Addressing the Behavioral Health Needs of Older Adults

December 2, 2015 2:00 p.m. Eastern

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Cosponsored by Grantmakers In Aging

Substance Abuse and Mental Health Services Administration
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The Silver Wave

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Addressing the Behavioral Health Needs of Older Adults Webinar
December 2, 2015

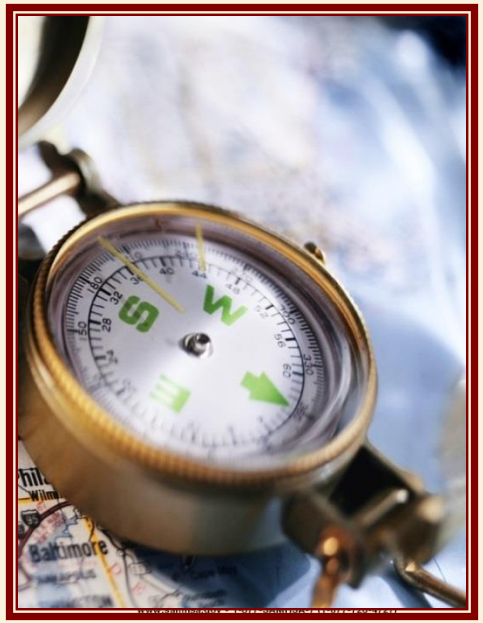
DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

SAMHSA's Vision, Mission and Roles

- **Vision:** A Nation/Community Free of Substance Abuse & Mental Illness & Fully Capable of Addressing BH Issues that Arise from Events of Physical Conditions

- **Mission:** to reduce the impact of substance abuse and mental illness on America's communities

- **Roles:**
  - Voice and leadership
  - Funding - service capacity development
  - Information and communications
  - Regulation and standard setting
  - Practice improvement



Observations

- It appears that we humans have resilience and ability to cope with inevitable changes in our health, our functioning, and even our sense of ourselves.
- The elderly comprise an age group spanning about 40 years, during which time there are major changes in life experience and neurophysiologic functioning that varies from person to person.
- Elderly individuals should be treated as younger counterparts, with careful diagnosis, good medical care, and compassionate prescribing.

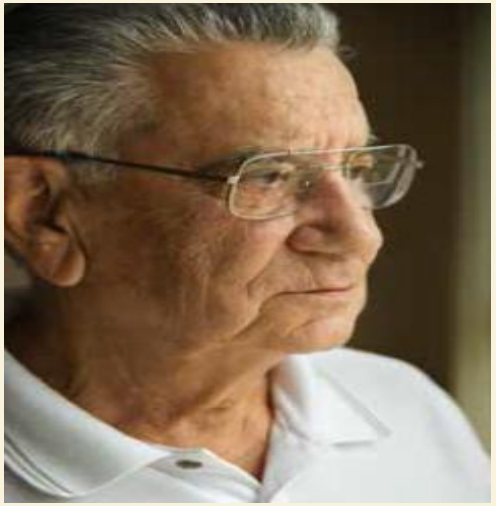
Observations (cont)

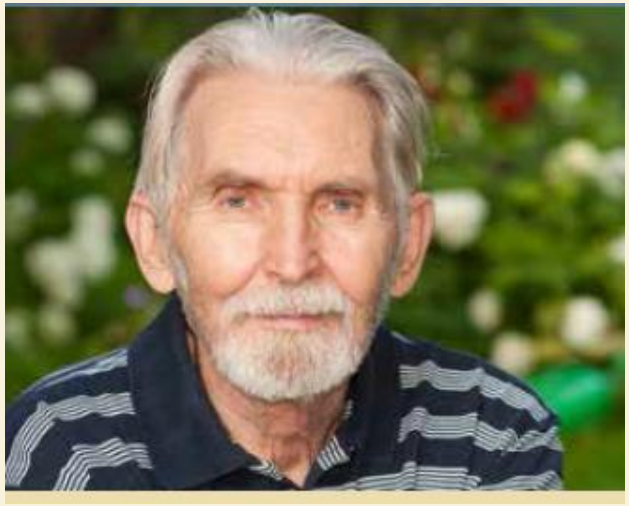
- The approaching “silver tsunami” is anticipated to nearly double the number of older adults w/ MH or SUDs by the year 2030, while current trends suggest that the total no. of geriatric psychiatrists will decrease, amounting to less than 1 geriatric psychiatrist for every 6K older adults in need of treatment.

- According to a recent SAMHSA report, older adults (aged 65+) represent only 4.4% of those served by state MH agencies even though they account for 13% of the population. The Institute of Medicine report [2] concluded that no government agency had been designated to assume responsibility for this rapidly growing high-cost, high-risk group that is “in no one’s hands”.

[2] REFERENCE: Eden J, Maslow K, Le M, Blazer D, eds: Committee in the Mental Health Workforce for Geriatric Populations; Board on Health Care Services; Institute of Medicine. The mental health and substance use workforce for older adults: in whose hands? Washington, DC: National Academies, 2012

Older Americans Behavioral Health





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ACA & Geriatric Behavioral Health – Implications

About 6 to 8 million Americans aged 65 or older have a MH or SA disorder, and it is estimated that this number will nearly double to 10 to 14 million by the year 2030 [1]

A recent Institute of Medicine report – subtitled "in Whose Hands?" – concludes that this unprecedented demographic wave will overwhelm an inadequate MH professional workforce unless major reforms are made w/respect to financing, organizing, & delivering service to this high-risk, high-cost population. [1]

[1] REFERENCE: Stephen J. Bartels, MD, MS, Lydia Gill, BS and John A. Naslund, MPH. The Affordable Care Act, Accountable Care Organizations, and Mental Health Care for Older Adults: Implications and Opportunities. President and Fellows of Harvard College. 2015

Patient Protection & ACA

- Important ACA reforms related to care for older adults include restructuring Medicare reimbursements from fee-for service to bundled payments,
- Providing single payments to hospitals or physician groups for defined episodes of care,
- Provisions for measuring quality, support for health information technology, &
- Payments based on quality over quantity

ACA & Geriatric Mental Health

Selected components of the ACA & potential implications for geriatric mental health, include:

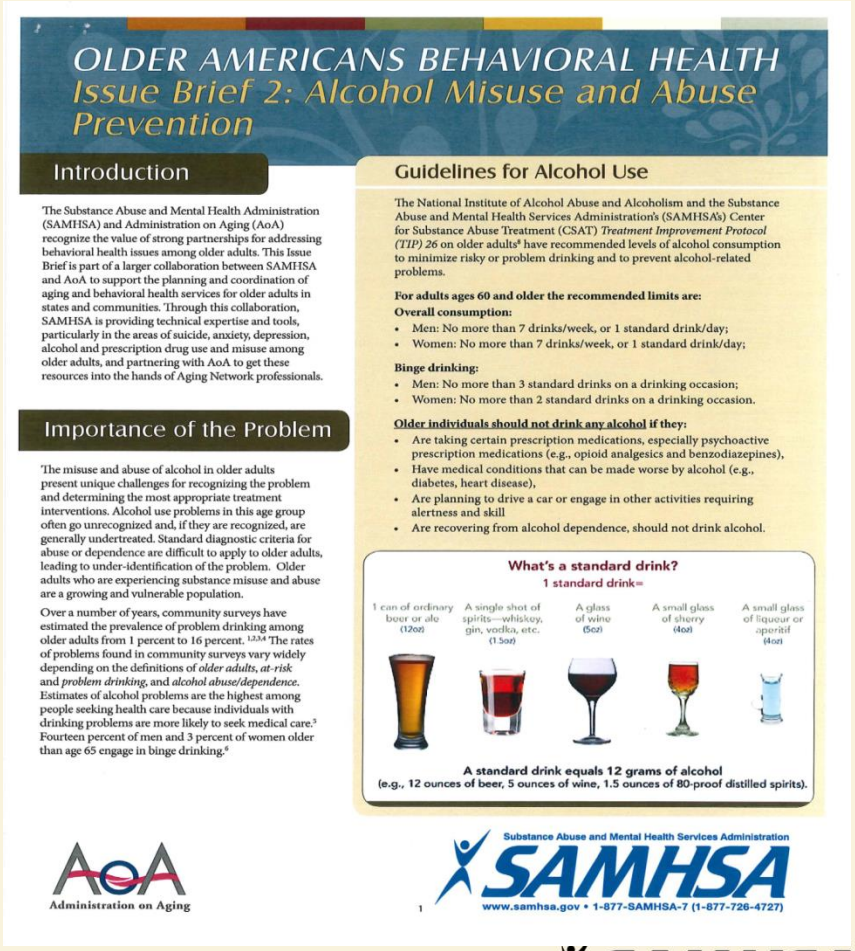
1. Accountable care organizations
2. Patient-centered medical homes,
3. Medicaid-financed specialty health homes
4. Hospital readmission and health care transitions initiatives
5. The Medicare annual wellness visit

ACA & Geriatric Mental Health (cont.)

6. Quality standards & associated incentives,
7. Support for health information technology & telehealth
8. Independence at Home & the 1915(i) State Plan Home and Community-Based Services program, &
9. The *Centers for Medicare & Medicaid Services' Medicare-Medicaid Coordination Office*; *Center for Medicare and Medicaid Innovation*; & *Patient-Centered Outcomes Research Institute*

SAMHSA ACL (AOA) Collaboration Series

SAMHSA & ACL collaboration to get resources into the hands of Aging network professionals



OLDER AMERICANS BEHAVIORAL HEALTH
Issue Brief 2: Alcohol Misuse and Abuse Prevention

Introduction

The Substance Abuse and Mental Health Administration (SAMHSA) and Administration on Aging (AoA) recognize the value of strong partnerships for addressing behavioral health issues among older adults. This Issue Brief is part of a larger collaboration between SAMHSA and AoA to support the planning and coordination of aging and behavioral health services for older adults in states and communities. Through this collaboration, SAMHSA is providing technical expertise and tools, particularly in the areas of suicide, anxiety, depression, alcohol and prescription drug use and misuse among older adults, and partnering with AoA to get these resources into the hands of Aging Network professionals.

Importance of the Problem

The misuse and abuse of alcohol in older adults present unique challenges for recognizing the problem and determining the most appropriate treatment interventions. Alcohol use problems in this age group often go unrecognized and, if they are recognized, are generally undertreated. Standard diagnostic criteria for abuse or dependence are difficult to apply to older adults, leading to under-identification of the problem. Older adults who are experiencing substance misuse and abuse are a growing and vulnerable population.

Over a number of years, community surveys have estimated the prevalence of problem drinking among older adults from 1 percent to 16 percent.[1,2,3,4] The rates of problems found in community surveys vary widely depending on the definitions of *older adults*, *at-risk* and *problem drinking*, and *alcohol abuse/dependence*. Estimates of alcohol problems are the highest among people seeking health care because individuals with drinking problems are more likely to seek medical care.[5] Fourteen percent of men and 3 percent of women older than age 65 engage in binge drinking.[6]

Guidelines for Alcohol Use

The National Institute of Alcohol Abuse and Alcoholism and the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT) *Treatment Improvement Protocol (TIP) 26* on older adults[8] have recommended levels of alcohol consumption to minimize risky or problem drinking and to prevent alcohol-related problems.

For adults ages 60 and older the recommended limits are:

Overall consumption:

- Men: No more than 7 drinks/week, or 1 standard drink/day;
- Women: No more than 7 drinks/week, or 1 standard drink/day;

Binge drinking:

- Men: No more than 3 standard drinks on a drinking occasion;
- Women: No more than 2 standard drinks on a drinking occasion.

Older individuals should not drink any alcohol if they:

- Are taking certain prescription medications, especially psychoactive prescription medications (e.g., opioid analgesics and benzodiazepines),
- Have medical conditions that can be made worse by alcohol (e.g., diabetes, heart disease),
- Are planning to drive a car or engage in other activities requiring alertness and skill
- Are recovering from alcohol dependence, should not drink alcohol.

What's a standard drink?

1 standard drink=

1 can of ordinary beer or ale (12oz) | A single shot of spirits—whiskey, gin, vodka, etc. (1.5oz) | A glass of wine (5oz) | A small glass of sherry (4oz) | A small glass of liqueur or aperitif (4oz)

A standard drink equals 12 grams of alcohol (e.g., 12 ounces of beer, 5 ounces of wine, 1.5 ounces of 80-proof distilled spirits).

AoA Administration on Aging

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Alcohol Misuse & Abuse Prevention

- NIAAA/CSAT TIP 26 Guidelines for Alcohol use
- Levels of risk (low risk, at risk, problem use, alcohol dependence)
- Use of SBIRT
- Strong association between alcohol use disorder & depression
- Use PHQ-9 screening instrument

Preventing Suicide in Older Adults

- Higher suicide rates in older white males (30 per 100,000)
- Risk Factors: depression, marked feeling of hopelessness, co-morbid general medical conditions, pain and declining role functions, social isolation
- Firearms the most common method of suicide
- Assessing & acting on suicide risk

Prescription Medicine Misuse & Abuse in Older Adults

- More use of psychotropic medications than younger adults
- Understanding use, misuse, abuse, dependence distinct from medication mismanagement (i.e. confusion, etc.)
- Use of SBIRT
- Require coordinated system of care that integrates medical/physical health, behavioral health & the aging services network to fully address
- *SAMHSA GET CONNECTED toolkit*

Depression and Anxiety: Screening & Intervention

- Depression NOT a normal part of aging
- Medical problem that can be successfully treated
- Symptoms are depressed mood, loss of interest, lack of energy, extreme quiet, worthlessness, etc.
- ↑ Incidence for individuals with mental illnesses
- Often under-recognized & under-treated in older adults
- Use of PHQ–9; Geriatric Depression Scale (GDS)
- Embed effective depression treatments into service models

  e.g. IMPACT, PROSPECT, PEARLS, IDEAS

Depression in the Elder Years

- It appears that we humans have resilience and ability to cope with inevitable changes in our health, our functioning, and even our sense of ourselves.
- We may have periods of unhappiness as we age, but here is an essential point for all of us clinicians: Unhappiness is not necessarily depression.
- What makes late-life depression different from earlier life?

Depression in the Elder Years

- But there are many other contributing factors, including changes with age, medical illness, inflammation and chronic disease, and medications and medical treatments themselves. The normal aging process includes a gradual decline in neurotransmitter and synaptic efficiency.
- Communication throughout the emotional regulatory pathways of the brain may be slower or dysfunctional due to alterations in neurotransmitter communication pathways and genetic transcription in neuronal nuclei. Late-life depression therefore is often associated with some degree of cognitive decline manifested as decreased attention, concentration , and working memory. The relationship between late-life depression and states of dementia or so-called pseudo-dementia has been known for years.
- The relationship between late-life depression and physical illness is also well known.

Integration of Behavioral Health & Physical Health Care

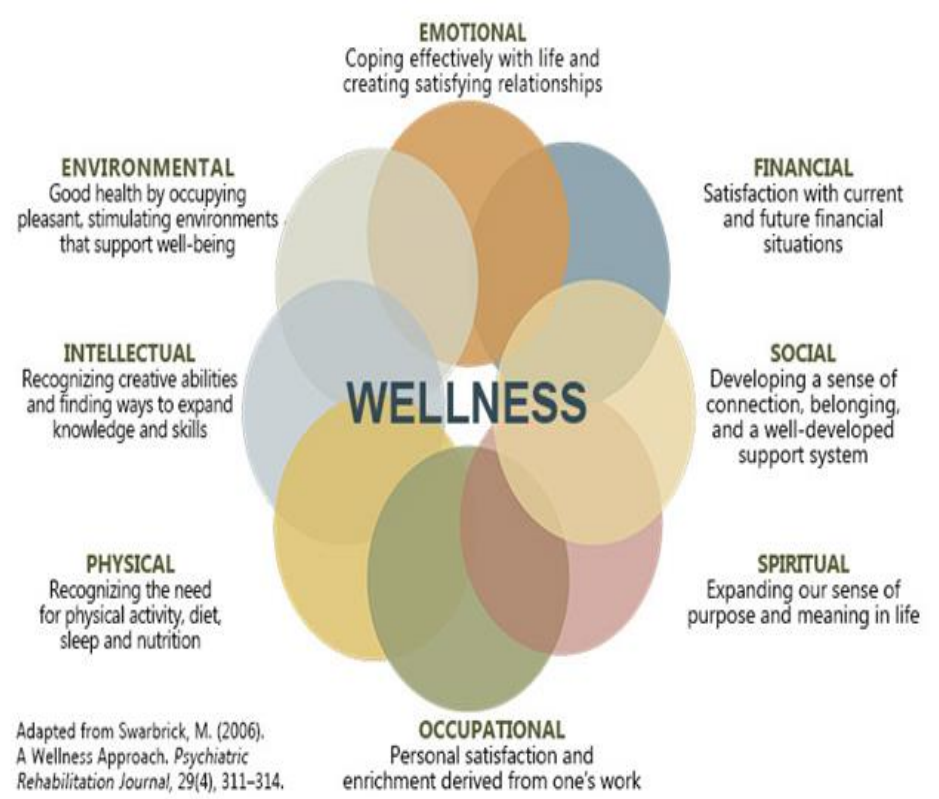
- PC Provider issue
- Patient issues
- System issues
- Financing issues

- Integrated Care Models

- Tip 34
- NREPP
- ACL Issue Briefs
- EBP: Treatment of Depression

SAMHSA
Wellness Initiative Focus

- Belief in overall recovery
- Connected to physical/mental care
- Focus on integration



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THANK YOU! QUESTIONS??

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Promising directions for funders: Archstone Late Life Depression Initiative

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Funder Webinar on Older Adult Behavioral Health

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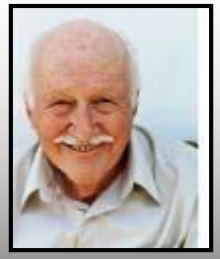
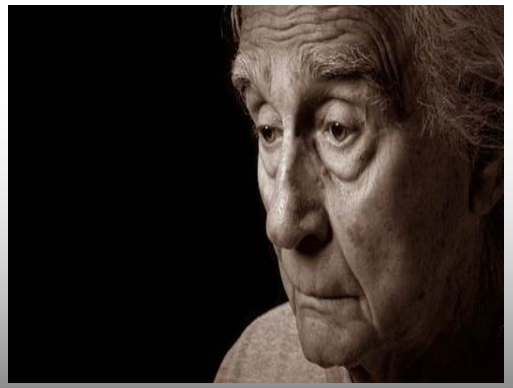
December 2, 2015



Overview

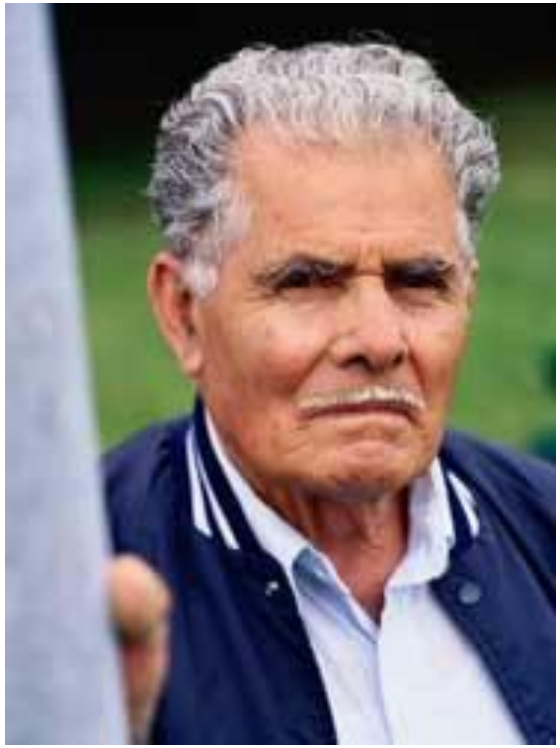
- **Public health importance of depression in late life**
- **Findings from a recently completed review on promising directions**
- **Archstone Late Life Depression Initiative**

Depression

- More than having a bad day or a bad week
- Pervasive depressed mood / sadness
- Loss of interest / pleasure

  Lack of energy, fatigue, poor sleep and appetite, physical slowing or agitation, poor concentration, *physical symptoms (aches and pains)*, *irritability*, thoughts of guilt, and thoughts of suicide

- A miserable state that can last for months or even years



Depression

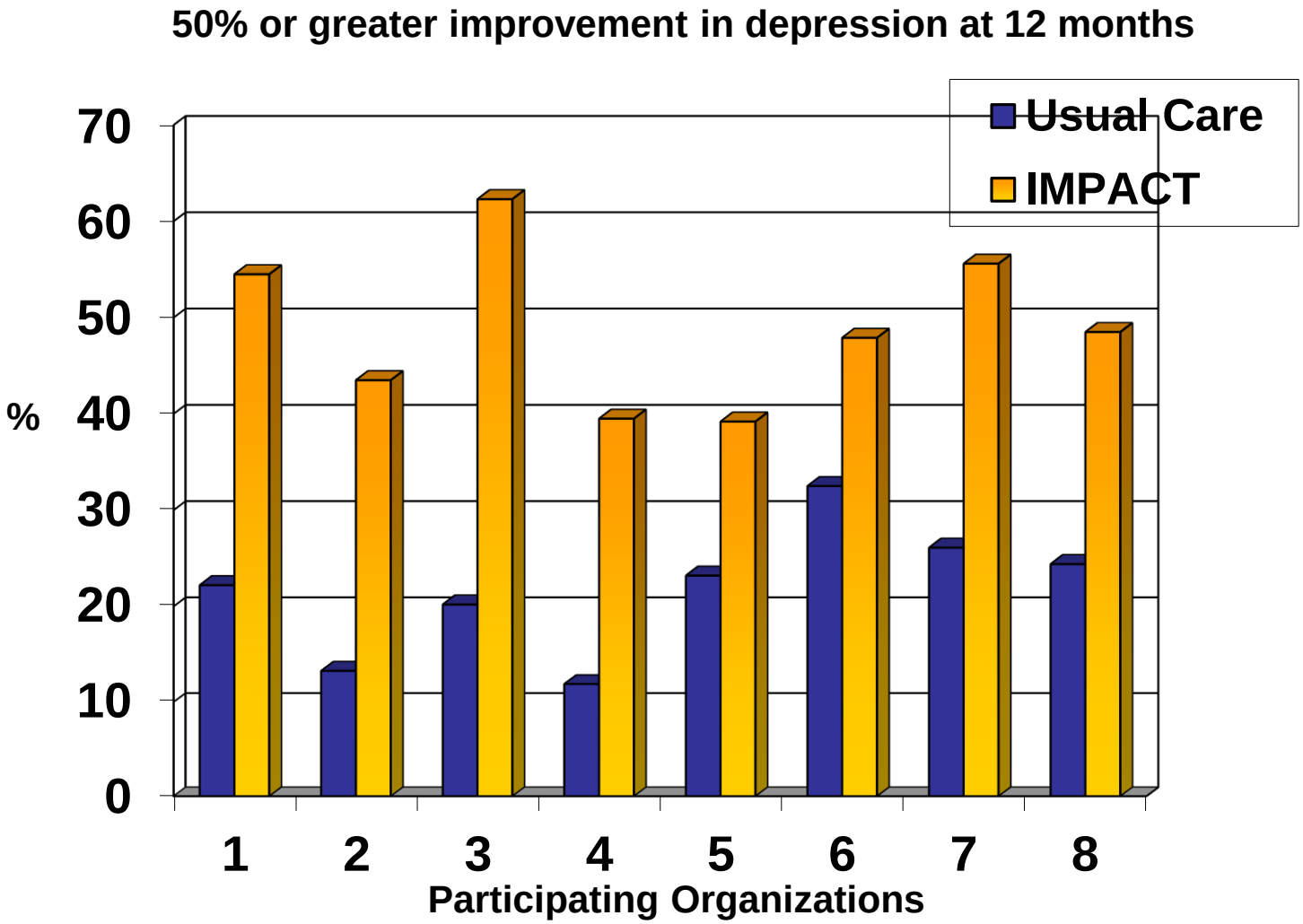
- **Common**
  - 10% in primary care
- **Disabling**
  - #2 cause of disability (WHO)
- **Expensive**
  - 50-100% higher health care costs
- **Deadly**
  - Over 30,000 suicides / year

Efficacious treatments for late-life depression

- Antidepressant Medications
  - **Over 25 FDA approved**
  - **All are effective in 40 - 50 % of patients if taken correctly**
  - **It often takes several trials to find effective treatment**
  - **Patients need support during this time**
- Psychotherapy
  - **CBT, IPT, BA, PST, etc.**
- Other somatic treatments
  - **Electroconvulsive Treatment (ECT)**
- Physical activity / exercise

Unutzer et al, NEJM 2007

Evidence-based models: IMPACT doubles Depression Care Effectiveness



Unutzer et al, JAMA 2002; Psych Clin N America 2004.

Subgroups at increased risk for under-treatment

- Racial and ethnic minorities
- Men
- Low income
- Low formal education
- Multiple medical co-morbidities
- Rural dwelling

Review of the literature

- **Archstone Foundation supported a literature review on promising directions for late-life depression (LLD) care**
- **Review included:**
  - **Peer-reviewed literature & grey literature**
  - **Interviews with experts in the field on most pressing areas for research and practice change**
- **Report – "Depression in Late Life: Opportunities for Program Development and Practice Improvement" & published article**
- **From recommendation list, two promising directions for improving engagement and treatment outcomes selected:**
  - **Involve family members and peers**
  - **Developing stronger linkages between health clinics and community agencies and non-treatment settings**
- **Additional recommendations in report and published article**

Directions for Effectiveness Research to Improve Health Services for Late-Life Depression in the United States

Theresa J. Hoeft, Ph.D., Ladson Hinton, M.D., Jessica Liu, B.S., Jürgen Unützer, M.D., M.A., M.P.H.

Considerable progress has been made in the treatment of late-life depression over the past 20 years, yet considerable gaps in care remain. Gaps in care are particularly pronounced for older men, certain racial and ethnic minority groups, and those with comorbid medical or mental disorders. We reviewed the peer-reviewed literature and

American Journal of Geriatric Psychiatry, in press

Recommendations from literature review
(Hoeft et al, in press)

- Build on continued interest in patient-centered care to address multiple care needs among differing populations through patient-centered outcomes research (PCOR)
- Extend care and outreach via community health workers (CHWs) and family members
- Develop models that can treat depression across settings, with a focus on the growing importance of transitions in care and care in community settings
- Determine if and how to involve technology in late-life depression care
- Study the mechanisms of existing and developing interventions to encourage development of scalable, cost-effective models of care that can be disseminated to a wide variety of communities

Archstone Foundation Late Life Depression Initiative

- ***Care Partners: Bridging Families, Clinics, and Communities to Advance Late-Life Depression Care***
- **RFP released in 2014**
- **7 sites (4 in Northern CA + 3 in Southern CA)**
- **Site specific activities + learning community**
- **UW (AIMS Center) providing technical assistance & UC Davis leading evaluation**
- **Goal is to improve access and outcomes**

Care Partners: Bridging Families, Clinics, and Communities to Advance Late-Life Depression Care

- **Evidence-based Collaborative Care for older adults with depression in primary care**
- **Plus**

  + Community-based organizations (CBOs)

  and/or

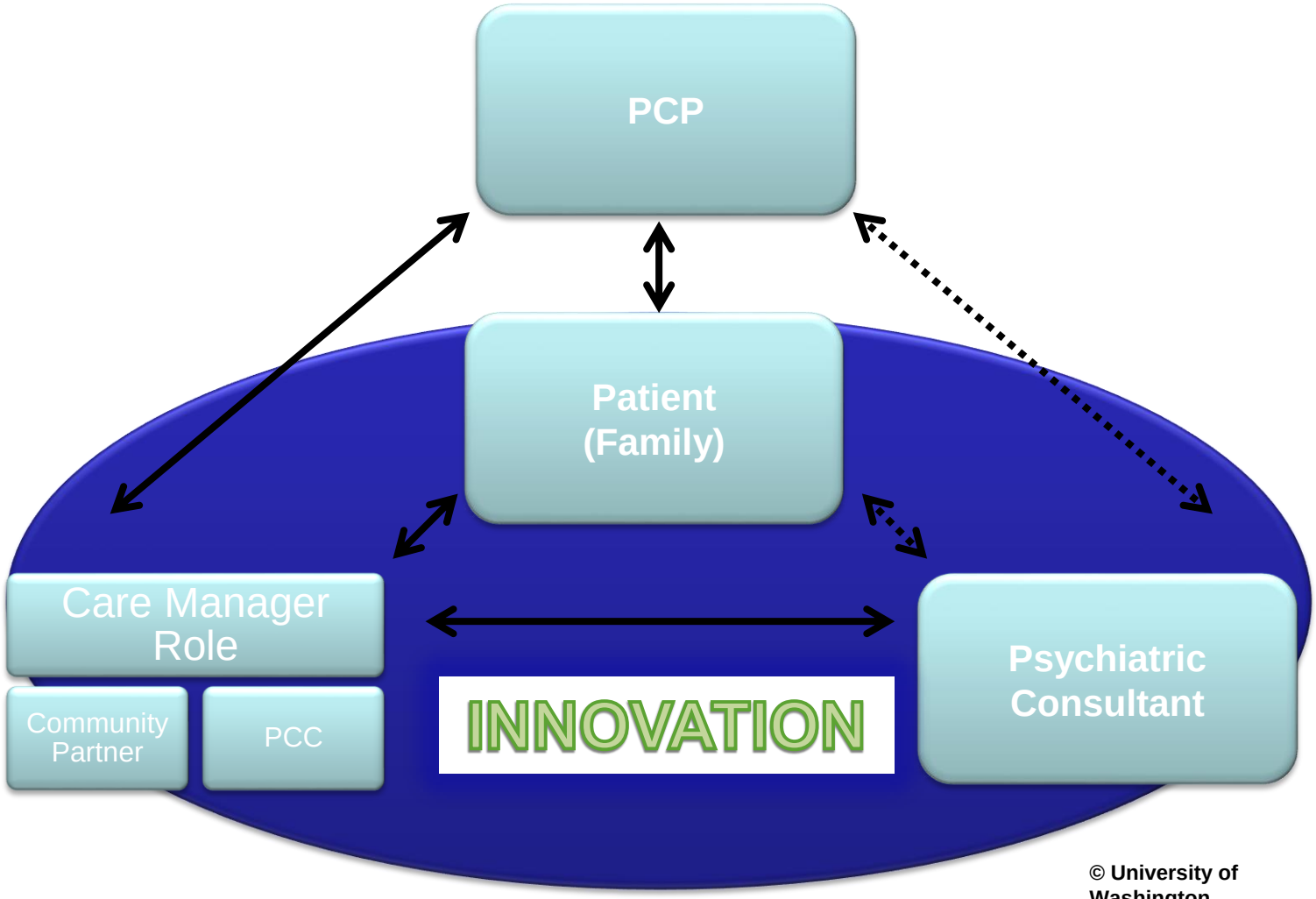
  + Family

Configuration of sites

Type of Partnership	Number of sites
Primary care – community-based organization*	**5**
Primary care – family	**1**
Primary care – community-based organization – family	**1**

***several with interest in family**

Partnering with a CBO and Family



Role of family and CBO in collaborative care for depression

- Depression screening and engagement in care
- Participation in assessment and treatment planning process
- Psychoeducation
- Supporting evidence-based care
  - Behavioral activation/problem-solving
  - Medication management
- Participation in primary care visits
- Facilitating connection to community resources
- Relapse and prevention planning

Why involve family?

- **Family members are often already involved!**
- **And patients want them involved**
- **But they are not well-supported by healthcare systems**
- **With recognition, support, and skills, family can be valuable depression care partners**

Acknowledgements

- **Jurgen Unutzer MD and the AIMS Center at University of Washington**
- **Funding: Archstone Foundation, National Institute of Mental Health, National Institute on Aging**

Thank you!

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Ideas for Funders: Supporting the Behavioral Health of Older Adults

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Why is Addressing the Behavioral Health of Older Adults Important and Timely?

- Of the 35 million now over age 65, 6.5 million, or 19%, are affected by depression
- Substance use/abuse is up overall, and the overdose rate for older adults has surpassed that of 25 to 44 year olds for the first time
- For older adults with a behavioral health disorder, 65% do not receive treatment or services

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Opportunities for Funders: Promote Healthy Aging across the Life Span

- Promote healthy aging across the lifespan
- Know the communities in your service area
- Start with modest goals
- If already supporting, think about next steps
- Potential areas of involvement:
  - Screening and treatment for depression and substance use/abuse
  - Peer support and recovery
  - Fully integrating behavioral health support into successful aging in community

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Communicating the Behavioral Health Needs of Older Adults to Your Constituencies

- Board Members: Communicate demographic data on your service area and availability of partner agencies; Have a plan for where to engage
- Potential Partner Agencies: Opportunity to learn together and create or deepen collaboration
- Community At-Large: Raise awareness and offer opportunities for active participation
- All Audiences: Reframe the topic with positive messaging; Promote and support healthy aging across the lifespan

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Thoughts on How to Get Involved

- Determine Objectives and Identify a Goal
  - Do you want to design a program, adapt or select an off-the-shelf program?
  - Where would your partnership/program fit in the matrix of resources already available?

- Distinctives of Behavioral Health Support for Older Adults
  - Prevention - What does it look like? Social Isolation is a major contributing factor to depression and overall decline of health – Promoting social engagement supports the behavioral health of older adults
  - Prevention can venture outside of conventional healthcare into spheres including the arts and continuing education

Thoughts on How to Get Involved

- Distinctives of Behavioral Health Support for Older Adults
  - Screening – Depression screening such as the PHQ-9 can be integrated into primary care protocols, but may need to build capacity to provide interventions when indicated
  - Screening for Substance Use/Abuse in Primary Care Settings – “Screening Brief Intervention and Referral to Treatment” (SBIRT) Validated screening instruments for prevention and early intervention
  - Treatment – Geriatric BH specialists
  - Recovery – Peer support and behavioral health community health workers

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What Might Collaborating Look Like?

- Leverage your assets and resources: Match your goals and key objectives with available partners
- Supporting the behavioral health of older adults is likely to bring about new partnerships
- Augment the primary care older adults are already receiving by adding behavioral care
- Senior centers, YMCA's, faith-based, Faith in Action, Social Services, and other Community Based Organizations
- Maximize existing strengths in behavioral healthcare: formerly case management, now care coordination/navigation is more understood and accepted, and will likely become a standard of practice

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Behavioral Healthcare and Older Adults

- Why: Need is documented and opportunities abound
- How: Confer with GIH and GIA colleagues already active in supporting and advancing the behavioral health of older adults

Questions?

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GRANT MAKERS IN HEALTH

- More webinars on this topic?
- New topics you want to tackle or learn more about?
- Innovative work that you want to share?
- A question you want to pose to your colleagues?

Contact us at aging@gih.org