaws were adopted.

NCMHA Website

The website has been revamped and is now in need of a volunteer(s) to regularly post new information. Marissa Whitehouse, formerly with NCOA, had been posting material to the website; however, she has moved to the HHS Administration for Community Living (ACL) and is no longer available for this task. A number of features requested by the membership and Executive Committee have been added including a new State and Local Chapters tab to replace the Calendar tab. Marcia Marshall who oversaw the website redesign, offered to help in a limited manner until a regular volunteer is identified.

Presentation: National Association for State Head Injury Administrators (NASHIA)

Rebeccah Wolfkiel, the new Executive Director of the organization, was introduced and briefed the Coalition on NASHIA and its current work. Ms. Wolfkiel noted that she purposely sought out aging and mental health organizations and was led to NCMHA by Kathleen Cameron of NCOA. The mission of NASHIA is "To assist State governments in promoting partnerships and building systems to meet the needs of individuals with brain injury and their families." Formed in 1989, it is the only organization representing State employees working to support individuals with brain injury and their families. Today the organization's membership includes State employees from various agencies including Public Health, Vocational Rehabilitation, Medicaid, Mental Health, Education, Developmental Disabilities, and Aging, plus advocacy organizations, service providers and consumers.

NASHIA works through advocacy, training and technical assistance. Through advocacy, the organization working with others has been successful in securing funding for the Traumatic Brain Injury (TBI) Act programs (ACL/CDC); NIDILRR Research; DOD Research; and VA rehabilitation programs. NASHIA pursues legislation including the TBI Act; Juvenile Justice and Delinquency Prevention Act; Older Americans Act; Violence Against Women Act; and more; plus the Congressional TBI Taskforce and March TBI Awareness Day.

The training offered by NAHSIA includes webinars: Professional Ethics; Person Centered Planning; Partnerships with Protection & Advocacy; and Elder Falls/Brain Injury Series plus its Annual Conference. Technical Assistance includes State TA: State Plans; State System Development; Dedicated Funding Sources/Trust Funds; Registries; Medicaid Waivers; Brain Injury Council Development; Advocacy; and more. Federal TA includes HRSA TBI Program TAC; and, ACL National Center for Advancing Person Centered Planning Systems (NCAPPS). NASHIA is working with NCOA and ACL on falls prevention with a focus on state brain injury efforts.

Rebeccah reviewed information on traumatic brain injury (TBI) and identified opportunities to increase awareness about the issues. She noted that a TBI is caused by a bump, blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain. TBI is a major cause of death and disability in the United States; TBIs contribute to about 30% of all injury deaths. In 2013, about 2.8 million TBI-related emergency department (ED) visits, hospitalizations, and deaths occurred in the United States. TBI contributed to the deaths of nearly 50,000 people. TBI was a diagnosis in more than 282,000 hospitalizations and 2.5 million ED visits. These consisted of TBI alone or TBI in combination with other injuries. Those who survive a TBI can face effects that last a few days, or the rest of their lives. Effects of TBI can include impaired thinking or memory, movement, sensation (e.g., vision or hearing), or emotional functioning (e.g., personality changes, depression). These issues not only affect individuals but can have lasting effects on families and communities.

Rebeccah then reviewed rates of TBI noting that from 2007–2013, while rates of TBI-related ED visits increased by 47%, hospitalization rates decreased by 2.5% and death rates decreased by 5%. These data indicate that more individuals are aging with brain injury! In 2013, falls were the leading cause of TBI. Falls accounted for 47% of all TBI-related ED visits, hospitalizations, and deaths in the United States. Falls disproportionately affect the youngest and oldest age groups. Among TBI-related deaths in 2013, falls were highest for persons 75 years of age and older and, falls were the leading cause of death for persons 65 years of age or older. Among non-fatal TBI-related injuries in 2013 - hospitalization rates were highest among persons 75 years of age and older. Emergency Department (ED) visits increased by 70% for Older Adults between 2001 and 2010, falls accounted for over 50% of the increase in TBI-related ED visits.

Older adults with fall-related TBI have more co-morbidities than those with motor vehicle crash TBI, with the highest rate among those with dementia, depression and Parkinson's disease. Appropriate screening, identification and treatment is imperative to ensure against incorrect diagnosis and subsequent prescribing that exacerbates the injury. States like Iowa, Massachusetts and Nebraska have prioritized this population. NASHIA has been collaborating with NCOA to provide training opportunities broadly. Rebeccah discussed aging with brain injury (as opposed to injuries that occur later in life). She noted that where individuals with TBI would not have survived decades ago, due to state-of-the-art protective equipment and medical innovations these individuals not only survive their injury but age in society. Many of these individuals are in need of similar services and supports as those in the broader disability community (housing, transportation, enhanced medical supports, etc.). Differing from the

broader disabilities community, this population often has significantly increased rates of co-occurring behavioral health and substance abuse issues. She noted that more data on people living with TBI, ages and resources sought, should be collected through the CDC Concussion Surveillance System.

There are behavioral health links to TBI. Depression is frequent following TBI, plus rates of anxiety and psychosis are higher. "72% percent of participants in treatment for dually diagnosed substance use disorders and severe mental illness reported a history of at least one TBI. Participants with TBI had greater morbidity as reflected in more complex psychiatric diagnoses and greater likelihood of being diagnosed with an Axis II personality disorder." Dr. John Corrigan (Pub. 2009)

Opiates are commonly prescribed for people with a TBI. 70%-80% of hospital visits by people with a TBI injury go home with opiates. Acquired Brain Injury (ABI) is a potential result of an opioid overdose due to lack of oxygen to the brain. Drugs such as naloxone make it possible for individuals who overdose to survive; however, they may have received a cognitive impairment due to lack of oxygen during the overdose.

Training and education are essential. NAISHIA and its State members offer training to recognize symptoms of brain injury plus information and referral services and supports. Training is directed to ED departments/First Responders, mental health providers, primary care providers, caregivers and Area Agencies on Aging. Their fact sheet, Brain Injury and Opioid Overdose: Fast Facts was shared with members.

Rebeccah suggested potential collaboration with NCMHA and member organizations. She noted that collaborative work was underway with NASMHPD, NASUAD, and NCOA including joint conference participation, joint webinars, federally funded papers, and future teaming opportunities for federal grants and contracts. Future action could include an Opioid Use and TBI Fact Sheet. Joint Congressional advocacy and briefings and joint awareness efforts could be undertaken through sharing materials, especially with Senate Select Committee on Aging/Congressional TBI Taskforce. Brain Injury Awareness Day conducted each March is also an opportunity for collaboration.

Kathleen Cameron, NCOA, asked whether NASHIA worked with veterans. Rebeccah noted that some activity around rehabilitation had been undertaken but much more could be done. Michele Karel of the VA agreed to be in contact with NASHIA. Kathleen also asked whether the state office members of NASHIA are aware of and participate in state mental health & aging coalitions. Rebeccah will alert her members to these opportunities.

Joel Miller raised a concern that perhaps hospitals give more attention to potential brain injury than to other issues like mental health. Rebeccah said that she would raise this concern with CDC. Joel further noted that possibly NCMHA and state coalition members could be helpful in state data collection. Serena Davila of the APA policy office indicated she is willing to work with NASHIA and NCOA on the Older Americans Act reauthorization and funding.

Members thanked Rebeccah for the presentation. Rebeccah encouraged NCMHA members to reach out to her at execdirector@nashia.org or 202-681-7840.

SAMHSA Update: Strengthening Service Coordination for Older Adults with SMI Meeting, ISMICC, 2019 National Older Adult Mental Health Awareness Day

Eric Weakly, Western Branch Chief, SAMHSA Division of State and Community Systems Development, Center for Mental Health Services provided the Coalition the SAMHSA update. He noted the recent national meeting of Aging and Disability Resource Centers (ADRCs) in which older adults with Serious Mental Illness (SMI) was discussed. Representatives of several HHS agencies participated including ACL and SAMHSA plus representatives from several Coalition states including MD, NC, NY, OR, VA and many others. Kimberly Williams, Vibrant Emotional Health (formerly New York Geriatric Mental Health Alliance and Kathleen Cameron, NCOA, both of whom serve on the NCMHA Executive Committee, moderated sessions or presented. The participants were briefed on the 2015 *Aging and Disability Resource Center Older Adult Behavioral Health Asset Mapping Study - Final Report*. The study was conducted by UConn Health Center on Aging under a project for Enhanced ADRC Options Counseling funded by ACL and the Connecticut Department on Aging.

The Behavioral Health Asset Mapping Study report includes the tool used in the study plus recommendations for states in areas of Education and Awareness, Integration of Behavioral Health, Physical Health and Aging Services, Workforce Development, Strengthen Community Assets, Policy, and Research. Erik Weakly brought special attention to recommendations in areas of increased integration of care in service systems, building peer and family expertise, building mental health expertise and technology into systems of care, use of the public health model and movement from assessments of deficits to assessments of strengths.

Eric reported that on September 7, 2018 the Older Adults Peers Meeting was held. Cynthia Zubritsky, PhD, of the University of Pennsylvania presented on a Medicaid funding model. Eric then reported on the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) established by the 21st Century CURES Act. The HHS Assistant Secretary for Mental Health and Substance Use chairs the ISMICC, with management and support services provided by SAMHSA. Mr. Weakly noted that ISMICC includes both federal agency personnel as well as outside experts including a geriatric psychiatrist and psychologist. ISMICC is charged to report to Congress by 2022 on ways to improve SMI care along with financing strategies. Joel Miller, NCMHA Chair, called into the June meeting and made two recommendations: that a federal entity be identified as point for older adults, and, federal funds be allocated proportionate to different population groups. ISMICC efforts are ongoing and minutes of workgroup meetings are being issued, offering some insight into preparations for the final report. Mr. Weakly encouraged other Coalition members to call into these meetings. All recommendations are passed up to leadership. Information is available on https://www.samhsa.gov/about-us/advisory-councils/ismicc. An update on the workforce serving older adults will be posted on the website in mid-November.

Eric announced that the next Older Adult Mental Health Awareness Day would be held on Monday, May 20, 2019. There will be a meeting that afternoon in the Great Hall of the HHS Humphrey Building in Washington, DC. Eric and the work group are working on the agenda for the meeting and soliciting input through regular phone calls with the planning committee. NCMHA Executive Committee members, Kim Williams, Joel Miller, and Debbie DiGilio are on the May 20th planning committee. Alixe McNeill suggested that the planning committee consider naming a professional media person to moderate the May meeting. In response to a query, Mr. Weakly said he would send the archive of the 2018 meeting to the Coalition.

(Editor's note: The recording of the webcast of Older Adult Mental Health Awareness Day is now available.

Discussion: State and Local Coalition Public Education Campaign Efforts: What Works & What Doesn't
One purpose for this discussion was to inform planning for a NCMHA's national education campaign. Kim Burton, representing the Maryland Coalition on Mental Health and Aging, reported that some of their efforts have been successful in educating directors of some important state programs about older adult mental health including legal services and advocates, behavioral health services, mental health, cognitive health, substance abuse, and brain injury. The MD Coalition is raising workforce gap issues and PASSAR concerns. There is a growing number of requests for education on older adults substance misuse including opiate use. They are considering offering education on reimbursement so that families and providers know the availability of funding options. Kim Burton is willing to speak with other states about MD Coalition's education efforts. She noted that MD developed a guidebook on older adult mental health resources based on a guide created in Kansas. Some of the Coalition materials can be found on their website: www.mhamd.org/aging/.

Kim Burton then asked other states to assist her in addressing issues of hospitals seemingly "bouncing patients" to keep them out of institutions. What has been successful in transitions of care?

Karen Orsi, representing the Oklahoma Coalition on Mental Health and Aging, reported that their education efforts use a "wellness" focus. They have addressed workforce gaps. They offer Mental Health First Aid training and now have Peer Supporters trained.

Joel Miller, NCMHA Chair, asked that other states with Public Education Campaigns please let the NCMHA know about their work. Debbie DiGilio, APA, asked for "links" to good resource material such as materials mentioned from MD and CT.

Member Updates
AARP – Olivia Dean of AARP Public Policy staff reported that the Global Council on Brain Health released a report today titled *Brain Health and Mental Well-Being*. She commended the report to Coalition members. The Global Council is an independent collaborative of scientists, health professionals, scholars and policy experts from around the world working in areas of brain health related to human cognition. The GCBH focuses on brain health relating to peoples' ability to think and reason as they age, including aspects of memory, perception and judgment. The GCBH is convened by AARP with support from Age UK. A press release on the report is also available.

Administration for Community Living (ACL) - Shannon Skowronski reported that ACL had made a new round of Chronic Disease Self-Management Education (CDSME) grants in September. The WRAP program for older adult peer support in recovery, developed by the University of Chicago, and had been pre-approved along with other evidence-based programs eligible under CDSME funding to states. Shannon Skowronski also noted that a new RFA will be released for a three-year project, the first to address older adults with Serious Mental Illness (SMI). Shannon will share the RFA with the Coalition when it becomes available.

American Mental Health Counselors Association - Joel Miller reported on the AMHCA annual conference noting that there were several sessions on health service integration, plus sessions addressing military issues, and neurological issues, among the many topics covered. The 2019 meeting will be held in

Washington, DC. The Association offers a Diplomate Program for an advanced practice credential that includes education on integrated care and geriatric care.

American Psychological Association – Deborah DiGilio announced that a Twitter Chat on Geriatric Mental Health Workforce issues will be held in collaboration with the Eldercare Workforce Association and other organizations on October 10th. The Office on Aging also held a webinar, *Black Aging Matters: How to Better Address Racism-Related Stress in African American Older Adults* that is now available with other race-related stress materials, including a tip sheet for providers, on their multicultural aging webpage. Serena Davila of the APA Policy office noted they were offering advocacy training and conducting in-district visits to advocate for funding for Kevin and Avonte's Law with AutismSpeaks. The bill's primary purpose is to help those individuals who wander.

Maryland Coalition on Mental Health and Aging – Kim Burton reported earlier in the meeting.

N4A - National Association of Area Agencies on Aging – Rebecca Levine reported that she was attending the meeting on behalf of Amy E. Gotwals, Chief of N4A Public Policy & External Affairs. They plan to return to regular participation with the Coalition.

National Association of Social Workers – Chris Herman reported that NASW is conducting a virtual conference on the opioid crisis on November 14-15, 2018. The conference will address all ages. It can be reached at virtualfoum.socialworkers.org. NASW is pleased with the numbers of people participating in previous on-line conferences.

National Board for Certified Counselors – Jacob (Jake) Jackson explained that the Board offers a series of tests or exams for state level licensure of counselors. Exams are available for licensure in every state.

National Consumer Voice for Quality Long-Term Care – Laurie Smetanka reported that the organization is becoming active once again with the National Coalition. She talked about the National Long-Term Care Resource Center that is operated by her organization. She noted that there will be a national meeting in Alexandria, VA October 22-24, 2018 and that she will send links to conference materials after the meeting.

National Council on Aging – Kathleen Cameron reported that NCOA will conduct a national conference on aging at the Renaissance Hotel in Washington, DC on June 17-20, 2019. The conference will focus on health, benefits and senior centers. NCOA will host a webinar on Suicide among Older Adults sometime in the next few months.

National Institute of Mental Health – George Niederehe reported that NIMH was conducting a Twitter session October 11, 2018 on Depression Awareness and Screening as part of Depression Awareness Month. The Geriatrics Branch of NIMH is releasing a RFA on Neuropsychiatric Symptoms of People with Dementia including Alzheimer's disease; $6 million is available.

Region 6 Behavioral Healthcare, Omaha, Nebraska – Lori Thomas reported that the group conducted their Second Older Adult Mental Health and Aging Conference. Some of the conference focus was on needed skills of the workforce. The Coalition is now working with a legislator interested in these issues.

Vibrant Emotional Health (formerly New York, Geriatric Mental Health Alliance) - Kimberly Williams reported that they convened a meeting to understand what is required to better meet the geriatric

mental health and substance abuse needs in New York State. She noted that the New York State Mental Health Planning Council has established a geriatric subgroup to make recommendations on the needs and priorities for older adults. Kimberly is a member of this subgroup along with state representatives and other stakeholders.

Oklahoma Mental Health and Aging Coalition - Karen Orsi reported that the Coalition is preparing to conduct a program in 2019 focused on reducing depression.

Oregon, Older Adults/People with Disabilities Behavioral Health Advisory Council – Jim Davis reported on the Council's success over the last few years; highlighting the $45 million Older Adult and Persons with Disability Behavioral Health Initiative. The behavioral health specialists placed throughout Oregon as a part of this Initiative have had extensive training and have produced strong research on the issuers. The Council's 2019 legislative agenda has several priorities: $10 additional funding for behavioral health services for older adults and persons with disability; Access to behavioral health care for persons receiving long-term care in their homes and in residential facilities; and, Create a Center of Excellence in Older Adult Behavioral Health working with Oregon State University. Although the Council has had success training staff on older adult behavioral health care, there simply is not sufficient numbers in the workforce. The Council plans to work closely with Community Mental Health Centers to have geriatric specialists in the Centers.

US Department of Veterans Affairs – Michele Karel reported that the Department has recently conducted considerable work on suicide prevention, especially looking at national and state data on Veterans vs the general public. The VA is working on suicide risk screening methodology. Michele Karel noted a VA virtual research conference on aging veterans, and work on suicide and Post Traumatic Stress Disorder. She offers the following links to VA resources.

- Veteran Suicide data, nationally and by state: https://www.mentalhealth.va.gov/suicide_prevention/data.asp
- Older Veteran Behavioral Health Inventory: https://www.mentalhealth.va.gov/communityproviders/docs/Older_Veteran_Behavioral_Health_Resource_Inventory_050418.pdf
- Brochure: *Preventing Suicide among Older Veterans: Resource and tips for Veterans, family members, caregivers, and friends:* https://www.mentalhealth.va.gov/suicide_prevention/docs/Older_Veterans_Brochure_508_FINAL.pdf

Proposed Follow-Up to the 2018 Older Adult Mental Health Awareness Day: A Campaign for the Mental Health of Older Americans

Joel E. Miller, NCMHA Chair, offered a proposal for a Campaign for the Mental Health of Older Americans noting that he believes it is called for as a follow-up to the first Older Adult Mental Health Awareness Day in May. The Power Point presentation that outlines the proposed campaign is being sent to members with these minutes.

Joel also distributed the paper "Addressing the Crisis in Older Adult Mental Health" built upon a previous NCMHA paper that was updated for the May Awareness Day. This paper was distributed at the meeting and is Attachment 2 to these minutes. Joel indicated that this paper could be translated into an infographics presentation to add power in delivery to decision makers.

Kathy Cameron reflected that the campaign outline was a good start but she wondered how this could be carried out considering bandwidth constraints. She encouraged the Coalition to partner with mental health organizations and seek funding. Perhaps the Coalition could also partner with workforce groups. Jake Jackson suggested partnering with the Behavioral Health Council.

Joel asked Coalition members to contact him with ideas and resources. Please contact Joel at jmiller@amhca.org. Input would especially be appreciated from outside Washington, from State and Local Coalitions. Chelsea Gilchrist, NCOA, suggested that the State and Local Coalitions be surveyed in preparation for the May 2019 Awareness Meeting. Kathy Cameron, NCOA, offered to help with such a survey. Joel suggested that a survey of all NCMHA members could be conducted on what is needed to inform the campaign.

NCMHA adjourned the meeting at 12:30pm.

Attachment 1. Revised Bylaws Adopted October 10, 2018

BY LAWS OF THE
NATIONAL COALITION ON MENTAL HEALTH AND AGING

Article 1: Purpose

a. The National Coalition on Mental Health and Aging provides opportunities for professional, consumer, and government organizations to work together towards improving the availability and quality of mental health preventive and treatment strategies to older adults and their families through education, research and increased public awareness.

b. One of the tenets of the Coalition is open discussion among members, and room for differences of opinion. The Coalition will focus on issues around which general consensus can be reached, and joint action undertaken.

Article 2: Members

a. Members shall be those organizations interested in older adult mental and behavioral health and wellness, including issues of aging, physical health and disability and approved by the Coalition.

b. To request Coalition membership, the interested organization must send a written request to the Chair that states its interest in becoming a member and outlines its activities related to mental and behavioral health and aging.

c. Members may withdraw from the Coalition at will, with written notice to the Coalition.

Article 3: Withdrawal of Status

a. The Coalition may withdraw the status of any Member of the Coalition pursuing purposes conflicting with those of the Coalition.

Article 4: The Coalition

a. The Coalition shall meet at a place and date determined by the Coalition. Extraordinary meetings may be convened by the chairperson or the executive committee.

b. Composition: The Coalition consists of the officers of the Coalition and representatives of the Members.

c. Quorum: One-third of the Members shall constitute a quorum.

d. Voting: Each Member shall have one vote. All decisions shall be taken by a simple majority of those present and voting, except that an amendment of the Bylaws or a motion withdrawing the

status of a Member shall be taken by a two-thirds majority of the Members present and voting either in person or via conference call, electronic voting, or email prior to the established deadline for voting.

e. Publicity: Stationery of the Coalition shall not list names of Members.

g. Correspondence: Letters and other correspondence will be written on behalf of the entire Coalition and signed by the Chair. No individual members will be listed.

h. The Coalition may form time-limited committees or work groups to work on specific tasks, issues, or initiatives.

i. The Coalition shall meet at least three times a year.

Article 5: The Executive Committee

a. The Executive Committee shall consist of the Chair, Vice-chair, State/Local Coalition Representative, Consumer Representative, three At-large members, elected by the Coalition, and the immediate past chair of the Coalition.

b. The Executive Committee is authorized to act on behalf of the Coalition between meetings of the full Coalition on all matters except establishment of policy, membership, and bylaws revision.

c. The term of office of the Executive Committee shall be two years. They may be re-elected for an additional consecutive term.

d. Vacancies on the Executive Committee other than the immediate past chair may be filled by the Executive Committee for the rest of the unexpired term subject to the approval of the Coalition at its next meeting.

e. The Executive Committee shall convene as needed either in person or by conference call.

f. A quorum in the Executive Committee shall exist if a majority of the committee are present and/or are participating electronically. Actions of the Executive Committee require a majority vote of those participating in the meeting. Proxies are not permitted for voting in the Executive Committee.

Article 6: Nominating Committee and Elections

a. The Executive Committee shall appoint a Nominating Committee of three (3) members who reflect the broad membership of the Coalition. The Nominating Committee shall establish a slate of candidates for the various offices of the coalition, having due regard also for the broad membership of the Coalition.

Attachment 2

Addressing the Crisis in Older Adult Mental Health

Older Adult Mental Health Needs

- The population of older adults in the U.S. will nearly double over the next 20 years. More importantly, adults 65 and older will increase from 13% to 20% of the population, roughly equal to the population of children under age 18.
- If the prevalence of mental health disorders among older adults remains unchanged, over the next two decades the number of older adults with mental health and/or substance disorders will nearly double from about 8 million people to about 14 million people. That is staggering growth, and our service systems are not prepared.[1,2]
- At least 5.6 million to 8 million older adults – nearly one in five - have one or more mental health or substance use conditions which present unique challenges for their care.[3]
- Unfortunately, fewer than 40% of older adults with mental health and/or substance use disorders get treatment. Of those who receive treatment, most go initially to primary care physicians, who provide minimally adequate care less than 15% of the time. [4]

Why Older Adult Mental Health Matters

- Mental health and substance use disorders are major impediments to living well in old age. They cause considerable personal suffering and make it difficult for older people to achieve their potential in old age. This is a population in critical need of education, targeted prevention and early intervention.
- Untreated mental health and substance use disorders among older adults exacerbate health conditions, decrease life expectancy, and increase overall health care costs.[5,6,7]

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[1] Grayson, V., and Velkoff, V., (2010), *THE NEXT FOUR DECADES, The Older Population in the United States: 2010 to 2050, Current Population Reports, P25-1138,* U.S. Census Bureau, Washington, DC. Retrieved from: http://www.census.gov/prod/2010pubs/p25-1138.pdf.

[2] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: 1999).

[3] Institute of Medicine. (2012). *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* Washington, DC: National Academies Press.

[4] Wang PS, Lane M, Olfson M, Pincus H, Wells KB, Kessler RC (2005). Twelve-Month Use of Mental Health Services in the United States: Results from the National Comorbidity Survey Replication. Archives of General Psychiatry. 62: 629-640.

[5] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: 1999).

- Mental health disorders, particularly depression and anxiety, are major contributors to—and are exacerbated by—social isolation, which results in diminished quality of life, further barriers to intervention and premature institutionalization.[8]
- Older adults have one of the highest suicide rates in the nation, completing suicide nearly 30% more than the general population. In particular, white males 85 and over complete suicide at nearly four times the rate of the general population. As life expectancy increases, it is reasonable to anticipate that increasing numbers of older adults will probably die by suicide.[9]
    - Depression, one of the conditions most commonly associated with suicide in older adults, is a widely under-recognized and undertreated medical illness.[10]
    - Many older adults who die by suicide — up to 75 percent — visited a physician within a month before death.[11]
- Untreated mental health disorders among both older adults with physical disabilities and family caregivers are a major cause of avoidable placements in institutional settings.[12,13,14]
- Treatment works. There are effective, evidence-based interventions that can improve the quality of life of older adults with mental health and substance use disorders, including dementia.
- Unfortunately, mental disorders among older adults are all too often neglected in our society due to the following factors:
    - Ageism – the false belief that mental disorders, particularly depression and dementia, are normal in old age. This belief is held not only by older adults, family members, and service providers, but is also rampant within society at large.
    - Stigma – the shame of having a mental disorder. Stigma discourages older adults and their family members from acknowledging mental health needs and pursuing treatment, ultimately decreasing quality of life.
    - Ignorance – the lack of education and understanding regarding age related vulnerabilities and impact of mental health disorders on older individuals. Without education on the diversity and

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[6] Husaini, B,A, et. Al (2000). Prevalence and cost of treating mental disorders among elderly recipients of Medicare services. *PsychiatricServices,* 51, 1245-1247.

[7] Katon,W., Ciechanowski, P. (2002). Impact of major depression on chronic medical illness. *Journal of Psychosomatic Research, 53*, 859-863.

[8] Warner, J. P.(1998) Quality of life and social issues in older depressed patients. *International Clinical Psychopharmacology*, 13, Supplement 5, S19–24.

[9] Mortality Reports. National Center for Injury Prevention and Control. Centers for Disease Control and Prevention. http://www.cdc.gov/ncipc/wisqars/

[10] Blazer, D. (2009). Depression in late life: Review and commentary. *FOCUS,* 7, 118-136.

[11] Luoma, J., Martin, C., & Pearson J. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *Am J Psychiatry.* 159 (6), 909-916.

[12] Grabowski, D.C., Aschbrenner, K.A., Feng, Z., & Mor, V. (2009). Mental illness in nursing homes: Variations across states. *Health Affairs*, 28 (3), 689-700.

[13] Dorenlot P, Harboun M, Bige V, Henrard JC, Ankri J. (2005). Major depression as a risk factor for early institutionalization of dementia patients living in the community. *Int J Geriatric Psychiatry*, 5, 471-8.

[14] Buhr, G., Kuchighatla, M., & Clipp, E. (2006). Caregivers' reasons for nursing home placement: Clues for improving discussions with families prior to the transition. *The Gerontologist*, 46, 52-61.

severity of behavioral conditions in later life, problems are not identified, treatment is not accessed and recovery is not obtained.

It is imperative that we develop geriatric mental health workforce capacity and competency to meet the growing and unique needs of late life mental illness and substance use disorders, and translate research findings into practice, invest in evidence based practices.

These investments are needed to improve the lives of older adults and their families and reduce overall costs to the health care system. In addition to the moral obligation we have to our older citizens, optimizing late life behavioral health benefits our families and communities in multiple ways:

- Healthy older adults make valuable contributions as employees in our workforce and as volunteers in communities and organizations with need.
- Family members can remain engaged in the workforce and personal pursuits as they do not need to prematurely leave the workforce to care for older loved ones with functional and health declines attributable to untreated behavioral health disorders.
- Unnecessary, premature and costly institutionalization can be delayed or avoided and caregiver burden and symptoms of depression reduced with effective programs of counseling and support for caregivers of persons with dementia.[15],[16]

Priorities for Addressing the Mental Health Needs of Older Adults

Assure access to an affordable and comprehensive range of quality mental health and substance abuse services including: outreach, home and community-based services, prevention, and intervention, coordinated with acute and long-term services and supports. Actions might include:

- Identify older adults as a priority population for behavioral health services and make prevention, screening, assessment, early identification, treatment services and recovery programs available across the lifespan including to older adults and their care partners through the spectrum of care settings.
- Foster state interagency actions for improved older adult behavioral health and services such as those drafted by participants of the 2012 SAMHSA / AoA sponsored Policy Academy Regional Meetings and those offered in the Older Americans Behavioral Health Issue Brief Series http://www.aoa.gov/AoARoot/AoA_Programs/HPW/Behavioral/index.aspx.
- Promote the availability and further adoption of effective older adult mental health program models.

[15] Mittelman MS, Haley WE, Clay OJ, Roth DL. Improving caregiver well-being delays nursing home placement of patients with Alzheimer disease. Neurology. 2006 Nov 14;67(9):1592-9.

- Encourage the state to direct some level of mental health and substance abuse prevention and treatment block grant and other funds to expand services for older adults and to improve the quality of services through the implementation of evidence-based practices. Encourage the state to report on the use of these funds and how these funds support development of service capacity and / or geriatric workforce competencies.
- Educate older adults, their care partners, service providers, and the state government about the major components of the Affordable Care Act (ACA) that impact older adult mental health (including, but not limited to, essential health benefits, home- and community- based options, screening services) and encourage it to make full use of these provisions.

Support the integration of older adult mental health and substance abuse services into primary health care, long-term services and supports and community-based service systems. Actions might include:

- Gain familiarity with concepts and community activity underway on such topics as behavioral health integration, case management for mental and physical health, interdisciplinary teams, mental and behavioral health integration with federally qualified health centers, primary care integration with behavioral health centers, Accountable Care Organizations (ACOs), and, Patient Centered Medical Homes and Health Homes.
- Ensure that older adult mental health and substance abuse prevention, treatment and recovery services are integrated into primary health care, long-term services and supports, and community-based service systems.
- Strengthen and/or develop new collaborations with other organizations interested in fostering integrated care models in Patient Centered Medical Homes and other institutional or community based settings.

Designate an older adult mental health leader or coordinator in federal, state and local agencies responsible for mental health services.

Address severe provider and faculty shortages in mental health, behavioral health and substance abuse for older adults by expanding geriatric traineeships for a broad range of mental health and health professionals, and targeting national financial incentives such as loan forgiveness programs and continuing education funding. Actions might include:

- Review and consider state and local implications of (a) Affordable Care Act provisions related to geriatric mental health workforce development and (b) recommendations within the Institute of Medicine (IOM) report, *Mental Health and Substance Use Workforce for Older Adults: In Whose Hands* (2012) see http://www.nap.edu/openbook.php?record_id=13400.
- Encourage federal policymakers to appropriate funds for the Affordable Care Act workforce provisions that authorize training, scholarship, and loan forgiveness for individuals who work with or are preparing to work with older adults who have mental health and/or substance use conditions.
- Contact community and state educational institutions to encourage coursework to prepare individuals for work with older adults.

- Encourage local and state organizations to promote the competency of their staff to work with older adults by sharing existing geriatric competencies, such as the *Multidisciplinary Competencies in the Care of Older Adults at the Completion of the Entry-level Health Professional Degree* developed by the Partnership in Health and Aging.

[16] Substantial literature confirms that family caregivers are the primary source of care in the community for persons with dementia and behavioral disturbances of persons with dementia are associated with caregiver depression including: Covinsky KE, Newcorner R, Fox P, et al. Patient and caregiver characteristics associated with depression in caregivers of patients with dementia. J Gen Intern Med. 2003;18(12):1006-1014.