**SUMMIT on OLDER ADULTS:**

Behavioral Health Issues and the Coming Wave

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.

**Introduction**

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.

General Background

The Summit | Welcome and Overview

**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.

**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:

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:

V 11.4% suffer from anxiety, including panic and obsessive compulsive disorder.

V 7% of the population suffer depression, compared to 10% for under 65.

V 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:

V Ongoing support for the Massachusetts Partnership on Substance Use in Older Adults since its

beginnings in 1987.

V Sponsorship of the annual Aging with Dignity Conference for 19 years.

V 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.

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

with prescription medications.

V The Commonwealth’s Prescription Monitoring Program data shows adults between ages 51 and

70 fill the most prescriptions for medications with abuse potential.

V 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.

V 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:

V 51% of suicide victims had a documented current mental health problem such as depression;

V 37% were currently receiving some form of mental health treatment; and

V 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?

V 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.

V 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.

V 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.

V 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:

V Mental Illness can double or triple the cost of care to Medicaid and Medicare for those who are

dually eligible.

V 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:

V Depression kills older women 7 years after hip fracture.

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

V Older men with depression have a higher rate of suicide.

**7.**

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

V Integrated service delivery in primary care.

V Mental health outreach services.

V Mental health consultation and treatment teams in long-term care.

V Family/caregiver support interventions.

V Psychological and pharmacological treatment.

V 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:

V Self-monitoring.

V Health data entry.

V Self-management education.

V 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:

V Community programs, research, education.

V Health coaches, self-management.

V 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:

V 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.

V 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:

V 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.

V Untreated mental illness is often the decisive factor in predicting nursing home placement.

**9.**

Some solutions to consider:

V 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.

V Studies have shown mental health screenings at annual physicals will result in approximately one

third of the patients requesting a referral for treatment.

V 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:

V Dually Eligible Demonstration Projects, including one in Massachusetts known as One Care.

V Community-based Health Homes.

V 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:

V Dementia.

V Depression.

V Anxiety.

V Medication challenges.

Lastly, as part of the challenge to keep the dialogue going, Ms. Power asked all Summit

participants to answer the following questions:

V What is your role in addressing the Coming Wave?

V What barriers do you see as surmountable or insurmountable?

V What partners or collaborations need to be established or expanded?

V What policies need to change?

V 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:

V Responding to the Shortage of Physicians

V Stigma

V Training and Specific Populations within the Senior Community

V Advocacy and State Government

V Educational Outreach and Information on Available Services

V Topics for Future Summits or Meetings

V 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.

**Bernie Carey**

Massachusetts Association for Mental Health

Lisa Colozzo

Massachusetts Department of Mental Health

Michelle Cormier Tallman

Massachusetts Department of Mental Health

Carol Girard

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Chet Jakubiak

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Massachusetts Association for Mental Health

Eleanor Shea-Delaney

Massachusetts Department of Mental Health

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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**

Planning Committee Members

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:

V Prevention

V Building a system of community-based services

V Residential Care

V Staff Development or Training

V 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 populations 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. ~

**16.**