Testimony for Aging and Long Term Care Subcommittee
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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 2047.

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 2047 in meeting those needs.
(2) The importance of direct service combined with public outreach and community networking in geriatric mental health.
(3) A description of the Senior Outreach Services program as an example of the type of program that this bill could help fund in a rural area including key outcomes.

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). Kansas desperately needs the help of HB 2047 to start developing a workforce to meet these needs.

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 our catchment area 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.The direct services provided by SOS targets these symptoms and other issues through treatment 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.

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.

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 case example demonstrates both the severity of the issue and the success that can be achieved with effective treatment:

Last summer, the crisis department at Four County Mental Health Center received a call from a family member of an older man, who was concerned for his well-being reporting that he was depressed and having thoughts of suicide. Two crisis workers went to his home to check on him. Upon arrival, this gentleman revealed that things were going "terrible" and indicated that he was planning on ending his life today. He showed the two crisis workers a pistol that he intended to use. Both crisis workers tried to intervene, but he insisted that he was going to end his life and asked them both to leave. The older gentleman got in his car with two firearms with the intention of driving out to a country road and shooting himself. They observed the man leave his home and drive to the country road he referenced. They saw him pull over in his vehicle. At just that moment law enforcement arrived on the scene.

This story could have ended very tragically, but fortunately, it didn't. Fred now looks back on that day with both regret and joy. "It's been a complete turnaround"
At that time, Fred believed that suicide was the only way to escape his feelings of depression, loneliness, and multiple stressors he was dealing with at the time. "I held it in until I was too late." At that time, he was isolated, grieving over the recent loss of his wife, and believed that there was no one that could help him. After this event, things

began to change for Fred. He was hospitalized and treated in a geriatric psychiatric facility. He was discharged and began to receive outpatient treatment through Four County Mental Health Center. He was provided medication services, crisis supports, and began to participate in therapy and case management through Four County's geriatric specialty program known as "Senior Outreach Services." In fact, some two of his follow-up providers were the same workers who responded on that dark day. It is also important to recognize that Fred approached his services with an attitude of acceptance, appreciation, and desire to improve himself.

Today, his life looks much different. He participates in volunteer activities and visits friends and family on a regular basis. He has close relationships with his family and is willing to use them as supports. Fred goes to visit people in need at the nursing home and repairs broken furniture for friends in the community. He also has agreed to help other clients with mental health issues by encouraging them and teaching them woodworking skills. He has developed a trusting relationship with his case manager and members of the crisis department. "I never met anyone out there (Four County) that I didn't like or that wasn't nice to me." He now appreciates his life and is a contributing member of his community.

There are two important points we should take from Fred's story. First of all, many older adults struggle with depression, anxiety, and other mental health problems just like Fred. Many times, like Fred, these individuals have never received treatment for mental health issues. Many older adults do not understand the benefits of getting treatment and are not comfortable discussing these kinds of problems with their primary care providers due to stigma and limited education on the topic. This is why specialized geriatric mental health services are needed in communities throughout the State. Fred recommends that older adults struggling with depression or other mental health should seek help earlier rather than later. "They should talk to somebody and get things off their chest."

Second, Fred's recovery was not a straight climb to the top. He had periods after he was discharged where he became depressed and thought of suicide. However, this time he had adequate supports from his providers and community members to help him get through the tougher times. Mental illness can often have peaks and valleys. It is crucial that older adults have adequate services to assure they are safe and well. Fortunately, Fred received those services at just the right time. These services are not available in many communities throughout Kansas. This is why advocacy and support of geriatric mental health legislation as well the existing mental health service delivery system is so important. Without intervention, it is likely that Mr. Jones wouldn't be here to tell his story. Fortunately, he got the help he needed and his family, community, and Fred are all better off as a result.

I will close this section with an example of a senior, who didn't get help in Montgomery County. 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 next 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). SOS provides in-service presentations to educate providers on depression and suicide in older adults on an ongoing basis The SOS model has found partnership and collaboration with other providers invaluable in reaching seniors especially in rural areas.

The SOS approach also involves many other partners in the community.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 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.

Key Outcomes

Access

The SOS program successfully completed a 3 year grant project in May of 2010.has outreached or would you want to say served over 300 seniors since 2007. 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 and public education to help seniors access services at a higher rate,

which was the primary purpose of the project.

Treatment

The program has also demonstrated effectiveness in the treatment model for the patient's directly served through SOS services. The following key outcomes were achieved with statistically significant data.

- Reduction of Psychiatric Symptoms at admission, discharge and 3 month intervals
- Improvement in quality of life on SF-36 Health outcomes survey
- Increased participant satisfaction in social activities, relationships, & overall life satisfaction
- ***89% of program participants continued to live independently in the community***
- ***93% of program participants did not require inpatient psychiatric hospitalization during treatment***

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 were funded solely through federal grant dollars, which ended 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 2047. 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.I would like to thank you for your time and consideration on these crucial issues.