Content Notes

Florida Commission on Mental Health and Substance Abuse
6/23/00
Tallahassee, FL

<u>Invited Speaker</u>

*****(9:20 a.m.) Dr. Gema Hernandez, Secretary, Florida Department of Elder Affairs** Dr. Hernandez reminded the Commission that her first career had been as a counselor in the substance abuse field. This is still an important area to her and she welcomes integrating it into her work in elder affairs.

She reviewed the long-used Jellinek curve that identifies alcohol use and challenged the Commission to develop a similar curve that identifies substance abuse that develops later in life in older adults. She stated that more cross training of professionals is needed, utilizing people who come into daily contact with the elderly such as public housing coordinators, primary care physicians, Assisted Living Facility (ALF) administrators, and home care workers, among others. She also advocated a clear state policy for mental health and substance abuse issues specific to older adults.

Dr. Hernandez also suggested that alcohol treatment be integrated in the long-term care continuum, better utilizing the role of case managers. She emphasized the importance of developing new societal roles for elders, including “aging with purpose” (which includes meaningful activities such as mentoring, volunteering, and other community activities). She stated that Florida needs a new outreach and treatment approach for elders, including different identification mechanisms than are used with younger populations. While substance abuse is usually identified in younger people when they have problems at work, with family, health and the law, older adults with problems (or at risk for problems) can better be spotted in senior centers and ALFs and by in-home health care workers and protective services investigators. She also advocated cross-training of staff regarding alcoholism and depression, noting that one problem is often mistaken for the other. In sum, she said, we need a coordinated, integrated system with a comprehensive, engineered plan of action.

We should be sending professionals out to places where elders live or gather rather than expecting them to come to professionals or seek help, which is often contrary to their habits and long-standing approach to dealing with problems. She noted the importance of age-specific treatment approaches for substance abusing adults, saying that group treatment with young drug abusers, for example, simply doesn’t work with elders who are unaccustomed to and uncomfortable with sharing feelings openly with others. She talked about her “Positive Aging Campaign” which is taking many of the above ideas to elders around Florida and noted that substance abuse (and depression) comprise a public policy issue because these prevalent problems are a budget issue. Dr. Hernandez said that nationally 37% of the working population care for, or are responsible for, an elderly relative, and the economy loses $7 billion as a result.

Following a brief business meeting, public testimony was taken.

Public Testimony

**** (10:38 a.m.) Miriam Williams, Clinical Administrator for Gulf Coast Jewish Family Services,** stated that Gulf Coast is likely the largest provider of outpatient mental health services for older adults in Florida. Ms. Williams also serves as chair of the Long-Term Care Subcommittee of the Florida Coalition for Optimum Mental Health and Aging. As a provider for more than 25 years, she said she has seen a decline in MHSA services for the elderly in Florida.

She noted that depression in elders is under-diagnosed, and geriatric depression is projected to affect up to 15 million elders by 2030. Symptoms are both physical and emotional, and the illness is often comorbid with medical illnesses. Depressed elders are at high risk for suicide.

Ms. Williams described Gulf Coast's geriatric crisis response team, which responds to this high risk group. The program was cut by 20% last year as general revenue was replaced by TANF (Temporary Aid to Needy Families) funds, which are inaccessible by the elderly. She described Gulf Coast's 75-bed residential treatment facility and licensed therapeutic foster homes, which place elders with serious mental illnesses in family environments. This program, with 80 placements, has long waiting lists. Clients who need more intensive nursing home placements are also at a disadvantage. Six years ago their program existed in 100 nursing homes, and today they are in fewer than 20 nursing homes due to changes in Medicaid.

Ms. Williams also noted that many elders need substance abuse services but are reluctant to seek help because of denial or shame. Studies, she said, suggest that seniors have the highest recovery rate of all age groups. Gulf Coast's new program called Elder Ed provides training on the prevention of medication mismanagement and alcohol abuse prevention.

Another barrier to adequate service provision to the elderly is inappropriate performance outcome measures, which unfairly evaluate elders' functioning and program effectiveness, thus impacting provider agency contracts. In summary, she asked the Commission to help stop the erosion of services for elders with mental illnesses and addictive disorders. Specifically, she asked that Commissioners recommend that DCF be required to maintain existing ADM services funding for elders statewide.

(10:48 a.m.) Kay Keller, a mother with three children with mental illnesses and a 67-year-old mother with paranoid schizophrenia, expressed a need for wraparound services for older adults like her mother, who is too paranoid to go to a senior center or access other services outside her home. She reminded Commissioners that stigma is an important issue for elders. Her mother, for example, associates treatment for mental illnesses with cruel institutions, lobotomies, old-style shock treatments, and other outdated treatment modalities. She said that elders need to be educated about the advances in treatment, and that issues such as loss of control and grief should be considered and factored into approaches used. She also noted that many adult children are in denial about their parents' alcohol and drug problems or wonder if it is worthwhile to take alcohol or drugs away from older people. Finally, she said that those who work in

areas such as animal control and protection should be trained to recognize child and elder abuse in addition to animal abuse, as they often co-occur in homes.

(10:55 a.m.) Anita Cape, Family Trauma Survivors Network, told the story of her parents and their – and her -- exposure to child abuse and trauma that left lasting scars and caused tremendous pain and disability. She noted that there is no one available in Pinellas County to treat trauma survivors, at least within her financial and insurance constraints.

Invited Speakers

****Richard Powers, MD, Director, Bureau of Geriatric Psychiatry, Alabama Department of Mental Health and Mental Retardation, Birmingham, AL** Dr. Powers first asked rhetorically, "Why worry about mental health and substance abuse in elders?" For one reasons, demographically we will soon see a tremendous boom in this age group, with people potentially living as long as 130 years. In the year 2030, he said, there will be more people older than 65 than younger than 18 in the United States, an unprecedented phenomenon.

Two additional reasons for addressing MHSA needs in the elderly are compassion and public policy, the latter especially in terms of finances. Elder care is very expensive and eats into the Medicaid budget. HCFA, he said, is pulling the federal government out of long-term care. They don't want to be involved in psychiatric care and don't want to pay for it, he stated.

How common is mental illness in older persons? Eighty percent of nursing home residents have a DSM diagnosis. He defined mental illnesses in two tiers, the first tier including depression, delirium, and dementia, and the second tier including schizophrenia, substance abuse, and MD **[DS: what does MD in my notes stand for, do you think**???]

The solutions to current problems are not rocket science, he said, but simply using existing technology. He gave the following statistics:

- 10% to 20% of hospitalizations in the elderly are attributable to adverse drug reactions
- 15% to 20% of elders take psychiatric medications (1/5 of all elders)
- 40% of elders take too much medication, with 10% to 20% prescribed medication needlessly

First, he said, we need to clean up prescription medications. "The problem is that many doctors don't understand prescribing drugs to the elderly. We aren't training enough geriatric psychiatrists, and the federal government is getting out of physician training. Also, most young doctors don't want to go into geriatrics."

To prepare for the coming boom in elder care, we need a huge number of caregivers, not only specially trained physicians but workers who can feed and handle patients who need one-on-one care.

Why should we treat dementia? Of individuals with dementia, 70% have behavior problems, 25% are depressed, and 30% to 40% have delusions and hallucinations. Half of all patients with Parkinson's disease (an illness characterized by movement, mood and

thought impairment) have depression. In fact, many illnesses of older adults have these qualities. These involve psychiatric morbidities that should be treated.

Delirium is common, with 15% of hospital admissions involving delirium, much of it brought on by medications. "These patients die faster. This condition is often unrecognized by doctors but it is often reversible."

Prevention in elder care is very important, Dr. Powers said. We need better early recognition of problems and intervention with the elderly. In people over age 65, depression can lead to mental illness, stroke and dementia. Ninety percent of elders can be treated effectively for depression. Increased intellectual stimulation can help stave off depression.

Nursing homes should do a better job of reviewing and monitoring patients' medications. The majority of patients still living at home, he said, see a nurse practitioner rather than a physician. In fact, doctors often don't know their patients.

(11:58 a.m.) Carol Colleran Egan CAP, ICADC, Director, Older Adult Services, Hanley-Hazelden. Ms. Egan seconded comments made early by Dr. Gema Hernandez regarding substance abuse in older adults. She noted that by 2030, one-third of the U.S. population will be older adults. ""We can – and must – educate people about aging." Three million older adults currently have problems with alcohol or medication misuse, a problem more prevalent in Florida than any other state because we have more elders. Many elders, she said, have alcohol-induced depression, and 94% of primary care physicians miss this diagnosis. She also noted that 50% of medications taken by older adults contain sedatives, and 70% of over-the-counter medications are consumed by older adults.

"Alcohol and drug abuse in the elderly is a hidden problem," Ms. Egan said. "There is a lack of appropriate screening tools and a lack of awareness about the problem. The DSM is simply not geared to older people."

Many symptoms of substance abuse mimic other disorders. "Seventy percent of all older adult hospitalizations are rooted in alcohol or drug problems versus 25% in other age groups."

The biggest issue [that prevents elders from getting help] is shame. Older adults grew up without the current societal emphasis on sharing and self help. Therefore, mixing generations in treatment settings simply does not work.

Once problems in elders are identified, there is often nowhere to go for age-appropriate treatment. In addition, Medicare will not pay for non-hospital care. Even in hospitals, Medicare only pays for basic detoxification. Better prevention programs are needed. "Brief intervention has great results with late onset alcoholism."

We also need better education for doctors, she said. Medical schools don't teach much about substance abuse at all, but especially as related to older adults. We need to educate the community at large as to what to look for in at-risk elders. We also need a case management system to coordinate care of older adults. "We need to get the message out that treatment works! Florida has the opportunity to be a leader in this area."

(12:15 p.m.) Dr. Larry Polivka, Director, Florida Policy Exchange on Aging, said that 20 years ago, Florida had a model aging program, Geriatric Residential Intensive Treatments (GRITS). "We've simply lost both the momentum and infrastructure for mental health services for older adults. This has had important effects, but now we know

more than ever about the impact of early intervention with older adults. What we now have is declining availability of care at the same time the literature shows the effectiveness of treatment."

Florida's Alzheimer's disease initiative, he said, has been stagnant for five years, and we are meeting less than 5% of the need now. In the long-term care system, in 1983, 23% of state public money went to community-based services. Now we are spending 88% of public statement money in nursing homes and just 12% on community-based services.

Dr. Polivka recommended a return to the GRITS model and increased mental health funding in the DOEA community-based long-term care program, contracting with community resources. "It's important to integrate mental health into home- and community-based systems. Let's mandate a level of funding for the care of older adults into the budget."

(12:28 p.m.) Cindy Meftah, Chief, Adult Mental Health, Department of Children and Families, said, "We know what works for elders, and we need to bring that back. Our department did a lot of planning for Senate Bill 358 that targets elders as a priority population, but it doesn't put anyone in charge of elders." She noted that Florida now has 400 elders in state hospitals. Ten years ago, there were 4,000 elders in state hospitals. We also need better education, individualized services, more funding, financial incentives for elder care, better coordination, and a clear public policy.

(1:30 p.m.) Amy Phillips, Chair, State Mental Health Planning Council, gave Commissioners the following "wish list" from the SMHPC:

1. increased funding, especially for consumers and families not eligible for Medicaid, noting that a minority of adults and children with mental illnesses are being served by the current system.
2. insurance parity
3. a Medicaid waiver for mental illnesses
4. a person-centered, recovery oriented model like a three-legged stool, the legs being support and services, housing, and employment
5. a statewide network of contacts to help with problems
6. a case rate reimbursement system to cover the actual cost of services
7. more services in jails and prisons
8. standards for measuring quality against guidelines
9. housing alternatives
10. Assertive Community Treatment (ACT) teams
11. therapeutic foster care programs
12. Ticket to Work programs that allow Medicaid recipients to work without losing their benefits
13. integrated dual diagnosis treatment
14. transitional services for adolescents becoming adults
15. more ADM personnel in the Tallahassee office