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Senior Mental Health Specialist Investment

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A report submitted to the Senior Mental Health Budget Note Committee

Participants
Thirty-five informants were interviewed or completed a survey for this report (see Appendix A). They represented the Budget Note Workgroup and others identified by workgroup members. Informants represented aging services, mental health, advocacy, and other sectors such as long-term care, quality improvement, and health/medical care. Both those with a statewide focus and those with a local agency or community focus participated, including people from rural areas of the state.

The Problem
According to informants, mental health needs of older adults are not being met because:
- Systems are fragmented. The organizations that could address these needs work in silos with different funding priorities, eligibility requirements, and knowledge base.
- Mental health needs of older adults are not a priority in any agency and services that exist are often not tailored appropriately to the population.
- Knowledge gaps are pervasive about normal aging, available community resources, best practices, and mental health.
- Resources and funding are limited at best. Agencies are reluctant to fund services felt to be the responsibility of other agencies (e.g., aging services reluctant to pay for mental health services, mental health services reluctant to pay for those over 65 with a mental illness or with a dual diagnosis of dementia).

How Coordination Currently Works
- The amount of existing coordination varies by region. It is ad hoc, often informal, and is dependent on efforts of a few individuals. What exists is limited in scope.
- Coordination is more likely if:
  - A person has an acute mental health episode placing self or others at immediate risk requiring immediate action. (Typically, Law enforcement, Hospitals, Mental Health [MH] come together).[1]
  - A person has resources (income, insurance and access to providers who accept the insurance, social support, can advocate for self, and is located along the I-5 corridor).
- Examples of local coordination described by informants include:
  - Placing Aging and Disability Resource Connections (ADRC) staff in a CCO to manage referrals.
  - Coordination between MH, CCOs, and Law Enforcement.
  - BIRRDsong (a local advocacy organization) working to network and coordinate services for people with acquired brain injury (Portland).
  - Mental Health First Aid (Wallowa).
  - MH partnering with ADRC implementing PEARLS (Rogue Valley).
  - Neighbors, families, informal supports creating pathways to services (rural communities).

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[1] Response by multiple providers in a crisis is not the same as providing appropriate and needed services.

- o Screening in primary care, can be a gateway to resources (rural).
- o APD and AMH work well together at the state level (e.g., multidisciplinary team, mental health & emotional disorders team).

Where the gaps remain
- Overall, participants emphasized the lack of coordination at both state and local levels. No system is in place; too many silos exist even within the same agency.
- Participants were asked to rate coordination on a 1 to 10 scale (1=no coordination; 10=very well coordinated). Scores of those who provided ratings (n=29) were as follows:
  - o Addressing chronic mental health needs, average=3.82.
  - o Addressing acute mental health needs, average=4.57.
  - o Preventive services, average=2.83.
- No one agency is willing to take the lead in assessing, coordinating, and funding services for individuals with dual or multiple diagnoses; therefore, these individuals typically do not get adequate or appropriate services.
- No consistent funding mechanism is available to support people with multiple, complex needs. Services and funding for those services require negotiation on a case-by-case basis.
- Each system has different needs (e.g., hospitals need to discharge, nursing homes and aging services providers don't have training to care for those with very challenging behaviors, mental health targets younger populations).
- Older adults, particularly those with a mental illness or cognitive disorder are not a top priority for any agency.
- Informants were asked about specific conditions. Older adults are not being well served in **any** area of need (e.g., depression, anxiety, suicidal behavior, substance abuse, severe & chronic mental illness, dementia, traumatic [acquired] brain injury).
- Many older adults with mental health needs are invisible to the system (i.e., they do not "create a ruckus"). As a result, needs are not addressed until there is a crisis.
- Lack of knowledge exists at all levels about aging, mental health, service system, options, best practices, and who else can help (providers do not know about existing services or have erroneous assumptions that services are available when they are not).
- Inadequate funding is found at all levels – all systems are already overloaded.
- Many individuals lack access (e.g., Medicare providers, transportation, eligibility, availability, personal care services, walk-in services not designed for frail older adults).
- No data sharing is available between most agencies: no centralized records, HIPPA requirements limit sharing, lack of a common electronic record.
- Stigma is associated with mental illness and cognitive impairment, particularly in the current older adult age cohort.
- Examples of specific services needed:
  - o Transitional housing
  - o Transition support when moving from an acute situation to community based care; including transitional care settings from those discharged from inpatient psychiatric hospital units.
  - o Supportive housing with wrap around services
  - o Accurate diagnoses

- o Early intervention to manage chronic conditions and to prevent acute episodes
- o Medication management (with medications and dosages appropriate for an aging population)
- o Guardians
- o Transportation
- o Caregiver support

How to address those gaps
- Develop systems to support people with multiple needs who do not fit into one system; bridge gaps between mental health, aging services, and health/medical services.
- Systems should include mechanisms to fund needed services in a holistic manner: ways that are seamless to the client, and are consistent and easy for providers to access and use.
- A mental health system for older adults requires collaboration. Key players should include those from aging services (AAAs/APD, ADRCs), mental health services, health and medical care (CCOs, primary care, hospitals), long term care (NH & CBC), law enforcement and other emergency responders, and the legal system.
- Develop preventive care services and outreach services for early diagnosis and early intervention. Most informants said that these services do not exist at all.
- Actively involve local communities in developing and implementing the senior mental health specialist (SMHS) role: who, why, where located.
- Increase funding for services & service delivery; this is required if SMHS are to be successful.
- Invest in upfront costs. Recognize that those with multiple mental health conditions require a lot of time and resources – time to build relationships with clients and time to coordinate services among multiple agencies.
- Provide more cross training in aging and mental health agencies at all levels and in all systems.
- Use community health workers to assist clients with mental health needs to navigate systems, manage chronic mental health conditions, and access preventive services.
- Address tension between autonomy & self-determination and safety & risk.
- Explore use of "hands-on" approaches to supporting those with challenging behaviors (e.g., explore the DD model).
- Identify successful models to address mental health needs used in other states.

Larger vs. smaller communities (rural/urban)
- Services are dependent upon population density.
- Rural areas are difficult to serve because of the travel time (e.g., home care workers aren't generally paid for travel time).
- Lack of privacy (i.e., everyone knows everyone else).
- At the same time, many elders live in isolation, particularly in frontier counties.
- Rural communities cannot compete in the production of better services (e.g., because of strict requirements for residential care facilities, it is hard to provide LTC mental health services in rural communities).
- Transportation, housing, and treatment services are particularly challenging in rural communities.

Senior Mental Health Specialist: Role

- The informants had mixed responses to the Senior Mental Health Specialist (SMHS) role. Most were very excited, but many had negative responses.
- Concerns of those who expressed reservations about the SMHS role included:
  - It's not a person who is needed, but resources and a system that cares for older adults; the need is for one-stop-shopping for management of multiple issues.
  - A better state agency structure and climate for change is needed first.
  - Without resources, what is there to coordinate? The State often gives people but not the funding for the people to do the work.
  - Do not want something else mandated by the state.
  - Worry that the person will become bogged down in crisis situations, becoming overwhelmed by case management responsibilities.
- When asked to envision the SMHS role, consensus from informants was that the key role of would be to bridge the multiple systems that serve older adults and people with disabilities (VA, Primary care, MH, Aging Services, etc.).
- Another theme was that the position must have authority/power necessary to assure that system changes be made to ensure service delivery systems will meet individual needs.
- Role/responsibilities:
  - Build partnerships between community agencies to address gaps identified above (particularly the gap in services for those with complex needs); be a convener.
  - Coordinate and leverage resources; have the flexibility and authority to ensure there is funding for services to meet individual need; have control of funds.
  - Establish positive influence with community partners; build relationships.
  - Provide or coordinate training.
  - Provide oversight and/or consultation on complex cases (but <u>not</u> as a case manager).
  - Identify and document community needs (but this documentation process needs to be simple and straight forward).
  - Promote independence, dignity, and choice while balancing issues of risk and safety (community and individual).
- Knowledge, skills, abilities, other traits needed:
  - Have content expertise: mental health and aging (academic preparation and credible field experience).
  - Be knowledgeable about the community (especially in rural areas).
  - Be knowledgeable about the service system.
  - Skilled in community development (e.g., relationship development, advocacy, negotiation).
  - Creativity.
- Possible locations identified for the position were: community mental health, ADRCs, AAAs, CCOs, county health department.

Proposal for on-going staff support at the agency to provide statewide coordination and provide feedback on accomplishments

- High-level commitment from the APD, DHS, AMH, OHA is needed to bridge service sectors and to advocate for SMHS, and establish sustainable long-term funding and programs. This should be a priority of the Governor.
- Agency leaders must model bridging and coordination of services at the state level, and build a statewide system.
- Dedicated FTE is needed for state level positions to serve as a resource for SMHS (e.g., identify evidence based best practices, help with problem solving, develop SMHS peer support network).
- Suggestions were made for FTE for two state level staff: 1) One with generalized knowledge in aging and mental health issues, one specializing in severe mental illness; 2) one from AMH and one from APD.
- State-level staff can support workforce development at the local level including use of community health workers, and professional development at all levels (e.g., primary care, emergency department staff, aging services and mental health staff).

Program Implementation options

- Provide facilitated community conversations to begin building community relationships, fostering support for the SMHS position, and engaging local decision making (e.g., location, performance measures).
- Some of the funding from the training budget could be used to help the community define the priorities and performance measures (facilitated process).
- Where the position is located should be a local decision based on established relationships and what is working well (CCO, MH, Aging Services, AAA, APD).
- Service and funding priorities identified most by informants were for prevention and health promotion followed by chronic illness management. A long-range approach is needed to reduce the need for crisis intervention, which currently is a fragmented and limited response to acute episodes.

Recommendations on the need for and priorities for other kinds of training.

- One-time training is ineffective alone – sustained efforts are needed.
- Training is difficult to plan without systems in place; training must be consistent and supportive with a new service system.
- Training must support program implementation.
- Emphasize evidence-based best practices.
- Informants were asked to assign ratings to importance of targeting specific audiences (1=*not at all important*, 5=*critically important*). All areas of training were rated between 4= *very important* and 5=*critically important*, except for the general public (rated *important*). Top ratings were for targeting primary care providers (often the first line of contact) and family members.
- At the local level, plan training calendars together and conduct joint training across agencies.
- Training plans should be responsive to local circumstances. For example, one respondent from a rural community expressed the need for training on traumatic brain injury.

Evaluation
- o Tie evaluation to systems goals.
- o Local communities should define at least one performance measure for their community (using a facilitated process).

Appendix A – Key Informants

Budget Note Workgroup Members

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Additional Stakeholders

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One participant requested to remain anonymous