Environmental Scan of Older Adult Behavioral Health: Training and Advocacy Implications

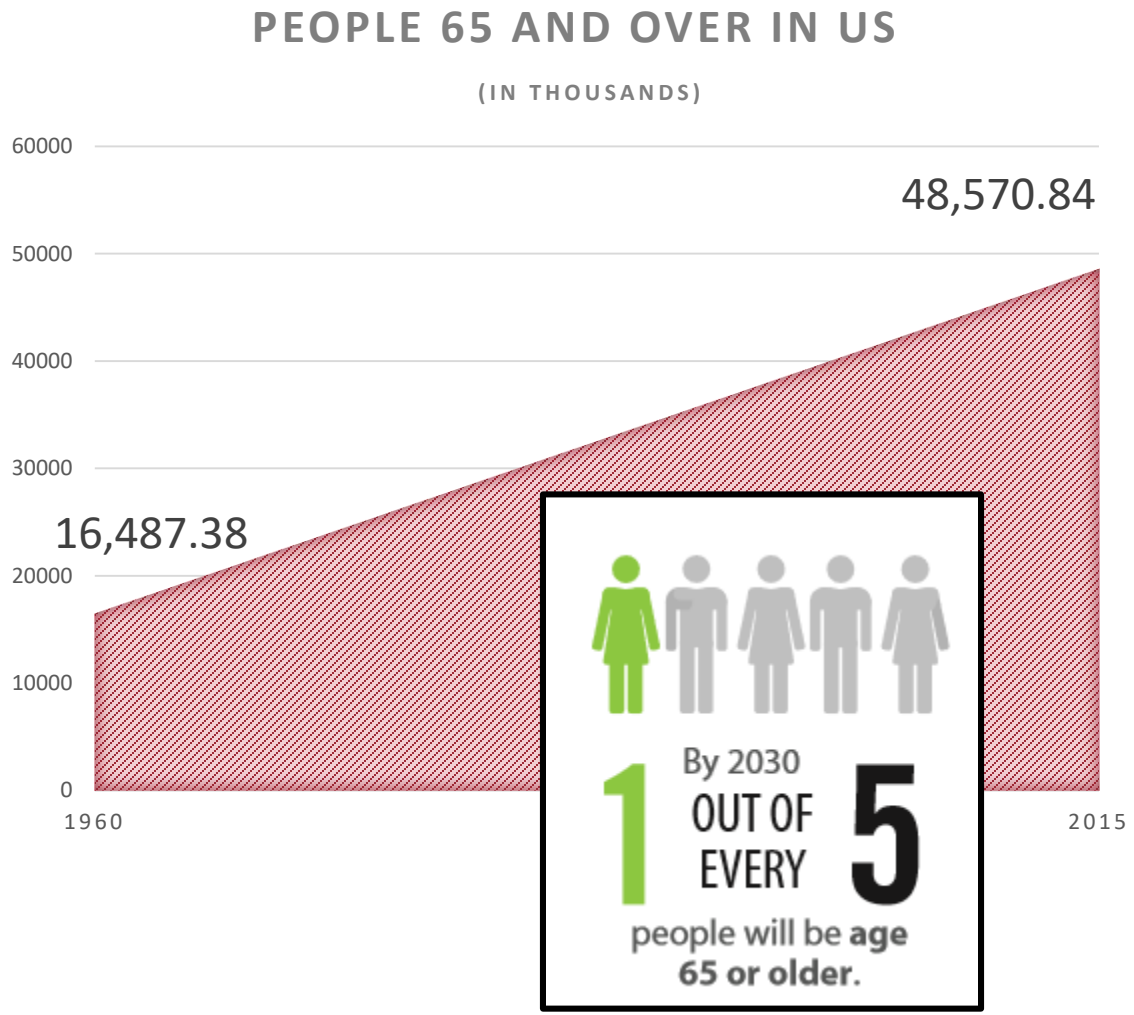
Massachusetts Association for Mental Health

Report done for the Massachusetts Department of Mental Health, Executive Office of Health and Human Services

April 2018

EXECUTIVE SUMMARY

The U.S. Population 65 and Older has almost Tripled from 1960 to 2015

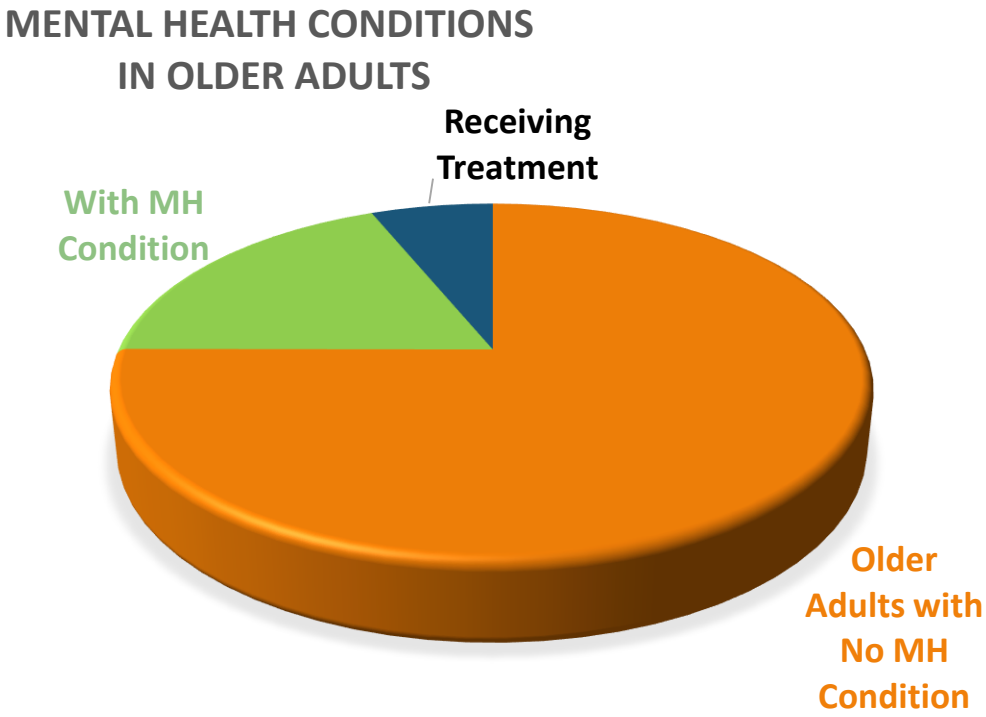


- As baby boomers age, the older adult population in Massachusetts is expected to grow from 14% in 2010 to 21% of the state population by the year 2030. Today 59%of older adults age 65 or older in Massachusetts are female, 50% are married, and 32% live alone.
- Per 2016 US Census Data there are 1.08 million people 65 and older in Massachusetts or 15.9%.
- By 2030, 1 out of every 5 people will be 65 or older (*Healthy Aging Report 2015*)

Facts about Mental Health for Older Adults

- The number of adults age 65 and over in Massachusetts with behavioral health conditions is growing rapidly.
- By 2035, 23% of Massachusetts residents will be age 65 or older.
- Nationally, it is estimated that 1 in 4 older adults has a mental health condition, such as a mood disorder, not associated with normal aging.
- Less than 33% of these older adults utilize mental health services.
- Males 75 and older have highest rate of suicide of any age group.

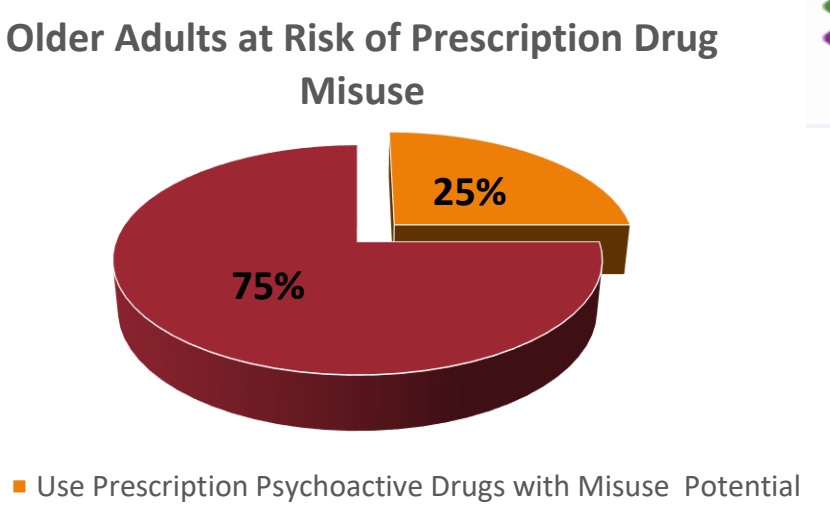
Source: https://mcoaonline.com/wp-content/uploads/2017/05/c7afa356-d275-4668-897d-e9e31b640f72.pdf

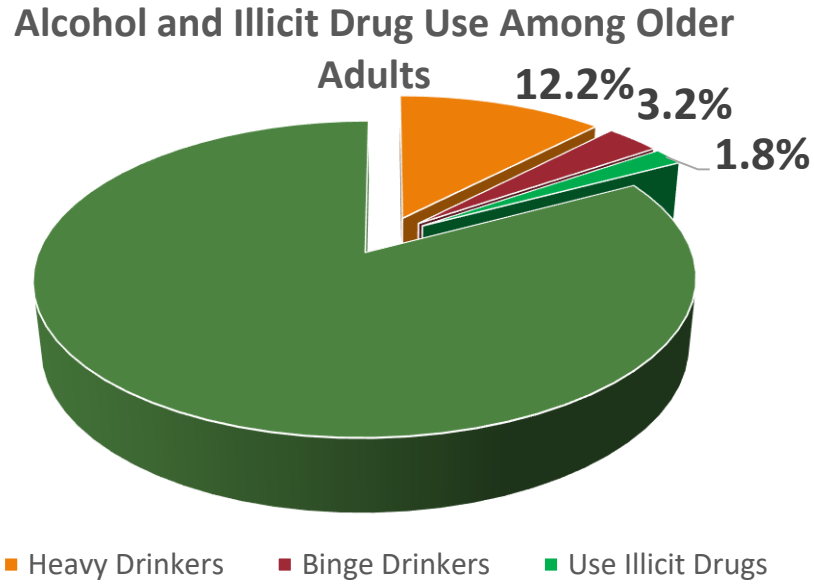


Alcohol and Medication Misuse and Abuse Risks

Alcohol and Medication Misuse and Abuse

- Problems with drinking alcohol and psychoactive medication misuse are the most common types of substance use problems seen in older adults.
- The National Survey on Drug Use and Health (NSDUH) (2002–2003) found that, for individuals age 50+, 12.2% were heavy drinkers, 3.2 % were binge drinkers, and 1.8 % used illicit drugs.
- An estimated 25% of older adults use prescription psychoactive medications that have abuse potential.
- Medication misuse can cause serious adverse drug events including falls, confusion, and delirium that is associated with a high rate of emergency hospitalizations and mortality.
- An estimated 1 in 5 older adults may be adversely affected by combination of alcohol and medication misuse.





Why BH Education and Training is Important for Consumers and Caregivers Interacting with Older Adults

Older Adults often have greater challenges accessing prevention, early intervention, evidence-based treatment and recovery services:

- Social isolation not only can lead to depression and other MH conditions, but also limits opportunities for interaction and engagement with health, MH, and other care providers.
- Stigma and reluctance to seek treatment.
- Misinformation about MH conditions being part of normal aging is pervasive.
- Lack of understanding about the efficacy of prevention and early intervention services on MH.
- Transportation barriers and affordability challenges
- Shortage of geriatric psychiatrists and other MH geriatric specialists for diagnosis and treatment.

- Older adults often do not understand that they may benefit from prevention and treatment because they are neither screened nor referred for diagnosis and treatment.
- MH conditions are often under-diagnosed due to the complexity of physical, neurological, and psychologic symptoms reported by many elders – screening for mental health conditions may get overlooked.

Source: SAMHSA

Proper Mental Health Screening for Older Adults is Lacking and Results in Under-Diagnosis and Lack of Treatment

- Older adults who experience psychiatric disorders rarely seek care from mental health specialists; rather, they tend to seek help from their general medical physician (Gallo, Rabins, & Illife, 1997).
- The primary health care clinic is therefore an important setting for the detection of mental health symptoms and subsequent treatment.
- Yet, older adults often present with a complex combination of medical, neurological, and psychological symptoms that increase the complexity of identifying and treating psychiatric difficulties (Jeste et al., 1999).

Points to the benefit of training about MH Screening for all Caregivers who have an opportunity to interact with elder clients.

- As such, primary care providers have been noted to under-diagnose mental health problems and to under-treat such problems when recognized (Unützer et al., 2000).
- Such under-diagnosis and treatment is costly as older adults with depression, anxiety, and/or alcohol abuse difficulties are more disabled by medical illness, use more health care services, and have higher rates of mortality.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4878701/

2012 Report by the Institute of Medicine (IOM) MH & SU Workforce for Older Adults Highlights

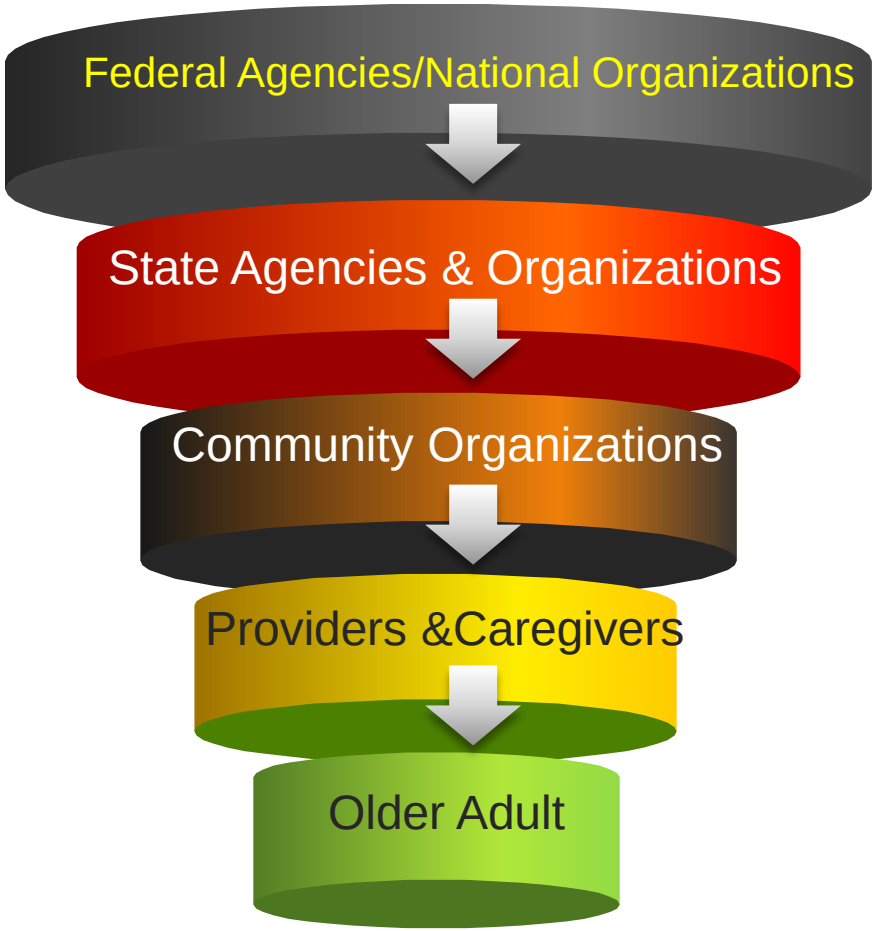
- Workforce Faces Unique Challenges and Requires Knowledge on BH Conditions.
- Many older adults who have MH/SU conditions also have acute and chronic physical health conditions, and some have cognitive and functional impairments.
- The interaction of physical health conditions, cognitive and functional impairments, and MH/SU conditions is a defining feature of the geriatric mental health and substance use fields and has critical implications for the workforce.
- The interaction of these conditions also results in difficult caregiving situations for families, physicians, and other health care professionals, and residential care and home- and community-based service providers. For example:
  - Age-related changes in the metabolism of alcohol and drugs, including prescription drugs, can cause or exacerbate alcohol and drug use conditions and increase an older person's risk of dangerous overdoses, even for people who have used alcohol and drugs at the same dose and frequency for many years without serious negative effects.
- Loss and grief are common in old age. The death of a spouse, partner, close relative, or friend can trigger or exacerbate depression and lead to severe, debilitating symptoms. Providers may find it difficult to distinguish major depression and grief when a patient is in the midst of a significant loss.
- Medications to treat common acute and chronic physical health conditions in older people can cause and exacerbate MH/SU conditions and, conversely, medications to treat MH/SU conditions can cause or worsen their physical health conditions.
- Cognitive and functional impairments can complicate the detection and diagnosis of MH/SU conditions. Cognitive impairment can also reduce an older person's ability to comply with treatment recommendations, including medications prescribed for the person's MH/SU and physical health conditions.

2012 Report by the Institute of Medicine (IOM) on MH & SU Workforce for Older Adults

Overarching themes on Need for Training and Role Development

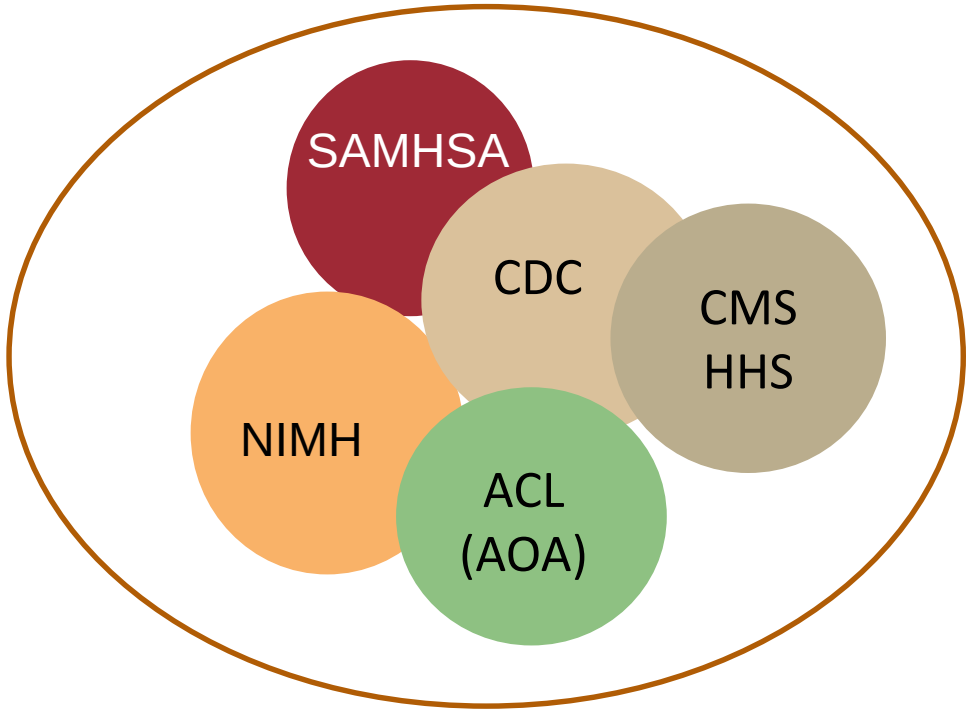
- **CLEAR ASSIGNMENT OF RESPONSIBILITIES:** The public health impact of mental illness and substance use in older adults is significant, but responsibilities for programs and policies to develop and support the workforce that is needed to relieve this burden are not effectively distributed across federal government agencies. The federal government can gain efficiencies and effectiveness by clear assignment and coordination of responsibilities for geriatric mental health and substance use workforce development across agencies.
- **DATA COLLECTION**: Available data about the service needs of these older adults are not adequate to guide future workforce development. More comprehensive and timely data are needed for this purpose.
- **LEVERAGE EXISTING PROGRAMS:** Many opportunities that exist in current federal programs have not been fully leveraged for the development and support of the geriatric MH and SU workforce. The necessary resources to ensure a viable workforce may be derived in large part from these programs.
- **TRAINING IS IMPERATIVE:** Training in essential competencies for the care of older adults with mental illness and substance use disorders must be provided across the workforce if it is to meet the challenges it faces and will face in the future.
- **NEW PROMISING MODELS:** Finally, new models of care must be put into place. Some of these models have been developed and demonstrated to be effective, and some remain to be developed.

Several Stakeholder Organizations are Working on Elder Behavioral Healthcare Issues



Key Federal Agencies

Involved in Elder Behavioral Healthcare



Substance Abuse and Mental Health Services Administration (SAMHSA)

- Federal Authority for Behavioral Health Policy (MH/SU)
- Funding to DMH and DPH/BSAS through Block Grants
- Standard Setting/Best Practices

National Institute for Mental Health (NIMH)

- Lead Agency for Research on Mental Health Disorders.
- Evaluates and promotes evidence-based treatment and prevention strategies
- Shares knowledge with scientists, patients, providers and public about the science of mental health conditions

Center for Communicable Diseases (CDC)

- Responsible for Health Security of US Citizens
- CDC's Healthy Aging Program monitors the MH status of older adults and connecting public health and aging services professionals with resources they can use to improve the health and quality of life of older Americans
- Collects Data, works with SAMHSA &NIMH on MH issues

Administration for Community Living (ACL) formerly Administration on Aging (AOA)

- Responsible for Older Americans Act oversight
- Funds State Programs to promote older adult well-being and independence thru Networks on Aging

Center for Medicare and Medicaid Services (CMS)

- Manages the Medicare and Medicaid programs which provide health coverage to more than 55M people over 65
- Fund PACE, SCO, and One Care programs for elders and disabled; Medicare ACOs
- Sets service delivery, payment and quality policies

Other Federal and National Organizations Involved in Elder Behavioral Health

Additional Federal Organizations

HHS BEHAVIORAL HEALTH COORDINATING COUNCIL (BHCC): A coordinated body within the US Dept. of HHS to share information and identify initiatives to include in the HHS BH agenda while avoiding duplication with SAMHSA. SMI, BH Integration, Prescription Drug Misuse, Trauma and EI, BH Quality metrics are addressed in subcommittees.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA): An agency within U.S. DHHS, it's the primary federal agency for improving health care for geographically isolated, economically or medically vulnerable people. HRSA has a "*no wrong-door approach*" to BH services & promotes BH & Primary Care Integration. HRSA emphasizes the availability of a highly skilled, professionally diverse and trusted workforce and funds BH workforce development programs.

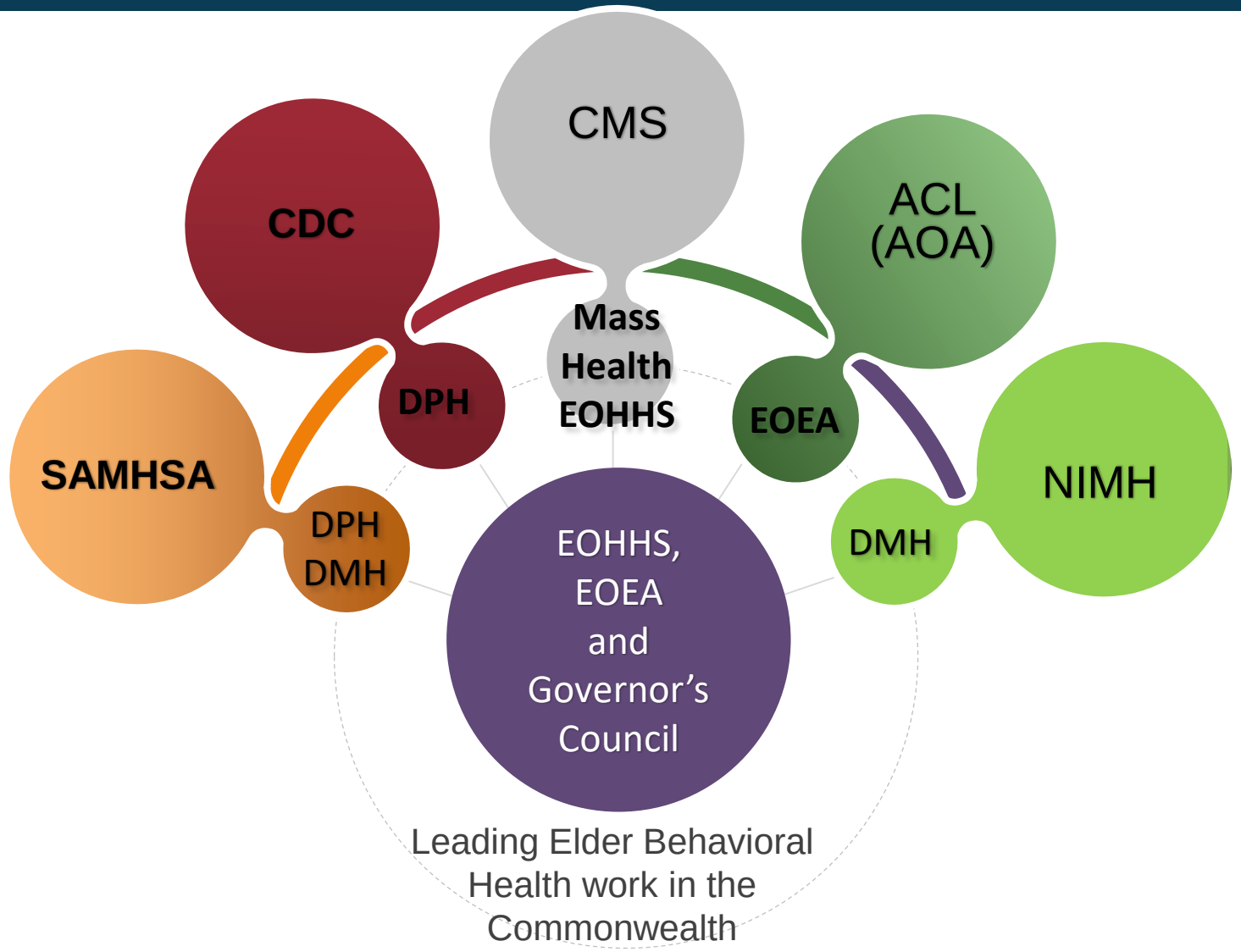
NATIONAL COUNCIL FOR BH (NCBH): A lead advocacy Organization on BH issues. Coordinates with Mental Health First Aid for education including on BH and Older Adults.

NATIONAL COUNCIL ON AGING (NCOA): Improve health & economic security older adults (60+). Advocacy and info for elders on chronic health but not focused on BH in particular, although collaborates with other stakeholders.

NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI): Nation's largest grassroots advocacy MH organization dedicated to building better lives Americans affected by mental illness.

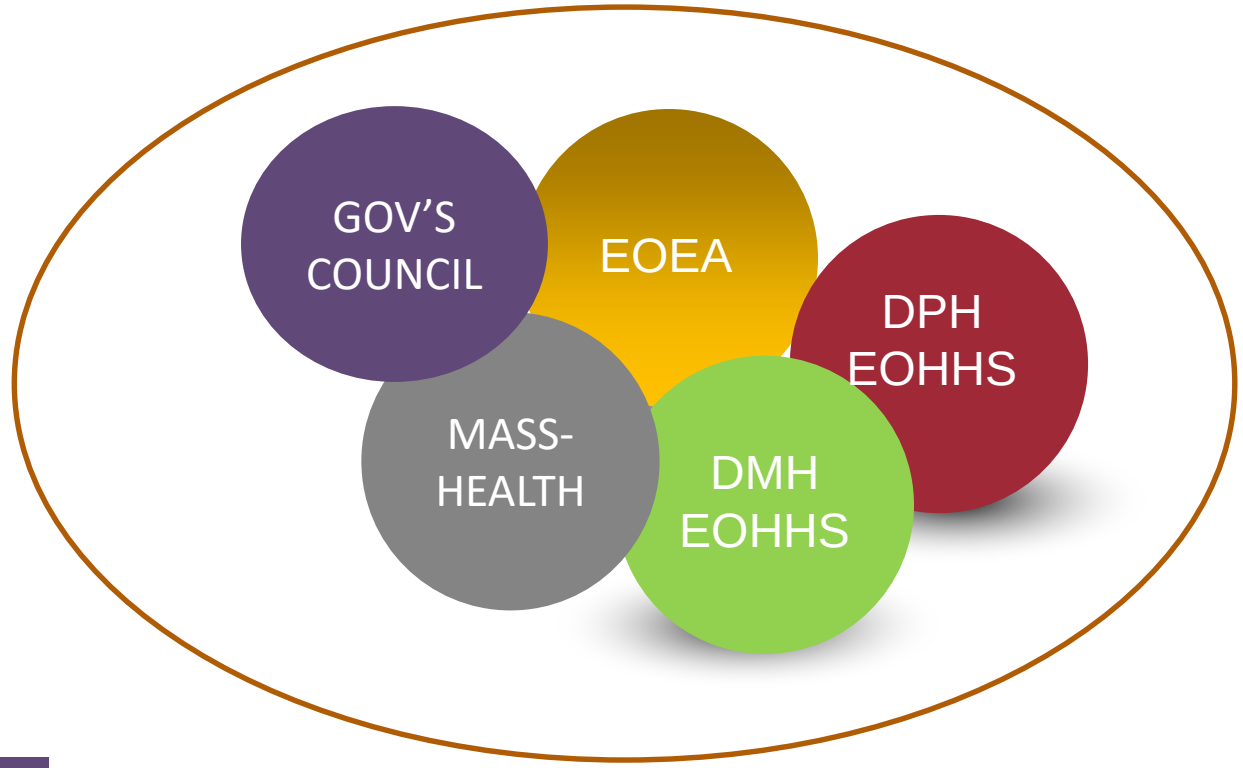
MENTAL HEALTH AMERICA (MHA): Leading community-based nonprofit dedicated to the needs of those living with mental illness and to promoting the overall mental health of all Americans.

Federal Oversight and Flow of Funds to Massachusetts State Agencies



Leading Massachusetts State Agencies

Involved in Elder Behavioral Healthcare



GOVERNOR'S COUNCIL TO ADDRESS AGING ISSUES IN MASSACHUSETTS

- Promotes Healthy Aging in the Commonwealth thru public awareness and access, leveraging innovation and technology

Executive Office of Elder Affairs (EOEA)

- Lead Authority for services and supports to Elders and their families
- Works closely with Aging Service Access Points and Councils on Aging across the state

Department of Mental Health (DMH/EOHHS)

- Lead Mental Health Authority in State Government
- MH Policy for all Mass Residents
- Care Delivery Focus is primarily targeted to individuals with SPMI

Department of Public Health/ DPH

- Lead Public Health Authority
- Operates Bureau of Substance Abuse Services (BSAS)

MassHealth/EOHHS

- Provides health coverage including for BH to 170,000 Elders
- Priority to integrate BH/Physical Health
- Funds One Care, SCO, and PACE programs for dual eligibles

Long Standing Massachusetts Collaboration - Grapples with the Growing Issue of MH Needs of Older Adults

Massachusetts has been addressing elder behavioral health needs through state agency and private non-profit collaboration for decades.

In recent years, Executive Office of Elder Affairs (EOEA), Department of Mental Health (DMH), and Department of Public Health (DPH) have teamed up to train communities in suicide prevention, train peer specialists and recovery coaches, provide grants to local organizations for outreach and urgent care, and build the skills of aging network agencies and their community partners on addressing behavioral health within the community.

Source: FY'17 Elder BH Health Initiatives Report

Factors driving Concern:

- People are living longer and the older adult population is growing.
- Living longer increases the risk of developing multiple disabilities.
- Many older adults are living along with increased risk of isolation and loneliness and related depression risk.
- Older adults who are isolated and/or have mental health conditions drive higher healthcare spending.

There has been growing concern that health systems will not have the capacity to keep up with the changes in demographics and the growing behavioral health needs in the state.

Snapshot: Massachusetts Non-Governmental Organizations

Leading Action on Elder Behavioral Health and Training in the Commonwealth

1. Mental Health Collaborative
2. Massachusetts Aging and Mental Health Coalition (MAMHC)
3. Healthy Aging Collaborative (HAC)
4. Mass Councils on Aging (MCOA)
5. Mass Home Care Association (MHCA)
6. Home Care Aide Council (HCAC)
7. Home Care Alliance of Mass (HCA)
8. Mass Association for Mental Health (MAMH)
9. Association for Behavioral Health Care (ABH)

10. BU School of SW, Center for Aging and Disability Research(CADER)
11. Jewish Family and Children's Services (JFCS)
12. UMass Boston Gerontology Institute, Healthy Aging Team (UMB)
10. The National Alliance on Mental Illness Massachusetts)
11. Mass Senior Action Council (MSAC)
12. Mass Association for Older Americans (MAOA)
13. The Healthy Living Center for Excellence (HLCE)
14. Massachusetts Housing Organizations
10. PACE and SCO organizations

A Key Question is: How to Leverage and Coordinate all these Valuable Resources to Benefit Older Adults with BH Needs

SUMMARY

- There are numerous stakeholder organizations committed to behavioral health issues for older adults.
- No single agency or organization in the Commonwealth has mandated leadership for this issue.
- Current collaboration among the complex network of federal, state and community organizations has the potential to provide a strong platform for cross-system knowledge enhancement efforts on older adult behavioral health.
- Awareness of and information sharing among stakeholders can drive a more cohesive approach to meeting the BH needs of older adults.
- System-wide understanding of the roles of each stakeholder organization and coordination of the services they provide improves efficiency in helping adults access to what they need.
- The sharing of best practices and expanding and replicating them across the Commonwealth should be one goal for the state-wide community serving older adults.
- Leveraging existing educational and training offerings of stakeholders and designing more targeted ones based on individual stakeholder group needs, is an approach to fill gaps and ensure system-wide knowledge improvement.

These themes are consistent with those of the Institute of Medicine Report cited on page 15 in term of needs:

- Clear assignment of responsibilities
- Data collection
- Leverage existing programs to the maximum
- Training is imperative
- Assess new promising models and develop new ones

3. Training Activities

On Mental Health and Substance Misuse in the Older Adult Population

Targeted Audiences for Training

All Community Frontline Staff working with Seniors should have BH training.

- Clinical professionals, MD, NP, RN, Psychologists, MSW, Home Health , Community Mental Health staff
- Paraprofessionals/Allied Health Professionals – Older Adult Peer Specialists, CHWs, Navigators, Home Care Case Managers, Home Care Aides, ASAPs and COA staff, ADRC coordinators, protective services staff,
- Residential Housing Coordinators and Supportive Health Care Aides in Elder/Disabled Housing Programs, Assisted Living Programs
- LTSS providers including meals on wheels, transportation providers, clubhouse staff
- Consumers and Family Caregivers
- State and Municipal Policy/Decision Makers

Existing Training Programs Related to BH

High level on the configuration of the system of care for older adult - who are the organizations and what services do they provide? Locally, State, and Federal. DMH, DPH, ASAPs, PACE, SCO, etc.

Clinical Training Basics – What are Mental Health risks and conditions. How to identify them, how to work effectively with at risk older adults, and when, where and how to refer them for needed services. (JFCS – Tips and Techniques)

More In-depth clinical training on MH and SUD, serving older individuals, and where and how to refer them for more intensive services. (CADER) for clinicians .

Twelve hour Training Curriculum developed by Home Care Aide Council for home health aids to work with individuals with BH conditions (not just seniors) plus a number of other individual training programs required for certification.

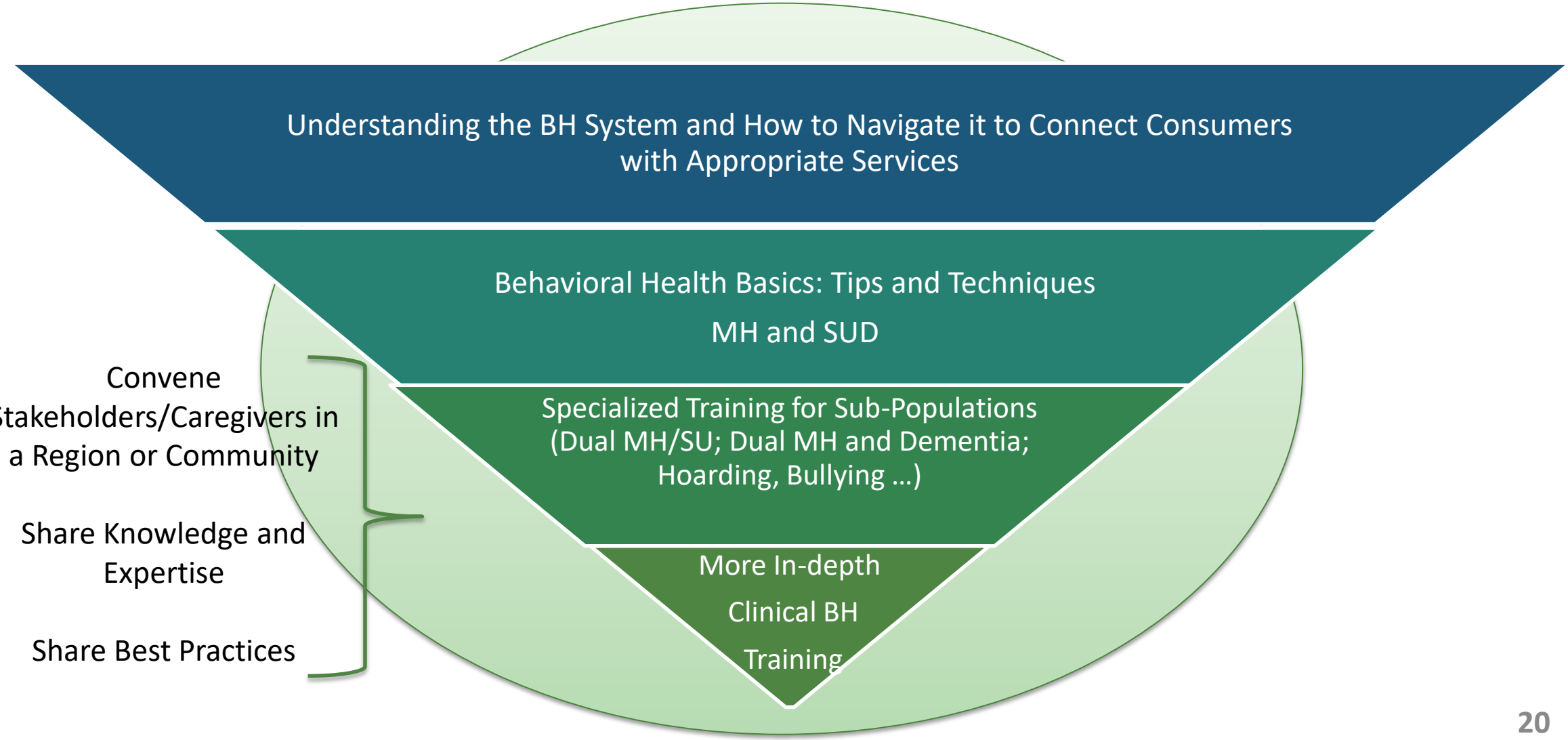
Best Practice program models and interventions: What they are and how they can be expanded and replicated. (Expand upon Spring Summit)

Peer Training to Certified Older Adult Peer Specialists; Social Bullying; Hoarding

Consumer Training – Navigating the system, Hoarding, Bullying, self awareness and how to manage their condition.

Training for Families – Navigation, Family-to-Family by NAMI, Basics of Mental Health conditions

All Stakeholders Need a Certain Minimum Level of Shared Understanding in Order to Communicate with Each Other Effectively and to Appropriate Serve Seniors in Need



DMH and Elder Affairs Training and System Enhancements

Significant Training Progress in FY17

TRAINING

Joint focus on statewide trainings across aging network and beyond to address elder behavioral health issues in the community, especially focusing on lonely and isolated elders.

- Training for Older Adult Peer Specialists
  - 21 were trained plus 5 facilitators
- **Basic MH Training** for 365 Housing & Community-based staff & Volunteers - JFCS
- **BU CADER Online Aging and BH Certificate** Training for 150 Direct-Client staff including:
  - 63 protective workers
  - 17 case managers
  - 17 COA staff
  - 14 nurses
  - 5 SCO-affiliated staff
  - 35 mixed group – SWs, LTSS coordinators, home care etc.
- **MH 12-hour Training** for 127 Supportive Homecare Aides partnering with 9 ASAPs developed by the Home Care Aide Council.

OTHER INITIATIVES:

- Augment Support for 3 existing Elder MH Outreach Teams (EMHOT)
  - Isolated or those living in difficult situations
- Massachusetts Health Aging Data Report to newly includes MH Indicators on the community level with UMass Boston (UMB)
  - Community study done on community factors impacting MH outcomes by UMass Boston Gerontology Institute Healthy Aging Team
  - 120 Indicators included in Profiles of all Massachusetts Cities and Towns & 16 Boston Neighborhoods
- Statewide Forum held by EOEA/UMB attended by 70 organizations and 110 people to foster collaboration at the regional level to support elders in the community
  - Share best practices, deepen working relationships, identify collaboration enhancements

Community Non-Profits Offer Trainings to Their Members and Constituents, Some using Training Partners like JFCS and BU CADER

MAMHC

- The Massachusetts Aging and Mental Health Coalition is hosting a May 2018 conference on Aging and Mental Health.

Mass Councils on Aging

- Provides many various trainings to COA staff including Suicide Prevention for older adults. **Home Care Aide Council**
- A non-profit trade association with over 150 home care agency and community-based organization members throughout Massachusetts.
- Provides a 12 hour curriculum to better prepare home health aides to work with older adults with MH and SUD conditions.
- Also provides many other trainings as part of certification and career ladder advancement.

Home Care Aide Council

- Offers many training and educational programs to their members for certification and career advancement a number of which are related to BH.

NAMI-Mass

- NAMI offers educational programs to consumers and family members with mental illness primarily led by peers, including a 12 week course entitled “Family to Family”

Mental Health America

- Offers an 8 hour course on Mental Health First Aid. The training helps caregivers identify, understand, and respond to signs of addictions and mental illnesses. (Not Specific to Older Americans)

The Healthy Living Center of Excellence

- Provides chronic disease mngt and other classes to promote health among seniors.(Not Specific to BH)

Massachusetts Senior Action Council:

- Statewide, grassroots, senior-led organization provides monthly training workshops on various topics primarily focused on Advocacy

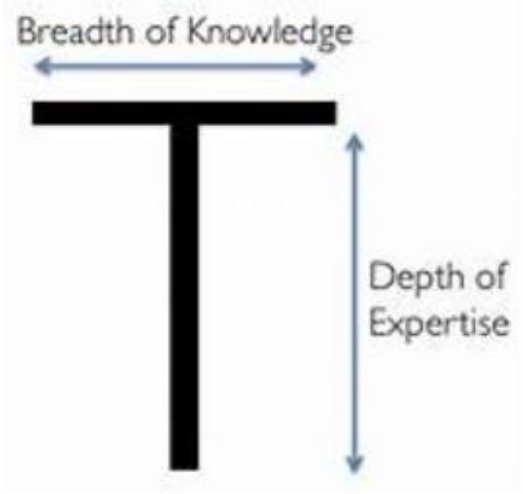
Mass Home Care Association

- A trade and advocacy organization comprised of all the 26 Aging Service Access Points (ASAPs) in the state.

Preliminary Impressions from the Research

(Further Informed by Key Informant Interviews and Inputs to follow.)

- There is a significant amount of attention to training and there are many different types of training programs being offered throughout the state to particular groups of stakeholders by the trade or advocacy organization to which they belong.
- Training is being developed and implemented in a fragmented way without a great deal of sharing and cross pollination across different provider types.
- There are experienced training resources/experts who can be leveraged to provide training delivery expertise and guidance.
- 2017 DMH/EOEA trainings provided on BH & Aging was well received and considered valuable, both in terms of content knowledge and opportunity to meet similarly aligned caregivers in a given region of the state.
- There is a need to determine who comprises the "workforce" and what breadth and depth of knowledge and competency each caregiver type needs to effectively do their work to the benefit of older adults.
- What appears to be lacking is a lead entity, a training strategy, and an infrastructure to roll-out trainings, and a dedicated funding stream.
- It will be valuable to convene stakeholders on a regular basis to drive continued workforce development and share best practices, or even establish a core training advisory group.



Key Informant Interviews and Input

TRAINING LEADERSHIP AND ORGANIZATION:

- The approach to BH training for older adults is fragmented and needs to be coordinated in order to have a real impact. A fragmented “shotgun” approach to workforce training driven by numerous organizations on the same or similar topics, e.g. MH, SU, is inefficient. Gaps remain.
- Trainings are offered by many different organizations in a “siloed” manner with the trainings customized to their particular service/business.
- Trainings are generally not tied to a an overall set of competency requirements for particular positions with some exceptions such as in the home care aide system.
- The role of DMH and EOEA is unclear in terms of which agency should take the lead in older adult BH workforce training, and the training requires DPH input on SUD.
- DMH is focused primarily on SMI or SPMI individuals and therefore, programs that focus on improving BH services to older adults at large are not as much of a priority in terms of funding and focus.
- Although the MAMHC serves as a collective group of organizations interested in BH needs and programs for older adults, the group is somewhat informal, without membership rules or enrollment guidelines and does not have a website where stakeholders can seek out information about initiatives including training.
- Lack of ongoing dedicated state budget funding for older adult BH workforce development is a deterrent to working aggressively toward a master BH training plan, and the sustainability of such a plan. Much work relies on grant funding with state funding being sporadic.

Key Informant Interviews and Input

TRAINING CONTENT:

- There is no training program available on the intersection of mental health and substance use among older adults. EOEA cited this as a major gap.
- Frontline staff have little knowledge and information on the substance use delivery system and how to navigate it.
- Once frontline staff identifies that a client requires help with a MH or SU condition, many do not know where to refer them or how to navigate the mental health or substance use system to get them the services they need.
- More in-depth orientation is needed on concrete steps in navigating the DMH system, how to identify and match the older adult's needs to the appropriate treatment, and what are the steps/path to getting that treatment. For example, calling 911 is often and understandably the default action when workers are not familiar with other options and how to reach them. The role of DMH and how to access DMH services is not widely understood. This training needs to connect the dots between BH condition and current symptoms and optimal treatment.
- The level and depth of training curriculum needs to be matched to the particular frontline staff's role in interacting with seniors, e.g., home health aides may not need training on different MH diagnoses, but instead need training on how to address behavioral issues, regardless of diagnosis.

Key Informant Interviews and Inputs

WHO IS INCLUDED IN THE OLDER ADULT WORKFORCE NEEDING TRAINING:

- Not only do older adult caregivers need training on BH, but conversely, BH providers need training on serving older adults. Recovery coaches have little or no training on dealing with older adults.
- It would be helpful to have an assessment done to identify which staff are in the older adult community workforce and quantify the numbers.
- Given the magnitude of the community workforce serving older adults in different capacities, and given the turnover factor, training needs to be ongoing and institutionalized if the goal is to have a workforce that is, at a minimum, culturally competent to serve older adults at risk for, or with, mental health and substance use conditions.
- All staff in a chain of command e.g., home care system, need training so that frontline staff have the support they need from supervisors to appropriately address situations they encounter.
- Community Mental Health Centers have not embraced working with older adults, and may require training and encouragement.
- Training at Community Health Centers on older adult BH does occur on a systematic basis.
- In area of Substance Use, most staff are accustomed to dealing with young males and very few specialize or have experience with older adults and detox, opioids, etc.
- If a the widest net was cast, it would include all individuals who interact with older adults in the course of their work, but each group would need a different level and depth of training depending on their role with seniors.

Key Informant Interviews and Input

TRAINING DELIVERY AND LOGISTICS

- Experience has shown that convening older adult care givers in the community has benefits beyond the technical training aspects, as this improves knowledge of aligned organizations, helps open lines of communication and improves coordination in the community.
- It is difficult for many staff to take time off for training sessions and pay for them, if there is a charge.
- The lengths of trainings should be limited to not more than half day in order to maximize attendance and not disrupt staff schedules.
- The training offerings have mostly been well received, however, they are not offered in a standardized manner, with attendance and mix of provider participants varying from region-to-region.
- Decisions need to be made on which delivery method works best for which audience – in-person, online, or a combination.
- Establishing outcome measures for training programs and tracking performance is important and does not generally occur currently.
- Data collection and tracking is needed to assess needs for training and keep track of training sessions, participants, and remaining gaps.
- There are a number of partner organizations with training expertise and their knowledge and advice should be leveraged to inform a plan for training delivery approaches.
- Difficult for agencies and members of the older adult workforce to find out about available training sessions and/or conferences. There is no central clearinghouse or website.

Recommendations

- **Develop a curriculum and offer training on the intersection of MH and SU**. Given that 50% of those with MH conditions also have a SUD, this is an important and relevant training to fill an identified gap.
- **Expand upon training for SUD**, working closely with BSAS.
- **Training on how to navigate the SU system** could be integrated into the training on the Intersection of MH and SU, and/or could be a stand alone curriculum.
- **Continue to share "Pockets of Excellence"** at the regional convening of older adult stakeholders, and perhaps develop a training on this and best practices nationally.
- It would be good to have **PACE and SCO programs** with good track records for BH service delivery share their experiences, findings and recommendations with broader group of stakeholders. (MAMHC perhaps or a training advisory group)
- **Consider a model like New York City's** Dept. of Geriatric MH whereby there is required training mandated for most caregivers working directly with older adults, including BH training. Basically certification requirements tied to training and advancement.
- Given the siloed nature of trainings that may be on the same topic but are customized to meet the specific needs of certain workforces, it makes sense to **develop "core frameworks" for BH training** with a standardized knowledge base and core curriculum. Agencies may build upon these core modules and add agency or job-specific technical details. This would save time and money by developing a shared curriculum and enable providers across the spectrum of elder services to have a common understanding of the "basics" and be able to communicate and work together more effectively.
- **Establish a lead "champion" for BH training in the Regions** building upon the approach used to implement the 2017 Regional DMH/EOEA training sessions.

Recommendations on Training

- **Develop a lead advisory group** of BH older adult stakeholders who are tasked with:
  - Identifying and mapping the older adult community workforce and categories of staff,
  - Identifying their training needs based on generally agreed upon competency parameters,
  - Reviewing existing training programs and developing an inventory
  - Assess existing training program's appropriateness to meet needs,
  - Identify training gaps and improvement areas
  - Identifying free, shared, or low cost training resources,
  - Develop a framework for a three or five-year training plan
  - Make recommendations, advocate for state funding, and identify grant opportunities.
- The advisory group could be a subgroup of the Elder Mental Health Collaborative but with some additional members to represent PACE, SCO, Housing providers, and other providers identified in the workforce analysis.
- **Establish a Training Clearinghouse**
  - Locate in one place on the web an updated listing of all training opportunities available to community staff working with older adults, including courses, workshops, conferences, and other forums.
- **Collect Data** on outcomes, participation, and remaining gaps. Survey older adults for before and after trainings for changes in service delivery, relationships with caregivers, and their understanding of BH as it relates to their conditions and treatments.
- **Review and share best practices** and promising models from within the state and nationally with the goal of replication.

Key Advocacy Issues

There is general consensus among stakeholders that the following issues are priorities for advocacy:

- Additional budget funding for BH resources for older adults
- Dedicated budget line item for older adult BH at either EOEA or DMH
- Expansion of the Elder Mental Health Outreach Teams
- MCPAP-like program for Older Adults, connecting primary care with geriatric psychiatry
- More funding to promote widespread adoption of existing training, the development of curricula to fill gaps, and resources for the coordinating infrastructure
- Expansion of the older adult peer workforce and promotion of funding and reimbursement models to support it.
- Adoption of minimum training requirements for aging services staff related to BH.
- Analyze, share information, and leverage innovative technology solutions that enable older adults to remain at home, e.g. Avatar program at Element Care PACE.
- Continue exploration and promotion of telehealth especially in rural areas of the state and for persons who which are less mobile.
- Develop policies and procedures to accommodate “new” clients to DMH who are seniors with serious and disabling mental health conditions and who cannot be well cared for outside of the DMH system, e.g., PACE clients with SMI.

Summary and Next Steps

- Massachusetts is fortunate to have several community organizations dedicated to providing high quality services to older adults in the community, and state agencies that are equally committed.
- One entity needs to be the designated lead for BH Training for older adult caregivers with clear assignment of responsibilities including establishing a clearinghouse of training resources.
- Existing training programs and Subject Matter Experts (SMEs) need to be leveraged to benefit the wider workforce.
- Best Practices and Promising Models should be examined for replication.
- Data needs to be collected on outcomes.
- A systematic coordinated approach to BH training with a master plan will serve not only to advance a training agenda, but can be used to advocate for resources.
- There are a number of key advocacy items, most of which are already being discussed and addressed and the MAMHC.

Note: List of References is contained in the full environmental scan document.