Approved: February 25, 2010
Date

MINUTES OF THE HOUSE AGING AND LONG TERM CARE COMMITTEE

The meeting was called to order by Chairman Bob Bethell at 3:30 p.m. on February 16, 2010, in Room 784 of the Docking State Office Building.

All members were present except:
Representative Owen Donohoe- excused
Representative Scott Schwab- excused

Committee staff present:
Doug Taylor, Office of the Revisor of Statutes
Iraida Orr, Kansas Legislative Research Department
Kathie Sparks, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Judith Holliday, Committee Assistant

Conferees appearing before the Committee:
Janice Dinkel, LSCSW, Associate Professor of Social Work, Kansas State University
Skye Westerlund, LMSW, Executive Director, National Association of Social Workers-Kansas
Annette Graham, Executive Director, Central Plains Area Agency on Aging
Steve Denny, Senior Outreach Services, Four County Mental Health Center

Others attending:
See attached list.

Chairman Bethell asked for approval of the February 9 meeting minutes. Representative O'Brien made the motion to approve the minutes, seconded by Representative Hill. The motion carried.

Panel Discussion on Geriatric Mental Health Task Force

Chairman Bethell thanked Representative Furtado for her efforts in securing speakers for the panel discussion on the geriatric mental health task force. He told the group that each speaker would have about ten minutes to summarize their comments, followed by a question and answer period at the end.

Representative Furtado told the Committee that her intent was to have a discussion and exchange ideas on the subject of geriatric mental health and determine how to frame a plan for looking ahead and dealing with mental health issues in an aging population.

Representative Furtado mentioned the following: examining the manifestations of mental illness by decades; develop a timetable for workers to develop the skills necessary to deal with the aging population, including worker replacement and recruitment needs; assessing the educational programs available and how to steer the best individuals into the area of geriatrics; and addressing community involvement, such as through volunteers and philanthropy. After these components are assessed, then the Committee can look at the needs and how to bring about a solution.

Janice Dinkel, LSCSW, Associate Professor of Social Work, Kansas State University, addressed the Committee on the social work curriculum and how the profession is preparing for the upcoming aging boom. (Attachment 1) Ms. Dinkel spoke to the participation of Kansas State University in a three-year initiative to help infuse aging content into the social work curriculum. Graduates are capable of differential diagnosis–determining what really ails the older adult; can perform risk assessment for suicidal individuals; and refer the individual to health professionals for further diagnoses.

Skye Westerlund, LMSW, Executive Director, National Association of Social Workers--Kansas Chapter, commented on the changes that affect the mental health of a diverse group of older citizens. These include poverty; kinship care– intergenerational families with rising elder abuse; depression and high suicide rates in the elderly; chronic illness; retirement; and end of life or palliative care. (No written testimony)

Ms. Westerlund stated some challenges in recruitment of workers, mainly that caring for older adults is harder, plus the aging work force takes many skilled workers out of the picture without being replaced. The

non-profit agencies supply 37% of the care for aging adults, public agencies provide 24% of the care, and private sector provides care for 17% of the aging population.

Ms. Westerlund stated that we need to support families who care for the frail elderly and provide up-to-date information to them so they can access services they need. Finally, she stated that of people age 60 and older, 80% need at least one prescription.

Annette Graham, Executive Director, Central Plains Area Agency on Aging, addressed the urgent need to address the mental health issues of older Kansans. (Attachment 2) Ms. Graham stated that older adults experience significant mental health issues that negatively impact physical health, quality of life and relationships. She stated the need will continue to grow as baby boomers reach age 65 this year.

Twenty percent of older adults experience mental health problems, including anxiety disorders, mood disorders such as depression, and cognitive problems such as Alzheimer's disease and dementia. Substance abuse and suicide in the elderly is higher than younger populations. Inadequate treatment, misdiagnosis, inappropriate medications, and inadequate referral and follow up are part of the problem.

Ms. Graham told the Committee that the elderly are the most reluctant to seek out services for themselves, but even when services are desired there are many barriers that interfere with access: lack of transportation, homebound individuals, limited availability of in-home mental health services, cultural barriers, limited trained providers in aging issues, stigma among older adults, and rising costs of mental health services.

More older adults with a physical complaint will likely receive mental health care from a general physician; rarely do they talk about their mental health complaints. Often co-existing physical conditions, multiple medications and the interactions of prescription medications cover up the mental health issues. As many as 63% of adults age 65 and older do not receive appropriate mental health treatment.

The fastest growing segment of the population is age 65 and older, and the number will double between 2000 and 2030. Growing mental health issues will overwhelm the health care system, and entry into nursing homes will increase. As of now, very few doctors are trained in geriatrics. Kansas must take steps now to prepare to meet those growing needs, reduce excess disability, reduce medical and hospital expenditures, and reduce premature institutional placement.

Steve Denny, Senior Outreach Service (SOS), Four County Mental Health Center, spoke to the Committee about outreach services for the aging population. (Attachment 3) Mr. Denny is chair of the Aging Subcommittee to the Governor's Mental Health Planning Council.

Mr. Denny expressed his support for **HB 2057 - Enacting geriatric mental health act; establishing a geriatric mental health program.** He stated that this bill will help in meeting the mental health needs of older adults. Mr. Denny's testimony focused on four primary areas:

- The mental health needs of older adults. As the shortage of healthcare professionals trained in aging continues to increase, demand for the services will grow at 60 times the current rate. There is evidence that depression, which is treatable when diagnosed, can exacerbate the effects of cardiac disease, cancer, strokes, and diabetes. Yet, 60-80% of older adults who could benefit from treatment do not receive it.

  Major depression and anxiety disorders are the most commonly treated, and often lead to isolation, withdrawal, decreased self-care, low motivation, appetite changes, intense worry, hopelessness, feelings of worthlessness, and thought/plans of suicide in severe cases. Many SOS adults live independently or in assisted living, and it is the goal of SOS to emphasize and support independent living to cut down on premature nursing home placement due to mental health issues.

- The importance of direct service combined with public outreach and community networking in geriatric mental health. Stigma toward mental health services makes many adults fearful of family and friends discovering that they have mental health problems. One way to counter this stigma is to offer in-home services, which allow seniors to receive services and treatment in the privacy of their home environment.

environment. This will help seniors, especially in rural settings, achieve and maintain independence.

- **Services provided by the Senior Outreach program.** Although there is no reimbursement for Individual Outreach, identifying isolated older adults with mental health issues is crucial. During the outreach, SOS staff explains the program and seeks to connect and develop trust.

  Individual Outpatient Therapy, provided by a mental health professional, may be received in-home and is reimbursed through Medicare, Medicaid and private insurance. Medicare Part B only reimburses at 50% after co-pay, which is a deterrent for sustaining this program.

  Case Management is provided by bachelor's level staff, and is similar to traditional mental health case management. SOS Case Management is only reimbursable for Medicaid clients who meet the risk or functional criteria for psychiatric rehabilitation services.

  The SOS program initiates outreach and education through networking with AAAs, assisting living, physicians, home health agencies, hospitals, and health departments.

- **Workforce Development**. The SOS program is composed of mental health professionals and bachelor's level case manager who work together as a team. While there are classes available on aging, there is a need to provide educational resources in geriatric mental health to develop adequate skills. Graduate school classes and educational programs are needed, they are not overly expensive or complicated, and universities could partner with providers in offering these educational opportunities.

Data collected in the final project year on the SOS program indicates that access to the targeted population has been improved; treatment effectiveness is measurable, with 95% of SOS participants able to remain in the community versus moving to long-term care placements; and community awareness of mental health needs has increased.

Federal funding for outreach and education will end in May of 2010, and current budget cutbacks limit the agency's ability to sustain services unless support becomes available through **HB 2057**. This is a real opportunity toward development of a mental health and aging task force to address training and educational programs so we are prepared when funding does become available.

Written testimony was submitted by the following:
Ernest Kutzley, Advocacy Director, AARP Kansas (Attachment 4)
Alison Olson, LBSW, Information and Assistance Specialist, Wyandotte/Leavenworth Area Agency on Aging (Attachment 5)
Office of Aging and Long Term Care, University of Kansas School of Social Welfare (Attachment 6)

The next meeting is scheduled for February 25, 2010.

The meeting was adjourned at 4:50 p.m.

HOUSE AGING & LONG TERM CARE COMMITTEE

DATE: 2/16/2010

NAME	REPRESENTING
Kelly Jones	Office of Aging Long Term Care
Annette Graham	CPAAA
Tim Sandidge	SHC
Melsey Nepote	KNASW
Belinda Vierthaler	State LTC Ombudsman
Rosemary Chapin	Office of Aging and Long Term Care - KY
Jennifer Light	Intern for Rep Horst
Kathy Outlaw	KSNA
Dyrdlin Henry	A/Z ASSN
Amy Murphy	KMHC
Barb Conant	KDOA

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Why/How Social Work is Ready for the Aging Boom

Janice Dinkel, LSCSW, ACSW
Associate Professor of Social Work
Kansas State University
dinkel@ksu.edu

General Preparation:

- Graduates from Council on Social Work Education (CSWE) accredited schools are generalist practitioners and have "knowledge and skills necessary to work with individuals, families, groups, organizations and communities" and skills that can be used to enhance the functioning and well being of systems at all levels.

- Graduates must be able to "engage diversity and difference in practice." Areas of diversity include **age**, class, color, culture, disability, ethnicity, gender, gender identity and expression, immigration status, political ideology, race, religion, sex, and sexual orientation.

- CSWE curriculums are competency-based in the following general areas:
  - Engagement
  - Assessment
  - Intervention
  - Evaluation

- Students must complete a large field/practicum component – at least 400 hours, K-State requires 480. Graduate (MSW) programs require 900 hours.

- Upon graduation, students are professional social workers, ready to take licensure exams and hold professional social work positions. This is unlike other bachelor degree programs in the helping fields.

Additional Preparation for Working with Aged Population:

In the late 1990's CSWE joined with the John A Hartford Foundation in order to better prepare the social work profession's workforce for the upcoming aging boom. This has been a multi-faceted effort and has resulted in many national curriculum development initiatives (CDI's) at various universities around the country. Kansas State University has participated in one of these three-year initiatives to help infuse aging content throughout its social work curriculum. This infusion is now becoming the standard across the country, thanks to the efforts of the CSWE/Hartford initiative. In addition to the infusion of basic gerontological content, most social work programs offer specific courses on working with the aged population. K-State's program has an on-line offering: The Dynamics of Working with Older Adults. In addition, we utilize the Center on Aging at K-State for various courses to further augment our curriculum and better prepare our students.

The CSWE Gero-Ed Center was developed to help with curriculum infusion and more formally prepare social workers to address the growing needs of the aging population. Contact information follows.

National Center for Gerontological Social Work Education
http://www.cswe.org/CentersInitiatives/GeroEdCenter.aspx

SWE Gero-Ed Center
1701 Duke Street, Suite 200
Alexandria, VA 22314
Phone/Fax: 1.703.229.4021

Aging and Long Term Care Committee
Testimony on Geriatric Mental Health
February 16, 2010

Good afternoon and thank you Chairman Bethel and Committee members for allowing me this time to address your committee today. My name is Annette Graham; I am the Executive Director of the Central Plains Area Agency on Aging. Our agency coordinates the services for a tri -county region that includes Butler, Harvey and Sedgwick Counties. I am pleased to speak to you on the issue of mental health and older adults; this is an issue that I have been involved with for over twenty years.

My comments will focus on the urgent need for mental health services for older Kansans and the urgent need that Aging service providers see on a daily basis in our communities. Older adults experience significant mental health issues that negatively impact their health, their quality of life, and their relationships. There is a high level of unmet need among older adults, there are significant barriers to accessing services, the number of older adults experiencing mental health issues is increasing and there is an urgent need for Kansas to address this issue. This need will continue to grow, as the baby boomers begin turning 65 in January of 2011 we will see increased demands for mental health services.

Approximately 20% of older adults experience mental health problems which include anxiety disorders, mood disorders such as depression, severe cognitive problems such as Alzheimer's disease and other dementias. This is the highest of all populations and age groups. The number of older adults experiencing substance abuse is also a significant issue which raises this percentage even higher than the 20% figure. For the older population residing in nursing facilities the percentage that experience mental health issues ranges from 60 to 80% of the population. These conditions can be debilitating and they can be terminal. The highest rate of suicide is for males age 85 and over, the second highest rate is among adults age 75 to 84. The suicide rate for males age 85 and older is six times higher than that for the general population.

The data highlights that older adults do not receive adequate treatment: they face issues of under diagnosis, misdiagnoses, inappropriate medications, inadequate referral and follow up. Less than 3% of older adults receive treatment by a mental health specialist. In 2006 about 60% of older adults with mental health concerns had contact with a mental health professional and only about 4% of older adult visits to a Primary care physician resulted in a mental health diagnosis.

They are the age group who receive the least amount of mental health services and they are the most reluctant group to seek out services on their own behalf. Even when services are sought out there are many barriers that interfere with access: lack of transportation, individuals that are homebound, limited availability of in home mental health services, cultural barriers, limited number of providers trained in aging issues, the magnified issue of stigma among older adults, the compounding impact of ageism and the increased costs for mental health services.

The level of unmet need is immense and there is a need for specialized services for this growing population. Meeting the needs of this population is becoming increasingly critical as the population grows and as the boomers starts entering this phase of life next January. In Kansas, the percentage of adults age 60 and over is higher than the national average of 12%, Kansas is at 16.9%. In the rural areas that percentage is much higher. Too often the mental health needs of older adults are not identified, under diagnosed, misdiagnosed or inadequately treated. Older adults are more likely to receive mental health from a general physician and often they present with physical complaints, rarely do they present with a mental health complaint. The diagnosis process is complex due to the presenting problem often being not the mental health issue but rather a physical complaint, the multitude of co-occurring medical conditions, multiple medications and the interactions of these prescription medications. Often the mental health issues are not identified. Unfortunately, many people, including some professionals believe that depression is a normal part of aging. This belief contributes to lack of appropriate diagnosis, referral and treatment. Older adults are less likely to be referred for psychotherapy and treatment by mental health professionals, and more likely to be prescribed medication. Seniors utilize mental health services less than any other age group and it is estimated that as many as 63% of adults age 65 and older do not receive appropriate treatment.

The fastest growing segment of the population is the age 65 and over. Between 2000 and 2030 America's older population will double, growing to 70 million. The number of older adults with mental health disorders will also grow. Unless action is taken to address the needs of the growing population, the system of care will be overwhelmed and the medical utilization rates and costs will sky rocket. Government is already spending funds for the provision of services for this population. The medical care cost for the older adults with mental health issues is 50% higher than for those without mental health disorders. These older adults are three times more likely to enter a nursing home than a senior without a mental disorder. It is estimated that 60 to 80 % of older adults residing in a nursing home experience some type of mental disorder. We are already paying the price for the mental health problems in older adults; we are paying for it through increased medical

costs, excess disability, and premature institutionalization.

There are numerous barriers to accessing care. They include stigma which for older adults is even greater than for the general population, ageism which undervalues older adults and their well being and worth, inaccessible care, limited services, limited numbers of trained specialized mental health providers, lack of awareness about mental health issues of older adults by providers of services and lack of transportation. Older adults themselves are often fearful of seeking treatment, they worry about losing benefits if they identify themselves as needing mental health treatment and they worry about losing their independence, being labeled or viewed as "incompetent" and being put into a nursing home.

The need for services is critical; our population is growing older and living longer. In 2011 the first of 78 million baby boomers start turning 65. Life expectancy in the United States is at an all time high of nearly 78 years. The oldest old, those who are age 85 and over, are the fastest growing segment of the population. We are facing a looming health care crisis as we are not prepared for this "silver tsunami". We do not have enough doctors, psychiatrists, nurses, social workers, psychologists and home health aides that are trained and specialized in working with older adults and prepared to provide for the needs of this demographic group with the greatest overall health care needs. Very few doctors are trained in the care of the elderly. Currently there is only one geriatrician for every 10,000 baby boomers.

We must consider the workforce needs as we plan for meeting the mental health needs of seniors. In 2003 the President's New Freedom Commission on Mental Health recognized the severe shortage of practitioners in the mental health and aging workforce and acknowledged that professionals are not sufficiently trained in geriatrics. In 2004 The National Coalition on Mental Health and Aging recommended that graduate and continuing education programs train more health professionals in best practices in geriatric mental health. There needs to be a comprehensive strategy developed to improve workforce recruitment, retention, diversity and skills training in order for Kansas to be prepared to meet the needs of seniors. The growth in this population will increase steadily over the next two decades and Kansas must take steps now to be prepared to meet the growing needs, reduce excess disability, reduce medical and hospital expenditures and reduce premature institutional placement.

In closing I would like to than you for this opportunity to address this important issue. I would be happy to address any questions you might have.

Testimony for Aging and Long Term Care Subcommittee
February 16th, 2010
Steve Denny, LSCSW
Senior Outreach Services Coordinator, Four County Mental Health Center
Governor's Mental Health Services Planning Council, Aging Subcommittee, Chair

Mr. Chair and members of the committee, thank you for allowing me to present today. I'm here to testify on behalf of Senior Outreach Services (SOS), a geriatric mental health program through Four County Mental Health Center in Independence. This program serves Montgomery, Wilson, Chautauqua, & Elk counties in the Southeast part of the state. I also serve as chair of the Aging Subcommittee to the Governor's Mental Health Planning Council. On behalf of both the Aging Subcommittee and Four County Mental Health Center, I would like to express full support for House Bill 2057 and the development of a geriatric mental health workforce.

This testimony will focus on four primary areas that include the following:
(l) The mental health needs of older adults, and benefit of House Bill 2057 in meeting those needs.
(2) The importance of direct service combined with public outreach and community networking in geriatric mental health.
(3) Services provided by the Senior Outreach program and workforce needs related to those services.

Needs of the Target Population

Research indicates a direct link between symptoms of depression and higher risk of nursing home admission (*Abstr AcademyHealth Meet.* 2003; 20: abstract no. 381). Untreated mental health conditions lead to increased healthcare costs. The Journal of the American Geriatric Society reports that Medicare patients who have depression combined with diabetes or congestive heart failure have significantly higher health care costs than those who have these chronic diseases in the absence of depression (2009). Unfortunately, mental health issues are often overlooked or not discussed in primary care settings and older patients are rarely referred to specialized mental health services (Journal of American Geriatrics Society, 2007).

The healthcare delivery system is not currently equipped to meet these challenges as the first set of baby boomers will turn 65 in 2011. According to the American Association for Geriatric Psychiatry (AAGP), the United States has only one psychiatrist for every 10,000 individuals over the age of seventy-five. Within a few years, the demand will be six times greater than it currently is Moreover, in April 2008, the AAGP testified that this shortage affected other disciplines as well. The numbers are alarming: only 3.6 percent of M.S.W. students specialize in aging, though the need will grow to sixty times that by 2020. Only 3 percent of psychologists define their primary area of practice as

geriatrics and only 28 percent of all psychologists report having any graduate training in geriatrics (Alzheimer's Association, 2008). . The University of Kansas estimates that the number of older adults accessing CMHC services could amount to 12,000 additional consumers in the next 20 years (Older Adult Access to Community Mental Health Services Final Report 2005-2008). Currently, there are less than 10 specialized geriatric mental health programs in the state of Kansas to meet this growing need.

Limited access to mental health services for Americans age 60 and older is identified by the Surgeon General's Report on Mental Health as increasing risk for suicide, psychiatric hospitalization, and premature placement in long-term care facilities (Department Health Human Services, 1999). People age 65 and older represent only 12 percent of the U.S. population, but they accounted for a disproportionate 16 percent of all suicide deaths in 2004 (CDC, 2005). The majority of older adults, who commit suicide, have diagnosable depression (Conwell, 1996). The American Association for Geriatric Psychiatry testified that "there is accumulating evidence that depression can exacerbate the effects of cardiac disease, cancer, strokes, and diabetes (2005)."

The Surgeon General's Report (1999) estimates that at least 19.8% of older Americans (over age 55) experience mental illness. If one considers the challenges faced with aging, it becomes clear that this is not a coincidence. Declining physical health, personal losses, reduced independence, and financial burdens are just of the few issues faced by many older adults. Many people see seniors as just "slowing down" when in fact they may be exhibiting symptoms of undiagnosed and untreated depression. Misconceptions by providers, family, and seniors themselves result in failure to refer seniors for diagnosis and treatment that in turn can lead to serious consequences for seniors which can include the following:

- Increased risk of suicide
- Increased risk for both psychiatric and medical hospitalization
- Premature placement in nursing homes
- Exacerbation of physical problems
- Alcohol and/or drug abuse or dependence

The emotional and financial costs of each consequence are apparent. Both the statistics and personal observations show that many older adults are in need of mental heath or substance abuse treatment. Unfortunately only a few actually receive services. Almost two-thirds of older adults with a mental disorder do not receive needed services (Rabins, 1996). However, if diagnosed and treated 60 to 80% of older adults will benefit from treatment (Schneider, 1996). The rate of older adults accessing services on their own is particularly low due to a variety of factors including stigma and access issues.

The majority of SOS clients that we have served in Montgomery and Wilson county present with similar needs. Major Depression and Anxiety Disorders are the most common conditions treated in SOS. These illnesses commonly lead to isolation, withdrawal, decreased self-care, low motivation, appetite changes, intense worry,

hopelessness, feelings of worthlessness, and thought/plans of suicide in severe cases. Many clients struggle with multiple personal and physical losses. Chronic pain and physical illness often cause psychiatric symptoms to intensify. Often prescription medication or alcohol is used to cope with both physical and emotional pain. Seniors also deal with financial struggles, family conflict, and are vulnerable to physical and financial exploitation.

The SOS targets adults age 60 and older, who live independently or in assisted living. One of the primary goals of the program is to achieve prolonged independence in the community. Detecting and treating depression helps improve self-care, reduce isolation, and restore a sense of hope. By emphasizing and supporting independent living when it is safe and reasonable, SOS strives to counter premature nursing home placement Not clear why you have a citation since you are describing SOS services not presenting statistical data (Department of Human Services, 1999). The direct services provided by SOS targets these symptoms and other issues through treatmentand collaboration with community partners.

Direct Service

Stigma towards mental health services is a significant access barrier to treating mental illness in older adults. Many older clients are fearful of their family or friends discovering that they have mental health problems. Fear of losing independence, fear of being committed to the hospital, and negative media depictions are factors often cited by seniors in Southeast Kansas that contribute to stigma. One specific SOS client told staff that he parked two blocks away and walked so that his neighbors wouldn't see his vehicle parked at the Center. This type of stigma is a reflection of why seniors with mental health issues seek treatment at such a low rate.? not sure you need a citation – reads more like a conclusion you are drawing from an SOS example

One way that the SOS program addresses stigma is to offer in-home services. This allows seniors to share their problems in the comfort and security of their home environment. In-home services also help to address physical health and transportation barriers that often effect seniors in rural areas. As the following services are being described, it is important to understand that non-traditional methods such as in-home therapy are crucial to addressing stigma and outreaching seniors with mental health needs.

The SOS program provides three primary outpatient services to participants in the program: Individual Outreach; Individual Therapy; and Case Management. A brief description of each is provided below.

Individual Outreach: This is normally the first service provided when a referral is received on a new client. There is currently no reimbursement for this service, but it is crucial to reaching clients in rural areas. Research has supported the effectiveness of outreach services in identifying isolated older adults with mental illness (Citters, Bartel,

2004). During an individual outreach, SOS staff explains the program and most importantly seek to connect and develop trust.

Individual Outpatient Therapy: This service is provided by a mental health professional. SOS clients have the option to receive services in-home throughout treatment. This service is reimbursed through Medicare, Medicaid, and private insurance, which is our program's primary source of income. Unfortunately, Medicare Part B? only reimburses at 50% after co-pay as indicated earlier. ? missed where you discussed earlier This is a deterrent for sustainability since over half of our clients carry Medicare Part B as their primary insurance. Don't understand this – is it Medicare Part B that reimburses 50%? This reimbursement issue further justifies the support that this bill would provide.

Case Management: This service is provided by bachelor's level staff. Case Management is quite similar to traditional mental health case management. Case Management goals are often targeted towards increasing socialization, managing medications/medical appointments, and improving communication between different providers. SOS Case Management is only reimbursable for Medicaid clients, who meet the risk or functional criteria for psychiatric rehabilitation services. A very small percentage of SOS clients meet this criterion.

These services are currently provided by four staff serving Montgomery and Wilson Counties. All four positions are funded primarily by a three year grant through a "Rural Healthcare Services Outreach Grant." This grant is funded by the Office of Rural Healthcare Policy, a division of the Health Resources and Services Administration or "HRSA." Additional sources what additional sources ? third party payer sources? of income are discussed in the service descriptions. The program is comprised of two licensed masters' level social workers and two bachelor's level case managers.

The SOS program is currently working with Pittsburg State University to track outcomes and monitor the effectiveness of these services. Based on experience as a clinician in this program, I've found that a large portion of seniors do recover from mental illness. Many clients report improvement after only one outreach visit and never require admission to our program. I have observed multiple clients who have been discharged in full-remission of symptoms; however, success varies with each client. Factors such as severity of physical health problems, social supports, family history, and willingness to make changes play a role in achieving success. The following three case examples demonstrate this variation of success. They also exemplify common issues that contribute to mental illness in seniors. The names have been changed to protect client confidentiality

Irene *is a 92 year old white female residing in an assisted living facility. She was referred for symptoms of intense anxiety and depression including suicidal thoughts. Irene was struggling with the move from her home of over 60 years to a one bedroom apartment. She was quite isolative and had stopped many of the activities she once enjoyed. She responded very quickly to therapy and reported significant relief after one*

session. Irene returned to knitting and crocheting and began to interact more with the other residents. One of her friends secretly entered her cross-stitching project in the state fair. On our next to last session, she very proudly showed me a grand champion ribbon that she'd won for this project. She was discharged after six months of treatment. She is still doing well today, nearly two years later.

John *is a 76-year old white male. He is a war veteran and suffers symptoms of Post Traumatic Stress Syndrome after observing traumatic events in a Prisoner of War camp. In addition, John has financial stressors, family problems, and is dealing with multiple health problems. He has several medical appointments per week and multiple service providers. John's case manager attends all of his medical appointments and communicates regularly with John's primary care physician. He has been in treatment for nearly two years. There have been multiple hospitalizations, both medical and psychiatric, along with brief stays in the nursing home; however, John remains in the community today. It can be said with relative certainty that this would not have happened without SOS staff helping him manage his physical and psychiatric needs in the community.*

Bob *is a 66-year old Vietnam Veteran. He was referred by a psychiatric hospital after he became severely depressed. He reported intent, plan, and had access to guns to end his own life. His depression was fueled by severe breathing problems due to Chronic Obstructive Pulmonary Disease (COPD) along with loneliness and loss of his spouse. Throughout the first year of treatment, he reported ongoing thoughts and plans of suicide. In time, he began to improve slowly. A few months ago, when asked about suicidal thoughts, he replied in this fashion, "I've been thinking... My COPD is progressing about like it is supposed to. I know that I don't have much time left and I certainly don't want to do anything to shorten it." He remains in treatment today as he still continues to cope with depression and health issues. John was able to accept his physical health issues and still find meaning and reason to live.*

Each of these cases is examples of how geriatric mental health services have helped seniors in Southeast Kansas. I will close this section with an example of a senior, who didn't get help. A family friend and neighbor of over 30 years had been living by himself for almost 10 years since the death of his wife. He became ill and required hospitalization twice. Upon discharge from his second hospitalization, he began to receive home care services. One evening he called his home care nurse asking her to use the back door instead of the front. The next morning, she found him lying dead in front of his back door due to a fatal self-administered gun shot wound to the head. His depression was not reported, but is now evident in looking back. His providers, as well as family, were not able to recognize the depression, which is why the final section of this testimony is so crucial.

Public Outreach and Education

Mental illness is often unrecognized and not reported by seniors. Suicide, unfortunately, is one of the consequences of this fact. Research indicates that up to 47% of adults aged

65 and older, who committed suicide, saw their primary doctor within one week of killing themselves, while 70% saw their doctor within one month (NIH, 2001). Since May of 2007, SOS has provided over 25 in-service presentations to educate providers on depression and suicide in older adults. The SOS model has found partnership and collaboration with other providers invaluable in reaching seniors especially in rural areas.

The SOS program initiates outreach and education in a variety of ways. We seek to network and educate every referral source possible. These sources include the AAAs, assisted living, physicians, home health agencies, hospitals, and health departments. The SOS could not survive without referrals and strong relationships with these agencies. In 2007, the Senior Outreach Services Consortium was formed to oversee the Rural Healthcare Outreach grant project. This consortium consists of representatives from hospitals, assisted living, health departments, and AAA in both Wilson and Montgomery County. This group has committed to addressing the mental health needs of seniors in our community and provides further opportunity for public education through networking.

The SOS program has provided over 40 public presentations to the general public since the project start date. Examples include AARP, senior housing, hospitals, assisted living facilities, and community organizations such as Rotary Club. These presentations serve to educate the public on symptoms of mental illness in seniors and have generated numerous referrals and further opportunities for public education. Through these efforts, public awareness is increased and stigma is reduced.

One of our strongest partners has been the Southeast Kansas Area Agency on Aging. The AAA case managers have provided over 30 referrals to our program since the start of our project. We have collaborated on numerous difficult cases and serve together on several community projects targeting the aging. The AAA has also contracted with Four County Mental Health Center to provide caregiver therapy to caregivers. Our partnership has set an example of how mental health and aging services can work together. Similar types of partnerships will be essential in implementing this bill.

Workforce needs

The SOS program is made up of mental health professionals and bachelor's level case managers, who work together as a treatment team. This model is based off of the strength's model of case management, which is widely used by other targeted populations in the mental health system. While I am not qualified to testify on statewide data, I can speak to the need for improvement in educational resources to mental health professionals and bachelor's level behavioral health providers. resources targeting geriatric mental health

While classes related to aging are available, there are very few that address mental health and aging specifically. The majority of education received by mental health professionals in the SOS program have been obtained through continuing education after graduate

school. Bachelor's level staff have even fewer resources and depend mainly on clinical supervision and consultation with peers to develop adequate skills in this area.

Graduate school classes and educational programs are needed to prepare mental health professionals to work with older adults.. Similar resources wouldbenefit bachelor's level social service programs as wellSpecfically, education is needed in the following areas related to geriatric mental health:

- Common mental health issues and impact on functioning in older adults
- Suicide in older adults
- Diagnosing and understanding the impact of Dementia
- Strengths based aging case management training (course offered by KU as CEU)
- Interpersonal and social functioning and the aging process

In my opinion, these types of classes and programs would do not need to be overly expensive or complicated. I am confident that the universities and existing providers in the state could partner to provide adequate educational resources for students, who have interest in working in geriatric mental health.

Data results

Access

The SOS program has outreached or would you want to say served over 300 seniors since 2007. While data is still being collected in the final project year, the preliminary results are that the SOS model has been successful in improving access to the target population. Since the inception of the project, Four County Mental Health Center has seen a 50% increase in adults served, who are 60 and older in comparison to the two years prior to the project. Direct services, public education, and the aging of the "baby boomers" may be attributed to the overall improvement in the total number of seniors that are served by Four County Mental Health. Last sentence could use some work or you might want to leave that off since it raises questions about whether the SOS has been successful in bringing in more older adults for services or if there are just more older adults due to baby boomers coming of age.

Treatment

The program has also demonstrated effectiveness in the treatment model for the patient's directly served through SOS services. In the first two years of the project, 78% of program participants showed statistically significant improvement in mental health symptoms after 90 days of treatment. Over 60% of program participants, reported improved functioning after six months of treatment based on SF-36 scores which addresses emotional well-being. Most importantly, 95% of SOS program participants have been able to remain in the community versus moving to long-term care placements.

Awareness

The community outreach effort has also yielded positive results in reducing stigma and increasing awareness of mental health needs in older adults. The surveys have

consistently shown an excellent response from nearly 300 respondents, who have indicated that the public education has been effective in reducing stigma and increasing public awareness of mental health needs in older adults. The education efforts have diversified our referral sources and established the SOS program as a valid treatment option for older adults in Montgomery and Wilson counties.

Conclusion

The SOS program exemplifies the programs, services, and workforce needs in Kansas to improve mental health services for older adults. Four County Mental Health Center has collaborated with numerous agencies successfully and demonstrated increasing community investment in our services. Quality direct service, combined with public education, has helped SOS establish itself as a reputable program in Southeast Kansas. This has resulted in reduced stigma, increased public awareness of mental health needs in seniors, reduction in nursing home placement, and **most importantly,** higher quality of life for the people we serve.

The need for funding to sustain our program remains a major concern. Outreach and public education are currently funded solely through federal grant dollars, which will end in May of 2010. The current budget cutbacks will limit our ability as an agency to sustain these services if support does not become available through HB 2057. As stated earlier, these services are important in improving access to older adults with mental health needs in rural areas. The majority of rural areas in Kansas do not have specialized aging and mental health services and will not have the capacity to provide these services without supportive legislation.

In the midst of the current budget crisis, this is a key opportunity to take steps toward development of a mental health and aging workforce through development of training and educational programs so that we are prepared when funding does become available. The needs of the aging population will only increase each year without action. I would like to thank you for your time and consideration on these crucial issues.

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TO: Chairman Bob Bethell
House Committee on Aging and Long-Term Care

FROM: Ernest Kutzley
AARP Kansas Advocacy Director

DATE: February 16, 2010

RE: Geriatric Mental Health

Good afternoon Chairman Bethell and members of the House Aging Long-term Care Committee. My name is Ernest Kutzley and I am the Advocacy Director for AARP Kansas. We represent the views of more than 349,000 members across the state of Kansas. We appreciate the opportunity today to provide *written* comments regarding geriatric mental health.

Mental Health: Aging and Geriatric Overview:

At least one in five older Americans suffers from a mental disorder. Among Medicare beneficiaries age 65 and older, the most common mental disorders, in order of prevalence, are anxiety, dementia or other cognitive impairments, and depression. By 2030 the number of older people with such disorders is expected to double, to 15 million, equaling or exceeding the number of younger people with such conditions. Moreover, a substantial and growing percentage of older adults are misusing alcohol, prescription drugs, or other substances. Demand for mental health and substance abuse services is also expected to grow as the baby-boom cohort, which has tended to use such services more frequently and feel less stigmatized by seeking care, continues to age. Nevertheless there is a substantial unmet need for mental health and substance abuse services for older adults.

Older adults requiring mental health services are more likely than younger adults to receive inappropriate or inadequate treatment, due in large part to insufficient training in geriatrics among clinicians in routine settings. Most Medicare-covered mental health services are provided by primary care physicians, not specialists. General mental health clinicians may lack training in basic assessment and treatment of mental disorders connected to aging. Personal reticence of older adults to acknowledge mental health problems, as well as the perceived social stigma against those who do, further compound appropriate recognition of and treatment options for mental disorders. In addition, there may be limited adoption of proven practices as part of usual care or little evidence of treatments' effectiveness. For example, there is scant research on the effectiveness of treatments for anxiety, especially for older populations.

A 2006 Institute of Medicine (IOM) report, "Improving the Quality of Health Care for Mental and Substance-Use Conditions," found that mental disorders seldom occur in isolation. This is particularly true for older adults. About one-fifth of patients hospitalized

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for a heart attack suffer from major depression. Depression and anxiety are also strongly associated with symptoms such as headache, fatigue, dizziness, and pain.

Further, people with mental health or substance abuse problems are more likely to suffer from heart disease, high blood pressure, diabetes, and arthritis—all afflictions common in older adults. The IOM also noted that mental health is a key component in self-perceptions of overall health, a factor that becomes increasingly important with age. Thus, attention to mental health and substance abuse is required in order to improve the general health of the Medicare population.

Cognitive disorders are frequently undiagnosed or are misdiagnosed in older patients. Although geriatric mental health assessment tools exist, they are often not integrated into routine practice. Further, some physicians and other providers may be less likely to diagnose alcohol and substance abuse disorders among older adults. Many older people are also reluctant to seek counseling to help them cope with the challenges of later life, such as bereavement, disability, loneliness, and isolation.

The significance of these challenges is grimly evident in the fact that the 2005 death rate by suicide was highest for people age 80 years and older and was over 50 percent higher than the rate for teens age 15 to 19. Further, the suicide rate for white men age 80 and older in 2005 was more than three times the rate for males age 15 to 19.

While Medicare's coverage of mental health and substance abuse services has gradually improved over the years by adding a partial hospitalization benefit and eliminating the payment limit on Part B mental health services, coverage continues to reflect restrictions that do not apply to other health services. For example, there is a 190-day lifetime limit on psychiatric care in freestanding psychiatric hospitals. In addition, despite growing evidence supporting community-based geriatric mental health treatment teams, access to such care in the community remains limited by an institutional bias in Medicare's mental health policy.

Mental Health: AARP Federal Policy Recommendation:

- AARP believes that Medicare should reimburse for mental health and substance abuse services more adequately and eliminate the 190-day lifetime limit on inpatient psychiatric care in freestanding psychiatric hospitals under Part A.

Access and Quality: Issues for People with Cognitive and Mental Disorders:

Older adults with mental disorders include people whose conditions develop in old age and those whose disorders begin earlier and continue as chronic or recurrent illnesses. Mental disorders among older adults encompass a range of serious conditions, such as clinical depression, bipolar mood disorders, schizophrenia, Alzheimer's disease, vascular dementia, and delirium. They also include depression, anxiety, and conditions that are the secondary consequences of physical ailments or medical interventions. A recent National Institutes of Health panel noted that depression in the aging and aged is a major public health problem. Alcoholism and other substance abuse disorders also are found among older adults.

The occurrence of some forms of cognitive disorders —Alzheimer's disease and other kinds of dementia— increases with age. One in ten people over 65, and nearly half of those over 85, have Alzheimer's disease. A 2006 study found that 33 percent of people in assisted-living facilities had a diagnosis of dementia or Alzheimer's. By comparison, an estimated 50 percent of nursing home residents have moderate to severe dementia, as many as 75 percent have some form of cognitive impairment, and 20 percent experience depression.

Too often mental disorders such as depression go undiagnosed or are misdiagnosed. Moreover treatment for mental disorders among older people is generally provided by primary care physicians or physicians who lack training in psychiatric care. This problem is exacerbated by the shortage of mental health professionals trained in geriatrics and by the scarcity of nursing facility staff with education and training in the care of people with mental disorders. For example, it is estimated that there will be approximately 2,640 geriatric psychiatrists by 2030 (or one per 5,682 older adults with a psychiatric disorder). However, 4,000 to 5,000 clinical geriatric psychiatrists are estimated to be needed to meet demand in the near future, as well as an additional 2,100 physician and nonphysician faculty members to provide training in geriatric psychiatry.

Other professionals who can provide mental health services to older people, including gerontological social workers and gerontological nurse practitioners, are also in short supply. For example, less than 3 percent of graduate students pursuing social work degrees (about 1,000 students) select an aging concentration, although it was projected more than a decade ago that 60,000 or more gerontological social workers would be needed by 2020. Other barriers to mental health services are inadequate Medicare and Medicaid reimbursement and a lack of coordination among personnel in long-term services and supports.

Nursing Homes:
Despite the high prevalence of cognitive and mental disorders among nursing home residents, few have access to mental health professionals. In addition, research has shown frequent, inappropriate administration of psychotropic medications to nursing home residents. Also, facilities with fewer than 120 beds are not required to employ a full-time clinical social worker.

The 1987 Nursing Home Reform Act, part of the Omnibus Budget Reconciliation Act of 1987, required nursing homes to develop and administer a resident assessment-and-care-planning instrument to be used upon admission of a resident and every year thereafter. The instrument assesses care needs related to cognitive impairment and behavioral problems, among other issues. The Nursing Home Reform Act also mandated the Preadmission Screening and Annual Resident Review PASARR) program for states participating in the Medicaid program. PASARR aims to prevent the inappropriate placement of people with serious mental illness (SMI), mental retardation/ developmental disabilities (MR/DD), and related disorders in nursing homes and to ensure that people with such conditions receive necessary treatment and services in the most appropriate care setting.

Federal law requires that people who are eligible for Medicaid and have SMI, MR/DD or related conditions be admitted to nursing facilities only if they meet the minimum standards for admission and their treatment needs do not exceed the level of services that can be delivered in a nursing home setting, either by the nursing home alone or through supplemental services provided or arranged for by the state. Confusion over the PASARR requirements made nursing homes reluctant to admit people with a psychiatric diagnosis or history of depression or who use psychotropic drugs, particularly if they are Medicaid recipients.

In October 1996 Congress repealed the requirement for an automatic annual review of people identified through the PASARR screen. Now nursing homes must conduct subsequent reviews only in response to a "significant change in the physical or mental condition of mentally ill or mentally retarded nursing facility residents." However, allowing nursing facilities the discretion to determine when a reassessment is needed (as opposed to having a mandatory annual evaluation) allows them the chance to circumvent the main objective of the program: ensuring that residents with mental illness and mental retardation receive the services they need in the most appropriate care setting.

Supportive Housing:
Requirements for assisted living residences and board and care homes serving residents with cognitive impairments vary greatly from state to state. As of 2007, 45 states had specific requirements for assisted-living residences or other residential care settings serving people with Alzheimer's disease or other dementia.

Special Care Environments:
Special care environments (SCEs) provide specialized care either through tailored services or programs or in a discrete unit or facility. Because there is no consistent definition or set of standards for SCEs, there is much variation in the type of services they provide. A National Institute on Aging study found that SCEs, on average, had better trained staff, programming, and facilities than did non-SCEs. Many nursing facilities, supportive housing residences, continuing care retirement communities, and home-care service providers (e.g., home health agencies, respite services, and hospice care providers) have developed SCEs or services to meet the needs of residents with dementia.

AARP Policy Recommendations on Coordination, Availability of Treatment and Nursing Home Care:

Coordination and Availability of Treatment:

AARP Believes that:

- Federal and state governments should ensure that people with mental disorders receive necessary treatment and long-term services and supports (LTSS) in the most appropriate and integrated setting of their choice.
- States should coordinate mental health services among all appropriate health, LTSS, and aging network services. At the local level, area agencies on aging

should have cooperative working agreements with community mental health centers.

- States should expand programs that identify and increase awareness of and providers' sensitivity to depression, suicide risk, and substance abuse among older people. These programs should particularly target health and social service providers.
- Federal and state governments should offer additional services geared to the special needs of caregivers, such as caregiver training programs, caregiver assessments, support groups and mental health counseling; home-modification programs; hospice and respite care; and income support and transportation.

Nursing Home Care:

AARP believes that:

- States should ensure that people with mental illness or retardation who are not admitted to a nursing home as the result of a Preadmission Screening and Annual Resident Review (PASARR) have home- and community-based services and receive appropriate treatment in the most appropriate setting.
- Residents of nursing homes and supportive housing should be ensured access to a full range of mental health services provided by qualified mental health professionals with training and experience in treating mental health problems specific to this population.
- Federal regulations should require that staff in special care units for residents with cognitive and mental disorders receive supervision from a licensed health care professional with gerontological training or experience and participate in annual continuing education relevant to such care.
- States should require facilities without a social worker or registered nurse (RN) on staff to contract for social work, RN, and other psychiatric and psychological services as needed to ensure that residents with mental disorders and psychosocial problems receive professional help and that physical illness and disorders are not exacerbating cognitive and mental symptoms.
- States should ensure that all LTSS training programs for direct-care workers address the care of people with acquired brain injuries or mental disorders, such as serious mental illness, mental retardation and developmental disabilities, Alzheimer's disease, and other dementias.
- States should ensure that social workers and other mental health professionals who work in nursing homes or under contract to nursing homes have training in the special needs of older people and people with all types of physical and mental disabilities.

We look forward to working with this committee on geriatric mental health issues.
Thank you for your consideration of our comments.

February 15, 2010

To: Aging and Long Term Care Committee

From: Alison Olson, LBSW

I am an Information and Assistance Specialist for the Wyandotte/Leavenworth Area Agency on Aging. Though my title is not Social Worker, when I report to work each morning I am a Licensed Baccalaureate Social Worker (LBSW), effectively prepared through my education to serve the aging population. I hope to briefly demonstrate how important social work education is for practice with older adults and how its preparation for work in the field should be held in the highest regards. As the older adult population grows, the number of social workers in the aging field should grow in order to address their ever changing needs.

The core courses of a professional social work education include practice skills, research methods, the study of human behavior, and social policy analysis. This core foundation of knowledge is essential and incomparable to other fields. The following are examples of how I use this education on a daily basis.

- Practice Skills: Every day I listen and address the needs of older adults along with their families and caregivers. Through my education, I know how to appropriately interview each client, balancing open-ended and close-ended questions, redirecting and summarizing conversations, and listening with empathy and genuineness. These practice skills are used to obtain the information needed about the older adults in order to connect them to the appropriate agency or community services, refer them to case management for the coordination of multiple services, and evaluate their situation for possible crisis, abuse, neglect or exploitation. Practice skills also help you to learn and navigate diverse systems and practice with cultural competence. No other education would have better prepared a student raised in rural Jackson County to work with the widely diverse population of Wyandotte County as I have done.

- Research Methods: Qualitative and quantitative research for the practice with other adults is imperative. Because of my professional social work education, I am able to provide monthly reports that guide management decisions on current programs and help identify unmet needs. The research I have conducted on low-income Medicare beneficiaries in our county secured grant funding for an outreach program that will help them make application to a Medicare Savings Program that may save these beneficiaries on average $3,900 per year in out-of-pocket Medicare costs. Additionally, researching community resources is an ongoing project. I have the skills to examine program qualifications and applicable costs in order to guide older adults to solutions and not to frustrating dead-ends.

- Study of Human Behavior: The study of human behavior in the social environment goes beyond the biological development from birth to death and the psychological theories of Freud and Erikson; it is the study of a person in their environment. Through the study of the biological, psychological and social functioning of an older adult, I can effectively evaluate their needs and assist in increasing their mental and physical health and overall quality of life. For example, if biologically the older adult is arthritic and uses a walker we can provide in-county transportation to needed doctor appointments. If psychologically the older adult is having memory problems and forgetting to take their medication, there are services that will set them up weekly or monthly with reminders. Additionally, if the older adult is isolated we can connect them with volunteer groups, senior centers, fitness programs and other activities that increase their social functioning. All of these services benefit the older adult and improve every facet of their life. An educated professional social worker values the person in their environment and starts where they are in improving their overall functioning and quality of life.

- Social Policy Analysis: You cannot effectively assist an older adult without knowledge of major federal and state systems such as Medicare, Social Security and Medicaid. A professional social work education gives you the skills needed to analyze policies, find gaps in services, and advocate for change. Furthermore, federal, state and local policies affect the work professional social workers do every day. Knowledge of these systems helps us to advocate for our profession and those that we serve. As the Silver-Haired Legislative liaison for Wyandotte and Leavenworth Counties, I use the education I have received to provide information and updates to members and other aging advocates on current legislative issues.

There is not one skill I learned in my professional social work education that I have not utilized during my work in aging services. I cannot imagine being able to accomplish what I have done in the last year at the Area Agency on Aging without this foundational knowledge. The growing aging population brings with it unique challenges and older adults deserve to be served by professionals. I hope many will see like I have experienced how professional social workers can be part of the solution. I know that I will continue to do my part.

Thank you for your time and consideration.

Baby Boomers

Selected findings and excerpts from: ***"Older Adult Access to Community Mental Health Services Final Report, 2005-2008"***. This report was prepared by the Office of Aging and Long Term Care at the University of Kansas School of Social Welfare. This research was supported in part through a contract with the Kansas Department on Aging and the Kansas Department of Social and Rehabilitation Services.

Impact of Baby Boomers on Mental Health Service System in KS

A. Purpose and Scope

As with many long-term care services, mental health services will be greatly impacted by the Baby Boom generation as they age into older adulthood. Both demographic and generational factors will increase the demand for mental health services by aging Baby Boomers. The purpose of this section of the report is to identify and discuss demographic changes that will impact the mental health services system as more Baby Boomers turn 60 over the next 20 years. The key characteristics examined are: age, gender, race/ethnicity, urban/rural location, and chronic physical health conditions. A discussion of the demographic trends and the implications of these characteristics for the mental health system in Kansas are offered. A focus of this analysis is the potential demand for mental health services from CMHCs, as they are the primary provider of mental health services for Medicaid eligible older adults. Finally, additional factors such as generational characteristics that will impact the need for and supply of mental health services for the Baby Boom cohort will be discussed. As depression and anxiety disorders are the most prevalent mental illnesses experienced by older adults, and, as individuals with mental illnesses such as schizophrenia and bipolar disorder have access to unique resources provided for those meeting the state's definition of "severe and persistent mental illness", we will focus our discussion on those with depression, anxiety, and related mental health symptoms.

B. Background

The prevalence of mental illness among older adults is difficult to determine as it is often under diagnosed or untreated. It is estimated that 19.8% of adults age 55 and older have a mental illness (U.S. Department of Health and Human Services, 1999a). Although this figure is not specific to Kansas, it provides a rough estimate of the number of older Kansans who may be affected by a mental illness. Mental illnesses are often not diagnosed among older adults. In addition, older adults are typically underserved when it comes to utilizing mental health services. It has been documented that nationally CMHCs tend to underserve older adults (Jeste et al, 1999). One measure of mental health service utilization in Kansas is the database in which information about all community mental health center (CMHC) customers is deposited, the Automated Information Management System (AIMS). Detailed information about older adults who accessed the CMHCs during calendar year 2004 is contained in another section of this report; however, in order to provide a context for describing the changing demographics and need for future mental health services from CMHCs in Kansas, a short summary of these data is described in Table 19. Table 19 displays the demographic characteristics of older adults who accessed a CMHC in 2004. Because there are different services available

based upon whether a person meets Kansas' critiera for experiencing "severe and persistent mental illness" (SPMI), data are reported by SPMI status. During 2004, there were 4,923 older adults who accessed a Kansas CMHC, SPMI status was known on 4,689 of them.

Table 19: Older Adults (60+) Who Accessed a CMHC in 2004 (N=4,689)

	Non-SPMI (n = 3,409) Frequency (%)	**SPMI** (n = 1,280) Frequency (%)
Age		
60 – 69 (n=2,524)	**1,660** (49%)	**864** (68%)
70 – 79 (n=1,186)	**886** (26%)	**300** (23%)
80+ (n=979)	**863** (25%)	**116** (9%)
Gender		
Female (n=3,127)	**2,266** (66%)	**861** (67%)
Male (n=1,560)	**1,142** (34%)	**418** (33%)
Ethnicity		
White (n=4,192)	**3,080** (94%)	**1,112** (88%)
Black/African American (n=199)	**92** (3%)	**107** (9%)
Native American (n=44)	**32** (1%)	**12** (1%)
Hispanic (n=23)	**18** (1%)	**5** (--)
Other/Unknown (n=79)	**50** (2%)	**29** (2%)
Urban/Rural Classification		
Urban Counties (n=1454)	**950** (28%)	**504** (39%)
Rural Counties (n=2616)	**2011** (59%)	**605** (47%)
Frontier Counties (n=586)	**427** (13%)	**159** (12%)

As Table 19 indicates, the majority of the older adults who accessed a CMHC were in the young-old age group (60-69), were women, were White and lived in a rural county. The analysis of the 2004 AIMS data revealed that the most common diagnosis among older adults who accessed a CMHC were depressive disorders (43%) followed by schizophrenia/other psychotic disorders (18%), anxiety disorders (17%), bipolar disorders (13%), dementia/other cognitive disorders (12%), and personality disorders (9%).

The majority of older adults who accessed services at a Kansas CMHC in 2004 did not have a diagnosis of SPMI. However, there were some differences between the older adults with an SPMI and those without an SPMI. The older adults with an SPMI tended to be younger, a greater proportion of them were Black, and a higher proportion of them resided in urban areas as compared to the older adults without an SPMI. The specific characteristics of the Baby Boomer cohort will play a role in the scope and nature of needed mental health services. These demographic and generational characteristics are identified and discussed in the sections that follow.

C. Impact of Unique Baby Boomer Characteristics on KS Mental Health System

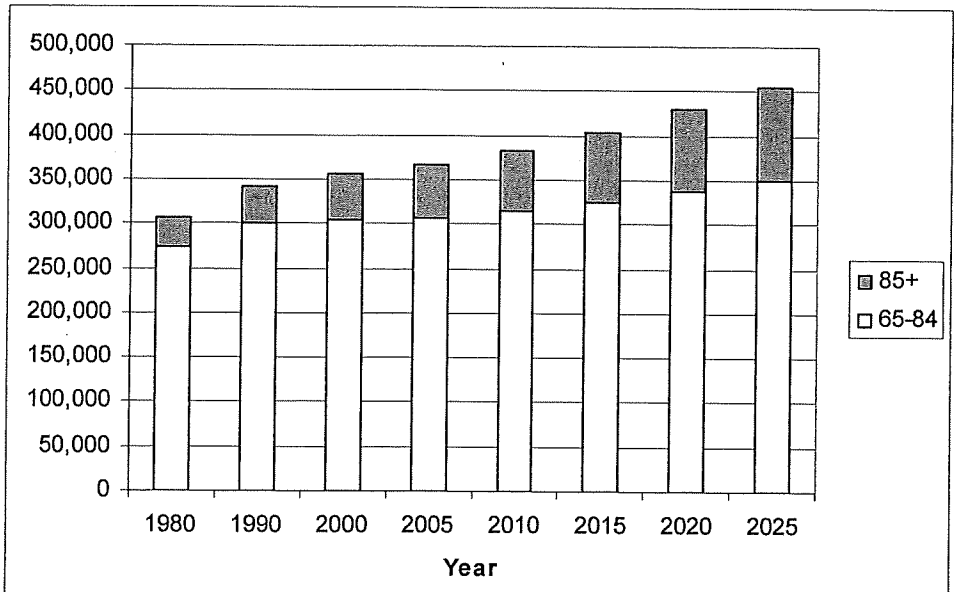
Population Size

National and state attention has been focused on the projected increase of the older adult population. The Baby Boom cohort, born between 1946 and 1964, will begin to turn 65 in 2011, and by 2030 the entire Baby Boom cohort will be aged 65 and older. The Census Bureau (2004) projects that older adults, age 65 and older, will increase from 35.9 million people or 12.4% of the population in 2003 to 63.5 million people or 18.2% of the population in 2025. In Kansas, this will result in an increase from 353,586 older adults or 13.0% of the population in 2003 to 605,000 older adults or 19.5% of the population in 2025 (U.S. Census Bureau, 2002). The projected increase in the older adult population will have implications for health care service utilization, including mental health service utilization.

Age

The national growth in the next few decades (through 2020) will be largely concentrated in the 65 to 74 age group (Redfoot & Pandya, 2002). However, in Kansas, the growth in the older adult population will increase steadily over the next two decades, with each age group growing at a steady pace (Chapin et al, 2006). Figure 1 below displays the projected population in Kansas for the 65 to 84 age groups and the over 85 age group through 2025 (Chapin et al, 2006).

Figure 1: The 65 to 84 and 85+ Population in Kansas, 1980-2025



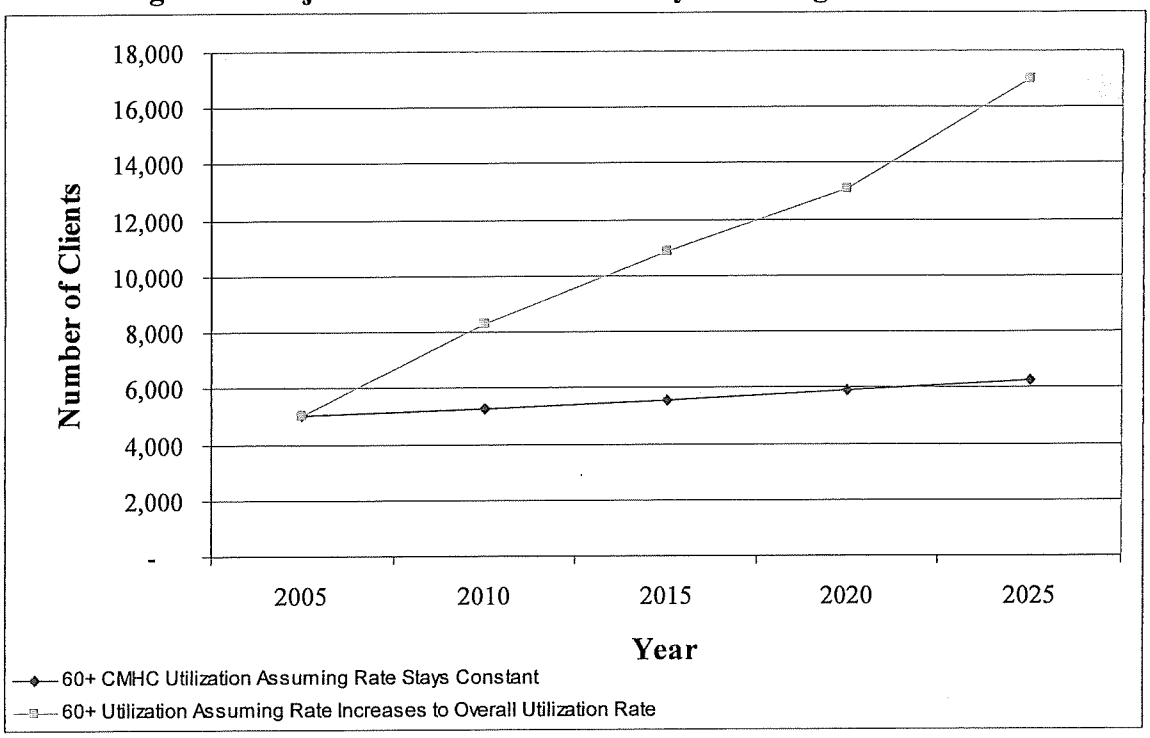
Source: Kansas Division of Budget, Kansas Certified Population Data; U.S. Census Bureau, 1980, 1990, and 2000 Census.

Due to this growth of the older Kansan population, there will be an increase in the number of older adults with a mental illness and, therefore, an increase in the need for mental health services. Utilizing 2004 AIMS and Census data, 1.1% of the older Kansan

population accessed the CMHCs in 2004. A higher percentage of "young-old" adults accessed the CMHCs than did "old-old" adults (1.3% of Kansans aged 60-69 versus <1% of older age groups). Given that the Baby Boomers have just begun to turn 60, if the trend continues, this rapidly increasing "young old" age group will result in a subsequently rapid increase in CMHC utilization for this age group of older adults.

Utilizing the more recent 2005 Census and AIMS data, in 2005, approximately 1.4% of the 60+ population accessed a CMHC in Kansas. In contrast, CMHC customers of all age groups comprised 3.75% of the Kansas population. In projecting the future utilization of CMHC services, it is useful to examine the trend assuming the current utilization rate of older adults would remain constant (1.4%), as well as assuming the utilization rate would increase to the overall population's utilization rate (3.75%). **Figure** 2, below, shows the projected number of CMHC clients age 60+ if the current utilization rate stays constant over time. It also shows the number of clients age 60+ if the utilization rate by older adults increases to the overall average utilization rate.

Figure 2: Projected CMHC Utilization by Adults age 60+ from 2005-2025



As Figure 2 indicates, assuming utilization rates stay constant, from 2005-2025, there would be approximately a 25% increase in the utilization of CMHC services by adults age 60+, representing more than *1,000* additional customers. If older adults were to begin accessing CMHCs at the same rate as the general adult population, the increase over the next 20 years would amount to *12,000* additional older adult customers.

Gender

Statistics indicate that men are beginning to live longer (Chapin et al, 2006). In Kansas, life expectancy for males at age 65 increased by .7 years between 1990 and 2000 (and female life expectancy decreased by .5 years) (KDHE, 2003). As men live longer, they begin to be affected by issues that have been previously been primarily associated with depression in older women (Smith, 2007; Zivin and Christakis, 2007). For example, a study by AARP (2004) found that a larger proportion of men are providing informal care in KANSAS (46%) as compared to the US (38%). Caregiving has been found to be associated with depression.

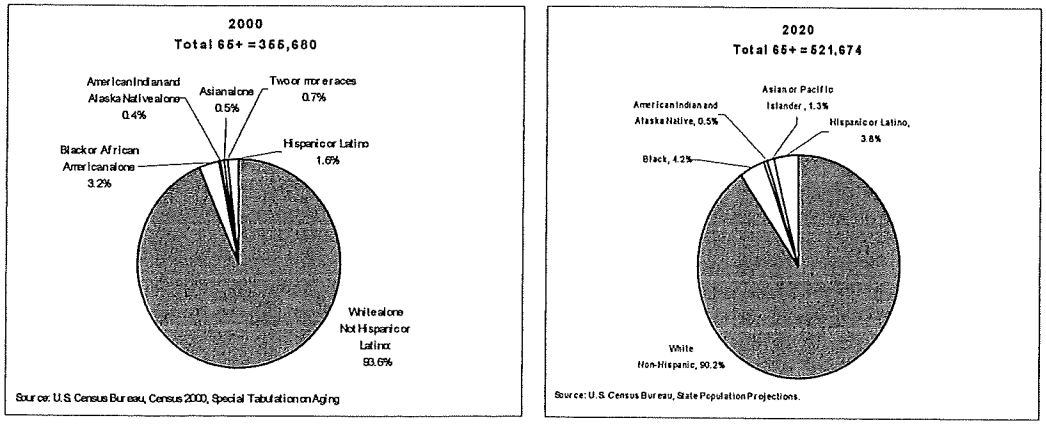
The prevalence of most mental illnesses is similar among men and women, with the exception of the incidence of depression, which is higher among women (World Health Organization [WHO], 2002; Burns, Cain, and Husaini, 2001). However, men and women often experience mental illness differently and access services differently (WHO, 2002).

In general, women are more likely to acknowledge mental health symptoms and to use outpatient mental health services. Men, however, typically delay seeking care for their mental illness until symptoms become severe (WHO, 2002). Perhaps, as a result, older men are six times more likely to commit suicide than are other age groups, and are more likely to incur high health care costs when suffering from mental illnesses such as depression (US DHHS, 1999; Burns, Cain, and Husaini, 2001). The 2004 AIMS data support these findings; women accessed CMHC services at a rate in proportion to their prevalence in the population, but men did not. While data indicated that all older adults were underserved, men were particularly undererved.

Race/Ethnicity

Older adults who are members of racial and ethnic minorities are expected to increase in number over the coming decades. In 2000, minority groups comprised only 6% of the older adult population in Kansas. According to the U.S. Census Bureau, the proportion of older Kansans who are members of ethnic minority groups are projected to increase 3.5% by 2020. The Hispanic/Latino older adult population is projected to have the greatest increase. The number of older adults who are members of a minority race or ethnic group is increasing at a faster rate than older White non-Hispanics (US Census, 2000a; Chapin et al, 2006). Figure 3 displays the projected change in Kansas (Chapin et al, 2006).

Figure 3: Percent of Adults 65 and Older by Race in Kansas, 2000 and 2020



The distribution of race and ethnicity among Kansans age 60+ who accessed a CMHC in 2004 was somewhat similar to the overall population of 60+ older Kansans (U.S. Census Bureau, 2000a). However, Black and Native American older adults accessed CMHCs at a higher rate than did Whites, while Hispanic older adults accessed CMHCs at a much lower rate than White, non-Hispanic older adults. In addition, older adults age 60+ with an SPMI were slightly more ethnically diverse than those without an SPMI.

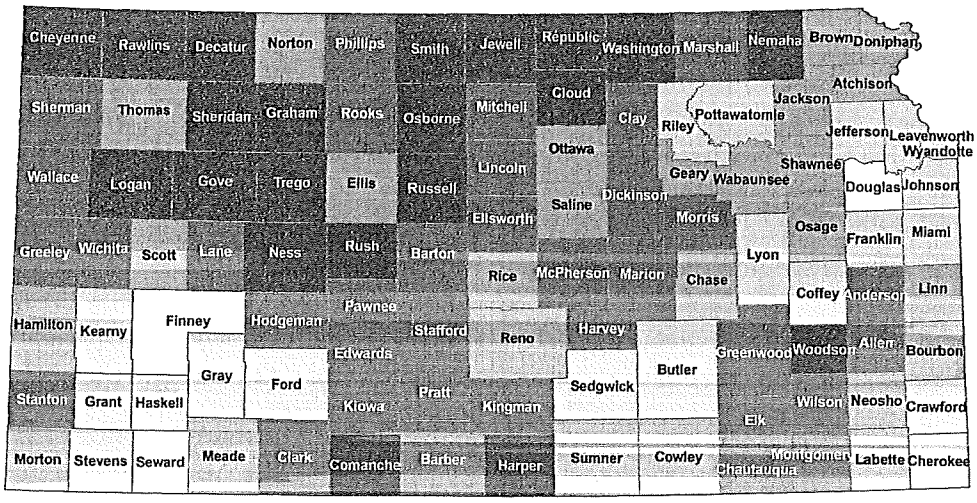
Some evidence suggests that, although the prevalence of mental illness is similar among whites and minority groups, adults who are members of racial and ethnic minority groups experience a greater burden of disability from mental health issues due to less access to services and poor quality of care (US DHHS, 1999b). Mental health risk factors such as poverty and disability may also disproportionately affect minorities. In Kansas, as of 2000, 18% of older Black/African Americans had incomes below the poverty level, as compared to only 7% of older White non-Hispanics (US Census Bureau, 2000b). More than half of Native American older adults in Kansas have some form of disability. Nearly half (44%) of Hispanic/Latino older adults in Kansas reported having a disability, as compared to only 41% of White non-Hispanic older adults in Kansas (U.S. Census Bureau, 2000a).

Urban and Rural Status

More than half (52%) of adults 60+ in Kansas live in rural or frontier counties. By 2025, 24% of the population of frontier counties in Kansas will be aged 65+, as compared to 13% in urban counties. In addition, the 65+ population in frontier counties is expected to grow by 18% by 2025. The urban counties are projected to have a 46.2% increase in the number of older adults age 65+ by 2025 (Kansas Division of Budget, 2005; U.S. Census Bureau, n.d.). Map 1 displays the overall percentages by county of the projected population age 65+ for the year 2025.

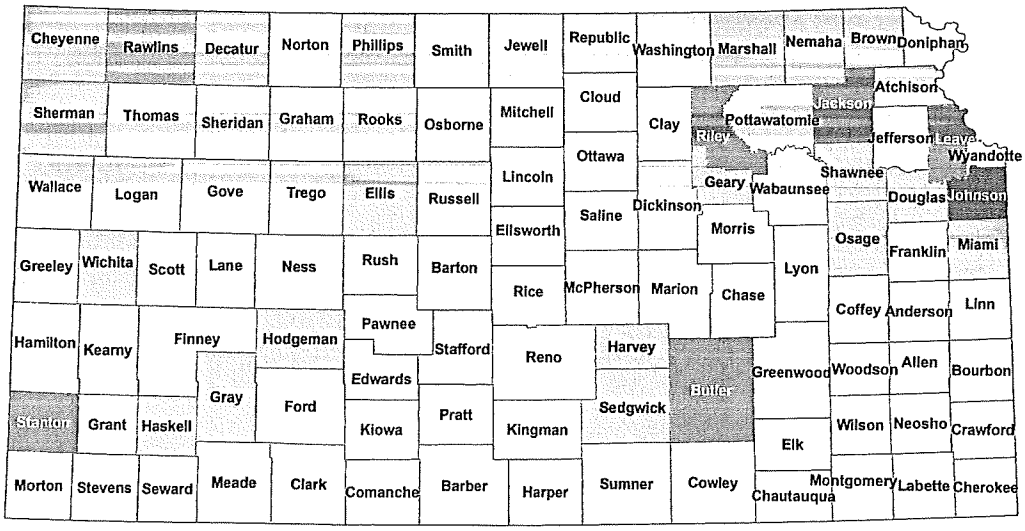
Map 1

Percent of Projected Population Age 65 and Over, 2025



Map 2

Percent Change in Population Age 65 and Over, 2000 - 2025



Source: Kansas Division of the Budget, January 2004.

Geographic location is a factor in older adult mental health (Hanrahan, 2003; Judd, Jackson, Komiti, Murray, Hodgins, Fraser 2002). The majority of research on this issue suggests that prevalence rates of mental illness among urban and non-urban older adults are similar (NRHA; Kessler, 1994). However, there is not much existing research on the mental health service needs of older adults in rural/frontier communities, though they are typically believed to be underserved (Kivett, 1997; Smith, 2007). It has been found that

rural older adults are more likely to commit suicide (New Freedom Commission on Mental Health, 2004).

Some national studies suggest that rural/frontier older adults are more apt to experience mental illness because of the likelihood of disability (South Carolina Rural Research Health Center, 2005; Hanrahan, 2003). Kansas is unique in that older Kansans who live in frontier/rural counties actually experience less disability than their urban counterparts (Chapin et al, 2006). Since disability is correlated with mental illness, this suggests that in Kansas rural/frontier older adults may actually be at a lower risk of having a mental illness than urban dwelling older Kansans.

However, rural and frontier dwelling older adults who do experience mental health problems have unique barriers to receiving services. Rural and frontier dwelling older adults have less choice in mental health service providers than their urban counterparts. Rural and frontier older adults are also more likely to encounter barriers when attempting to access services (New Freedom Commission on Mental Health, 2004). Some of these are limitations to service delivery when serving large, sparsely populated areas, while others are due to the culture of rural areas. Perhaps, in part, because of this, research has showed that rural older adults are more likely to perceive a lack of available mental health services than do their urban counterparts (Rost, Fortney, Fischer & Smith, 2002). Due to these barriers, informal supports, the use of indigenous healers, and interventions using telemedicine may be alternatives that need to be explored further for older Kansans living in rural and frontier counties (New Freedom Commission Report on Mental Health, 2004).

The 2004 AIMS data indicate that the majority (69%) of older adults who accessed CMHCs in 2004 lived in rural or frontier areas of Kansas. While demand for mental health services will increase as the population in those areas grow, the most dramatic increase will likely come from urban dwelling older adults. Outreach and service delivery need to be carefully crafted to take into account the differing mental health needs and ways older adults accesses mental health services based on geographic location.

Chronic Physical Health Conditions

The number of older Kansans living with chronic physical health conditions has increased (Chapin et al, 2006). In 2004, the top five leading causes of death in Kansas were: heart disease, cancer, cerebrovasular disease, chronic lower respiratory disease, and Alzheimer's Disease, all of which have been found to co-occur with depression or anxiety in a large proportion of individuals (KDHE, 2004; Miller, 2001; Merck Manual of Geriatrics, 2000; Weintraub, Furlan, & Katz, 2002; Rosenblatt et al, 2004).

In fact, mental health disorders frequently occur in conjunction with a number of chronic health conditions in older adults. In combination, these disorders impact functioning in subtle and complex ways. When mental health and physical health disorders coexist, typical declines become more pronounced, impacting long-term recovery and threatening the ability for self-care (Kelley, 2003). As the population living with these illnesses

continues to increase, then, the Kansas mental health system should not only prepare for an increase in older adults with mental health needs, but, they should also develop partnerships with medical and aging resources who meet their customers' physical health needs.

Other Characteristics

Cohorts of older adults may vary in their prevalence of particular mental illnesses (Yang, 2007). A number of studies have suggested that the prevalence of depression and anxiety among the cohort of Baby Boomers will dramatically increase (Compton, Conway, Stinson, Grant, 2006; Cross-National Collaborative Group, 1992; Jeste et al, 1999).

One reason for this is that a decrease in the mortality rate of older adults in general will lead to more individuals with early onset mental health problems living into older adulthood with their mental illnesses. In addition, it is predicted that there will be an increase in the overall number of older adults who develop late-onset mental illness, in part, because of the factors mentioned above. Some of the most noted researchers have estimated that the prevalence of older adults with mental illness will increase by at least 10% by the year 2030 (Jeste et al, 1999).

In addition to increases in the prevalence of depression and anxiety among Baby Boomers, a problem related to mental health, substance abuse, is also expected to increase, due to higher rates of use among Baby Boomers (Patterson and Jeste, 1999; Oslin, 2006; Gilhooly, 2005). In 2000, the number of older adults in need of substance abuse treatment nationwide was 1.7 million. It is expected to increase to 4.4 million by 2020 (Gfroerer, Penne, Pemberton, Folsom, 2003). It is likely that the prevalence of substance abuse among older adults is under-estimated because diagnosis criteria in the DSM-IV TR is focused on younger and middle age adults and because addiction is not often associated with older adults (Patterson and Jeste, 1999; Oslin, 2006). In the next decade, Baby Boomers will increase demand for substance abuse treatment, requiring the focus to be shifted to the unique needs of this generation (Gfroerer, Penne, Pemberton, Folsom, 2003).

Baby boomers will be more aware of their mental health, and will seek treatment more than previous generations. In addition, Baby Boomers have expanded their definition of health to include mental and spiritual aspects, and thus will demand improved access and non-traditional therapies to address their mental health needs (Kirsch, 2003). Although the majority of older adults are treated in the primary care setting for symptoms of mental illness, typical health care professionals are not adequately trained to treat geriatric psychiatric disorders (Jeste et al, 1999). Baby boomers will look to specialized mental health services as opposed to general medical services for treatment of mental health symptoms (Leaf, Bruce, Freeman, Weissman, and Myers, 1988). Therefore, not only will the need for mental health services increase but Baby Boomers will demand those services as well and expect them to be delivered by trained mental health professionals.

What they may find is that there no trained mental health professionals available to them. As of 2003, less than 7% of American psychiatrists had a subspecialty certification in geriatric psychiatry. Only 3% of American Psychological Association members report having older adults as their primary clientele. Of the 4,000 members of the American Psychiatric Nurses Association, only 16% have a subspecialization in geriatrics (Bartels, 2003). A 2005 survey of Kansas CMHCs found that less than half had one or more clinicians specifically designated to serve older adults. Only one-fourth (27%) routinely provided services in the home or other locations outside of their CMHCs. The credentials and availability of these clinicians varied. As Kansas has no formal training or certification program for mental health professionals who wish to specialize in serving older adults, their individual knowledge base and experience in serving the population could not be determined. While some CMHCs did discuss a desire to provide additional services to older adults, almost all reported that financial restraints including reimbursement limitations precluded their doing so (Reynolds et al., 2005).

D. Summary

Determining the number of older Kansans who will access the Kansas mental health system in the future is difficult, but what is clear is that older adults are currently underserved by CMHCs, and there is no indication that this trend will end. As Baby Boomers age into older adulthood an increase in the need and demand for mental health services will be felt by the CMHCs and the overall mental health system. The current primary users of the public mental health system are individuals under 65, not older adults. However, with the projected changes in the population over the next 20 years, aging Baby Boomers will emerge as a "primary population in need of services" (National Association of State Mental Health Program Directors, Older Persons Division). Using the information and data analyzed for this report, mental health providers should be prepared for a cohort of informed older adults who will seek out specific mental health services not just from their primary care physicians but from specialized mental health practitioners. In addition, if mental illnesses/symptoms go untreated, it results in higher health care costs overall – therefore there is an impetus for the State to act. The projected lack of mental health aging specialists highlights the importance of developing alternatives for providing adequate mental health care to older adults. Pilots and testing of innovative programs/interventions need to be undertaken now so programs can be in place as demand for services increases. Knowing the specific characteristics of the Baby Boom cohort should help policymakers and program administrators develop and enhance mental health outreach and services that can meet the growing and changing needs for mental health services from this group.

Kansas needs to build on the current strengths of its aging and mental health system to address the growing need for mental health services by older adults. According to the Department of Health and Human Services (1999) "Mental health services... need to be individualized in the clinical setting according to each patient's age, gender, race, ethnicity and culture". (From DHHS: U.S. Department of Health and Human Services. (1999, pg 11). Therefore, careful attention should be paid to the changing demographics and characteristics of the future mental health service users - the Baby Boom cohort. As

identified in this report, this cohort will be comprised of more women accessing mental health services and more men living longer with potential for increased need of mental health services. It will also be more ethnically diverse with a concentrated growth in Hispanic/Latino elders. Of particular concern will be access to services, as prevalence rates have been shown to be similar across racial/ethnic groups, but access to mental health services has been problematic for racial/ethnic minorities. The Baby Boom cohort in Kansas will have a substantial proportion of older adults in rural/frontier counties, and there will also be a large growth of older adults in urban areas. It can also be expected that this cohort will have a higher proportion of older adults with chronic conditions that are correlated with higher rates of mental illness such as depression. Other mental illnesses associated with the Baby Boom generation that will likely increase in prevalence are anxiety and substance abuse.

E. Key Findings and Related Implications

The aging of the Baby Boomers will result in an increased need for mental health services for older adults. Due to the increase in the number of older adults, there will be a corresponding increase in the number of older adults seeking mental health services. CMHC data indicate that older adults are currently an underserved population. CMHCs will need to plan to increase their capacity to serve older adults. This should include designing services provided by trained employees that meet the unique service needs of older adults.

The mental health needs of older adult men merit particular attention, given their increasing numbers. The older adult male population is projected to increase. With it will be a corresponding increase in the need for mental health services. The unmet mental health needs of older adult men are of particular concern, given their being the high risk group for suicide. CMHC data indicate that older adult men, as compared to older adult women, are currently an underserved population. Therefore, the Kansas mental health system will need to target outreach to ensure that older adult men have sufficient access to mental health services.

As the number of older Kansans who are members of racial/ethnic minority groups increases, so will the need for culturally competent care to meet their mental health needs. Census data indicate that there will be a significant increase in the number of older Kansans who are members of racial/ethnic minority groups. In particular, the number of Hispanic/Latino older Kansans will increase. CMHC data indicate that the Hispanic/Latino older adult population, as compared to other ethnicities, may be underserved. In order to meet this growing need, the Kansas mental health system will need to develop outreach and services that are culturally and linguistically competent.

The higher rates of CMHC utilization by older adults residing in frontier and rural counties may indicate that CMHCs have developed innovative strategies for outreach and service provision to a population with many barriers to service access. AIMS data for 2004 indicate that 69% of older adults who accessed CMHC services lived in a frontier or rural county. Further research is needed to determine how CMHCs have

been so successful in serving this population, so that others providing mental health services to older Kansans may benefit from this information. In addition, it may be that some of the strategies developed to serve this subpopulation of older adults are generalizable to other subpopulations.

As the number of older Kansans with chronic physical health conditions increases, so will their need for mental health services increase. As the population living with these illnesses continues to increase, the Kansas mental health system should not only prepare for an increase in older adults with mental health needs, but, they should also develop partnerships with medical and aging resources who meet their customers' physical health needs. Those serving chronically ill older adults will need education, training and resources to address their mental health needs.