Older Adults and Mental Health:
Preparing to Care for Those Who Cared For Us

MPA Capstone Paper

In Partial Fulfillment of the Master of Public Affairs
Degree Requirements
The Hubert H. Humphrey School of Public Affairs
The University of Minnesota

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7/31/2018

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Older Adults and Mental Health

Preparing to Care for Those Who Cared for Us

MINNESOTA BOARD ON AGING / August 2018

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MN2030 – Older Adults and Mental Health

The Minnesota Board on Aging (MBA) policy briefs offer an opportunity for stakeholders to learn about and engage in a planning effort to reform our system and to prepare communities and the state to meet the challenges and opportunities associated with an aging population.

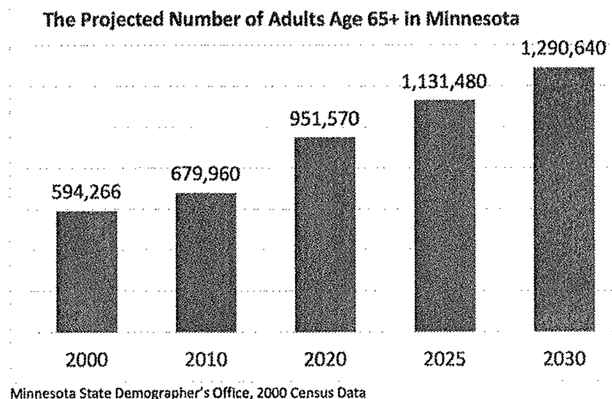
Issue

Depression and anxiety are often thought of as part of the normal aging process by many, including healthcare providers, who attribute symptoms as a natural reaction to life changes or illnesses that occur with aging.[i] Even though depression and anxiety are often treatable through psychological and/or pharmacological interventions, mental health needs remain widely under-recognized and under-treated amongst older adults.[ii,iii] As Minnesota prepares for 2030, and the demographic shift as a result of the Baby Boomer Generation, a focus on the mental health needs of older adults is needed. Research shows that while the prevalence of mental health diagnoses is not higher in older adults than other age groups, there are unique needs that contribute to older adults' use and access to mental health services. By addressing these needs, and increasing access to services, the Minnesota Board on Aging can lessen the impact on individuals and health care costs. For purposes of this policy brief, older adults are defined as individuals age 65+, and mental health needs exclude Alzheimer's or dementia-related diagnoses, serious and persistent mental health diagnoses, and substance use disorder.

Current Landscape and Background

Minnesota's older adult population is rapidly growing, partly due to lengthening life expectancies, and partly due to the aging Baby Boomer Generation.[iv] As shown in Figure 1, Minnesota's older adult population (age 65+) measured 679,960 in 2010 (12 % of the population) and is expected to grow to 1.29 million by 2030 (21% of the population).[v]

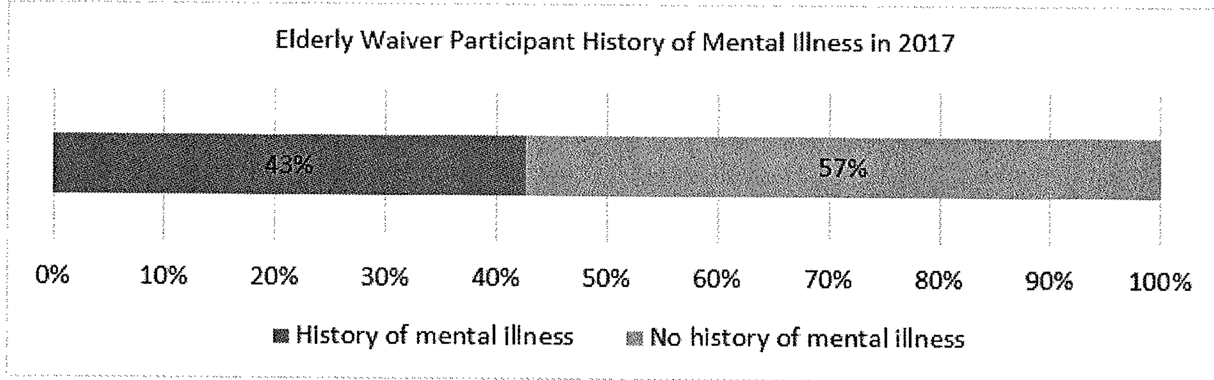
Figure 1



The growth in the size of this age group will impact the mental health system in Minnesota as research shows that 1 in 5 older adults have mental health needs and that depression and anxiety disorders are the most prevalent needs in this group.[vi,vii] Additionally, symptoms of depression can include thoughts of suicide, and the rates of suicide increase with age particularly among men.[viii]

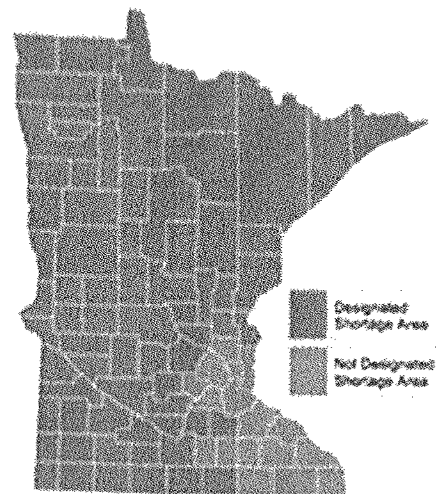
When determining eligibility for the Elderly Waiver (EW), participants complete long-term care consultation (LTCC) assessments. As part of this assessment, 43% of individuals in 2017 self-identified that they had a mental health diagnoses from a qualified professional (see Figure 2).[ix]

Figure 2



Minnesota's mental health system is not capable of providing adequate and timely services due to shortages of mental health professionals. In Minnesota, only two geographic areas – the Twin Cities metro area and the area surrounding the Mayo Clinic in Rochester – are not designated as mental health professional shortage areas (see Figure 3).[x] The shortage is even more severe for mental health professionals focused on caring for older adults; the American Geriatrics Society estimates that by 2030 there will be less than one geriatric psychiatrist per 6000 older adults with mental health and substance use disorders nationally, and according to the American Psychological Association, only 4.2% of psychologists focus on geriatrics in clinical practice.[xi]

Figure 3



The unaddressed mental health needs of older adults will also have an impact on health care costs and the economy more broadly. Depressive symptoms in older adults often leads to increases in their use of primary care health services.[xii] Older adults with mental health needs have higher rates of hospitalization and emergency room visits, which results in per person costs that are 47% to 200% higher than older adults without mental health needs.[xiii] In addition to the increased use of medical care, other costs include medications, transportation, social services, and productivity loss for unpaid caregivers, which has been estimated at $12.7 billion per year nationwide.[xiv]

Barriers

Older adults face different barriers in obtaining treatment for mental health issues than younger individuals. The following barriers impact whether older adults access mental health services, and if they do, how those services are received.

Access

- **Transportation.** A gap analysis regarding Minnesota's continuum of mental health services showed that transportation was a top priority for older adults with mental health needs as it contributes to quality of life and community connection.[xv] Social supports are one of the strongest indicators of well-being, and 12% of adults age 65+ report that they rarely receive the social and emotional support they need.[xvi] However, many older adults have difficulty finding transportation services to meet their needs, especially in rural communities, as private transportation can be expensive, and there are limited other options.[xvii]
- **Mental Health Professional Shortages**. As detailed above, there are mental health professional shortages throughout Minnesota that prevent individuals from accessing adequate and timely care. Stakeholder interviews revealed that these shortages result in long wait times, from weeks to months, and long travel distances for patients who may not have access to transportation. There is also decreased availability of trained mental health professionals that specialize in the specific needs of older adults.
- **Funding and Insurance Coverage.** In 2016, almost 99% of adults age 65 and older had health insurance, mostly through Medicare, but also Medicaid and private policies.[xviii] However, studies have shown that people with insurance still struggle to find mental health providers in their health plan networks. While mental health professional shortages may be part of the problem, research shows that only 55% of the nation's psychiatrists accept insurance compared with 88% of physicians in other medical specialties. Providers indicate that low reimbursement rates and heavy administrative burden contribute to their decision to not participate in health plan networks. Moreover, the severe shortage of psychiatrists and increasing demand for services further reduces their incentive to accept insurance.[xix]
- **Use of Primary Care Physicians.** 80% of individuals of all age ranges with mental health needs are treated in non-psychiatric medical settings.[xx] Additionally, there is evidence that primary care providers under-identify mental health needs and deliver suboptimal mental health treatment and follow-up.[xxi] One stakeholder attributed this trend to their belief that "we are a society that separates the mind and body, the physical always comes first."[xxii]
- **Integrated Mental and Physical Care.** The current traditional model of service lacks integration of mental health, health, and aging services.[xxiii] Integrated care models are often implemented in idiosyncratic ways that adapt the primary care practice by adding varying levels of affiliation and communication with mental health providers.[xxiv] Moreover, mental health professional shortages and geographic disparities limit how integrated care can be delivered.

Stigma

- **Mental Health Stigma and Ageism.** Individuals with mental health diagnoses often struggle with managing misconceptions and biases about mental health that result in avoidance.[xxv] For older adults, mental health stigma is combined with ageist beliefs that depression is part of the normal aging process and because of this, older adults may be especially prone to not seek help, but also may not recognize the need for treatment.[xxvi] Additionally, there are generational differences that affect the utilization of services as older adults "feel responsible for solving their own problems."[xxvii]

- **Cultural Factors.** Cultural factors, including a lack of knowledge about mental health and treatment options, can create a barrier to individuals accessing mental health services. Some individuals may consider a mental health diagnoses as a sign of being "crazy," or the concept of mental health may not exist in their culture, both of which inhibit the likelihood that the individual will seek treatment. Lack of awareness, language barriers and care navigation remain barriers for family members who often provide care for older adults in immigrant families.[xxviii] Moreover, because Minnesota lacks a diverse workforce, delivering effective mental health treatment that is "sensitive to the culture of the person being served" may be a challenge.[xxix]

Silos of Information

- **Lack of information sharing:** A key finding from stakeholder interviews was that there is a lack of information sharing across organizations. Stakeholders were aware that others were doing work in the area of geriatric mental health, but not aware of the details of that work. The lack of collaboration or sharing of information limits the ability to learn from strategies, successes, and setbacks from other programs/agencies. Several stakeholders indicated that they were waiting for an organization or agency to take the lead and guide more collaboration and information sharing.

Recommendations for Strategic Priorities

We developed a set of recommendations based on the findings above. These recommendations vary in terms of cost and potential impact on older adults.

1. **Education and outreach**

    - **Target education campaigns at older adults and their families/caregivers.** Collaborate with existing stigma campaigns, such as MakeItOK.org,[xxx] to expand and include material that is specifically targeted for older adults and their families/caregivers. Current campaigns like MakeItOk.org aim to destigmatize mental health diagnoses, but do not address the complex needs of older adults in their material and messaging. In addition, it is recommended that targeted and accessible educational resources are created for older adults, families, caregivers, and medical professionals, in order to promote the idea that depression and anxiety are not part of the normal aging process, rather they are treatable medical conditions.[xxxi] This could be paired with existing community resources or a new effort specifically designed for older adults with mental health needs in Minnesota. Additionally, education should focus on the importance of how older adults can continue to be engaged in their communities through programs like Little Brothers, Friends of the Elderly.[xxxii]
    - **Target education campaigns at cultural and ethnic communities.** Expand on previous work done by the MBA to specifically engage older adults within cultural and ethnic communities to ensure access to assistance with self-care, expand campaigns aimed at reducing social isolation, minimize mental health stigma, and promote best practices that will serve older adults in diverse communities with mental health needs.[xxxiii]

2. **Integration**

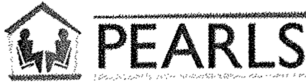
- **Train and support primary care physicians.** Explore and utilize clinical care models that provide standardized training and support for primary care physicians, to enhance their clinical skills in order to effectively treat depression and anxiety in older adults. Primary care physicians are often at the frontline to diagnose and treat older adults with depression and anxiety, as most mental health treatment occurs in the primary care setting.[xxxiv] Access to specialty mental health care providers is not always available for primary care physicians to make a referral, or accessible for older adults. With the right training and support, primary care physicians can take on a larger role to address mental health needs in older adults. One model that demonstrates success in this area is Project Echo. This is a clinical consult model that provides education, mentoring, and consultation to primary care physicians from mental health professionals to be better trained to recognize and treat mental health symptoms.[xxxv] Project Echo offers an affordable framework to support primary care physicians to gain skills needed to address depression and anxiety for older adults. This model has been highlighted for its ability to bridge the rural versus urban divide as it uses teleconferencing technology for the training, mentoring, and consultation of physicians. In addition to these exploring these models, work should be done with licensing and accrediting organizations to expand the existing training on mental health and older adults for primary care physicians.
- **Promote evidence-based integrated community care models.** Identify funding sources that can be leveraged to support the implementation of evidence-based integrated community care models. Home-based or community-based care is a key component to mental health services for older adults due to their unique barriers of limited transportation, co-occurring health concerns, potential cultural barriers, and the overall stigma that exists for treating mental health needs.[xxxvi] Models to consider as part of this research are: PEARLS (Program to Encourage Active and Rewarding Lives), Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors), and IMPACT (Improving Mood – Promoting Access to Collaborative Treatment). All three are national, evidence-based models that specifically serve older adults with mental health needs. Further information on each of the programs is located in Appendix A: Models of Mental Health Programs.

3. **Collaboration.**

- **Create a backbone organization** to coordinate the complexities surrounding this issue, as well as the needs of multiple stakeholders. It is recommended that this occurs at the state level by an organization that will take ownership and responsibility for leading and coordinating the current and future work to address the mental health needs of older adults. The goal of a backbone organization is to create space and structure that allows multiple stakeholders to understand the landscape and scope of work done thus far and identify gaps in services that may benefit from the collective efforts of the group. The backbone organization should focus on advocating for all aspects of service delivery models, including crisis mental health services and peer specialists; and ensure that older adults have an active voice in the process.

- **Utilize existing collaborative models to increase collaboration across organizations.** Sue Abderholden, executive director of NAMI Minnesota stated, "This is a difficult problem, and we need all stakeholders — people with mental illnesses, their families, counties, community providers and advocates — to gather the data, learn more about the causes, and understand what is happening now in order to build our mental-health system to meet people's needs."[xxxvii] There are existing models that bring together organizations and stakeholders to focus on a common set of objectives. Examples include ACT on Alzheimer's and Silos to Circles. The ACT initiative is a collaboration of volunteers in Minnesota working together to create supportive environments for anyone touched by Alzheimer's.[xxxviii] Silos to Circles works with multiple organizations to make systemic changes that "advance health, well-being, and equity in Minnesota."[xxxix]

Appendix A: Models of Mental Health Programs



PEARLS (Program to Encourage Active and Rewarding Lives)

- National, evidence-based treatment program for depression care management.[xl]
- A brief, time-limited program that teaches depression management techniques to older adults (60 and older) who are receiving home-based services from community agencies. For example, participants are taught to recognize depressive symptoms and problem-solving techniques for planning social and physical activities.[xli]
- Participants showed a 50%+ reduction in depression symptoms, higher health-related quality of life improvements, and lower hospitalization rates.[xlii]

LEAP (Life Enrichment Action Program) of Jewish Family Services of St Paul

- Modeled after the PEARLS program highlighted above. LEAP utilizes screening for depression, encourages clients to engage in meaningful activity, and promotes using a simple problem-solving technique to address the problems that get people down.
- LEAP is delivered by trained practitioners in a participant's home, which helps to overcome some of the barriers that are known to exist for older adults accessing mental health services.
- In SFY2017, the average depression screening score (PHQ-9) of individuals served went from 13.4 to 6.2 – more than a 50% decrease.[xliii]

Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors)

- An evidence-based program that integrates depression awareness and management into existing case management services provided to older adults, including those that are home-based.
- Healthy IDEAS is not based in a primary care or mental health clinic. It is specific for community aging service providers.[xliv]
- Healthy IDEAS participants experienced a reduction in depression severity and pain that non-specialty providers can be trained to successfully implement an evidence-based self-management intervention for depression with frail, high-risk, and diverse older adults.[xlv]

IMPACT

IMPACT (Improving Mood – Promoting Access to Collaborative Treatment)

- An evidence-based model that is the most extensive treatment trial for depression to date and has also shown a 50% reduction of symptoms for those served.[xlvi]
- Critical components of the program include: depression care manager completes an assessment and provides education on depression and available treatments. Physical and social activity are encouraged as part of the depression treatment, and medication management oversight.[xlvii]

Project Echo (Extension for Community Healthcare Options)

- This model provides primary care physicians with education, mentoring, and consultation that is done through videoconferencing in order to connect with specialty care clinicians such as psychiatrists. It allows primary care physicians the ability to access training resources on specialty topics that they may not otherwise have due to their rural location or lack of specialty resources, like mental health providers.
- Project ECHO is an innovative, feasible strategy to provide mental health education and consultation for existing primary care physicians in order to expand their capacity to care for the rapidly growing aging adult population.[xlviii]

Appendix B: Methodology

Minnesota's 2030 initiative is a joint venture between the Minnesota Board on Aging and the Minnesota Department of Human Services (DHS), to address the unique needs of our aging population. The MBA requested assistance from this Capstone group to research older adults and mental health needs, and to create a policy brief that will be included in the 2030 initiative. For purposes of this research, older adults are defined as aged 65 and older, and mental health needs exclude Alzheimer's or dementia related diagnoses, serious and persistent mental health diagnoses, and substance use disorder.

In response, the research team developed the following research questions:

1. What is the current landscape of mental health services for older adults in Minnesota?
2. What barriers to mental health services exist for older adults?
3. What models or practices exist for older adults experiencing mental health needs?

A research study was designed to investigate the questions using the following three strategies:

- A review of academic and practitioner literature. This literature review focused on a general overview of older adults and mental health needs; what barriers to accessing services exist; what barriers to providing services exist; and existing models of mental health services - both community based and clinic based.
- Interviews with 25 key stakeholders, including individuals from the MBA; Minnesota's seven Area Agencies on Aging; the Ombudsman for Long Term Care and the Ombudsman for Mental Health and Developmental Disabilities; various practitioners in the field; NAMI Minnesota; Minnesota Elder Justice Center; community based providers; and advocacy groups.
- An analysis of quantitative data available to evaluate the population trends and landscape of mental health services being provided in Minnesota. Data was obtained from the State Demographer's Office and the Minnesota Department of Health - Office of Rural Health and Primary Care.

Due to time and resource constraints, it was necessary to narrow the scope of research, resulting in a following limitations that should be considered when evaluating these recommendations. First, the recommendations and potential solutions will not assist all older adults equitably. For purposes of this research, all individuals age 65+ were grouped into one "older adult" category. Narrower age groups would provide a better understanding of the specific needs of older adults as they age. Additionally, older adults have varying needs based on individual characteristics. For example, an individual living in a nursing home, an individual living at home with supportive services, and an individual living independently will have different abilities to access and utilize mental health services.

Next, due to the scope and time limitations of the research, we did not conduct interviews with older adults, families/caregivers, and diverse populations to identify the needs, limitations, and barriers from their perspective. Moreover, because Minnesota's minority population includes refugees from several different parts of the world, research and interviews with these specific groups is necessary to identify culturally-specific and experience-specific needs and barriers to create a system of care that will address their unique needs.

Appendix C: Acknowledgements

The authors would like to thank the following subject matter experts who shared their expertise and insights on current challenges and opportunities for older adults and mental health.

1. Mike Saindon, Program Administrator for the Aging and Adults Services Division at the Minnesota Board on Aging
2. Reena Shetty, Planning Coordinator for the Aging and Adult Services Division at the Minnesota Board on Aging
3. Dr. Angela Fertig, Professor and Researcher at the University of Minnesota, Humphrey School of Public Affairs
4. Dr. Kevin Gerdes, Director, Master of Public Affairs and Capstone Programs University of Minnesota Humphrey School of Public Affairs
5. Shannon Nixon, MA, MFA LEAP Program at Jewish Family Services
6. Kristy Kane, Director of Arrowhead AAA
7. Lori Vrolson, Director of Central Minnesota AAA
    a. Natalie Matthewson, Community Development Specialist Central MN Council on Aging
    b. Mary Bauer, Community Development Specialist Central MN Council on Aging
8. Darla Waldner, Director of Land of Dancing Sky AAA
9. Dawn Simonson, Director of Metropolitan AAA
10. Linda Giersdorg, Director of Minnesota River AAA
    a. Tami Dorenkamper, Program Developer
    b. Betty Christensen, Program Developer
11. Laurie Brownell, Director of South East Minnesota AAA
12. Carol Geer-LaBine, Deputy Director of DHS Mental Health Division
13. Neerja Singh LICSW, LADC, Supervisor-Intensive Services and Evidence Based Practices, DHS Mental Health Division
14. Roberta Opheim, Ombudsman DD/MH
15. Cheryl Hennen, Ombudsman for Long Term Care
16. Amanda Vickstrom, Minnesota Elder Justice Center
17. Mandy Seymour, Senior Director for Mental Health at University of Minnesota/Fairview
18. Dayna Davis, Interim Manager of Older Adult Mental Health Program
19. Dr. Paul Goering, Vice President of Mental Health for Allina Health System
20. Dr. Roberta Meyers, MGS Board Member President, MN Association of Geriatrics Inspired Physicians Medical Director, Clinical Informatics, Documentation Quality, Office of the Medical Staff, Hennepin Healthcare System
21. Diane Graham-Raff, ElderCare Development Partnership Coordinator, Metropolitan Area Agency on Aging
22. Kay King, Older Adult Program Coordinator & Community Educator, NAMI Minnesota
23. Sandy O'Donnell, Little Brothers Friends of the Elderly
24. Dr. David Atkinson, Geriatric Psychiatrist at the VA
25. Adam Suomala and Jonathan Lips, LeadingAge Minnesota
26. Minnesota Department of Health - Office of Rural Health and Primary Care

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PREPARING TO CARE FOR THOSE WHO CARED FOR US

MN 2030 LOOKING FORWARD

Older Adults and Mental Health

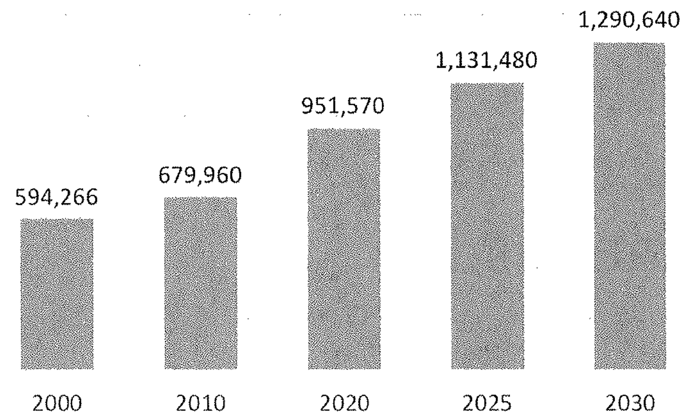
1 IN 5 ADULTS AGE 65+ HAVE MENTAL HEALTH NEEDS (1)

The rate of suicide in males aged 85+ is 4 times the nation's overall rate. (2)

Average health care costs are 47% to 200% per person higher for older adults if they have mental health needs. (3)

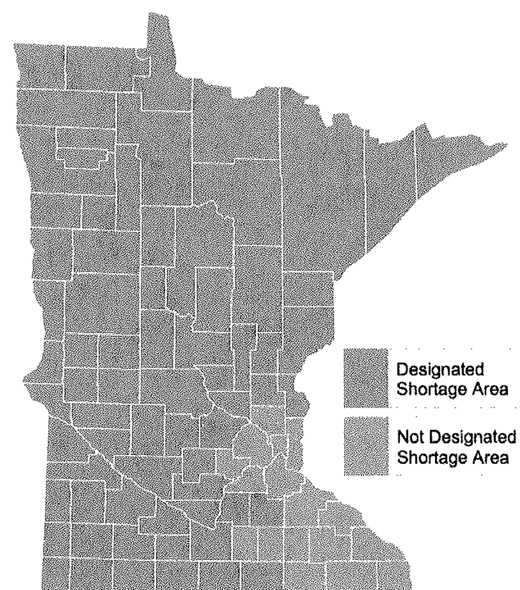
9 out of 11 geographic areas in MN are designated as Mental Health Professional Shortage Areas. (4)

The population of adults age 65+ in Minnesota was **12%** in **2010**, and by **2030**, will account for **21%** of the population. (5)



Nationally, only **4.2%** of psychologists focus on geriatrics in clinical practice. (6)

Most mental health treatment occurs in the **primary care** setting. (7)



Minnesota Department of Health: Office of Rural Health, 2016

(1) Centers for Disease Control and Prevention (CDC). (2008). The State of Mental Health and Aging in America Issue Brief 1: What Do the Data Tell Us?; Karel, M. J., Gatz, M., & Smyer, M. A. (2012). Aging and mental health in the decade ahead: What psychologists need to know. American Psychologist, 67(3), 184.

(2) Substance Abuse and Mental Health Services Administration (SAMSHA) and Administration on Aging (AoA). (2012). Older Americans Behavioral Health Issue Brief 4: Preventing Suicide

DEPRESSION IS NOT PART OF THE NORMAL AGING PROCESS; IT'S A TREATABLE MEDICAL CONDITION. (8)

CURRENT LANDSCAPE & BARRIERS

- **Access to Services.** Older adults are more likely to seek mental health treatment from their primary care physician. This may be due to a variety of factors including mental health provider shortages and access to transportation.
- **Stigma.** Many older adults do not seek mental health treatment because it is stigmatized or not recognized in their culture. In addition, older adults have a strong belief around self-reliance which may limit their willingness to seek treatment.
- **Care Integration.** Physical and mental health are often treated in silos, instead of a holistic way that treats the whole person. In addition, there is a need for increased communication amongst and across care teams and families.
- **Silos of Information**. Each stakeholder has their own unique perspective on this topic and there is a lack of leadership and coordination amongst each other.

RECOMMENDATIONS

Education

Expand existing stigma campaigns to have a geriatric and cultural focus.

Create targeted and accessible educational resources for patients, families, caregivers, and medical professionals.

Integration

Train primary care physicians on mental health needs and available resources.

Explore existing evidence-based community and integrated care models.

Collaboration

Create a backbone organization to coordinate the complexities surrounding this issue and the needs of multiple stakeholders.

To address this topic, you have to "embrace the complexity." - Stakeholder Interview.

Preparing to Care for Those Who Cared for Us:

OLDER ADULTS AND MENTAL HEALTH

1 in 5 adults age 65+ have mental health needs. (1)

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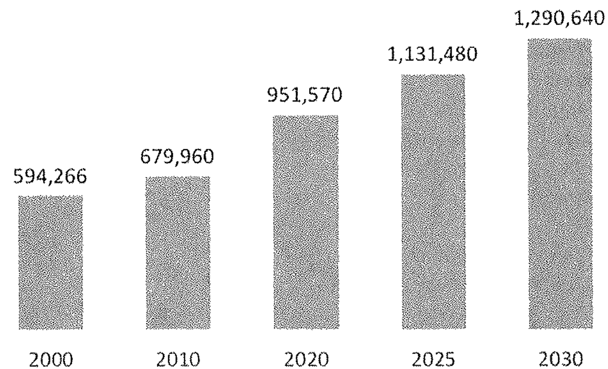


MN State Demographer's Office 2000 Census Data

Agenda

- Scope of the Project
- Research Questions
- Methodology
- Current Landscape and Barriers
- Models of Mental Health Programs
- Recommendations
- Questions

Scope of the Project

Mental Health defined as:
- Depression and anxiety
- Excluding dementia and serious persistent mental illness

Minnesota Board on Aging Ask:
- Gather research on current landscape of mental health services for older adults (60+)
- Identify barriers to services
- Conduct stakeholder interviews

Deliverables:
- Policy Brief
- Executive Summary
- Oral Presentation

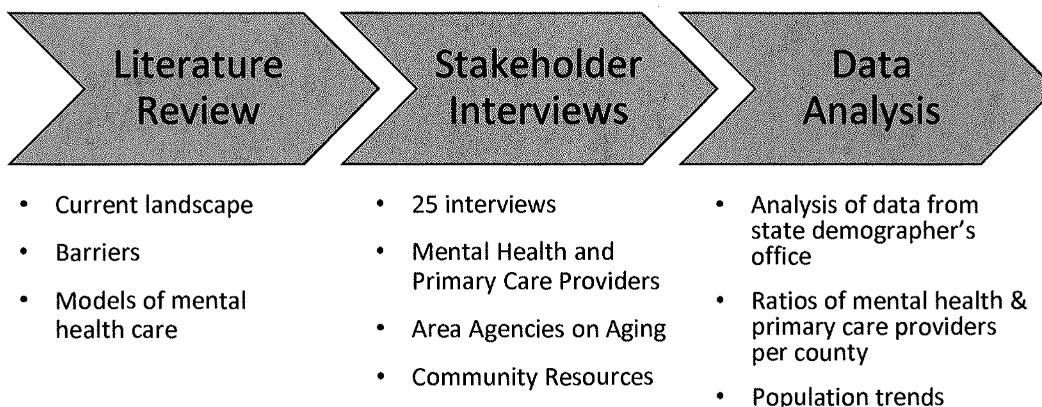
Timeframe from May – August 2018

Research Questions

1. What is the current landscape of mental health services, including possible barriers, for older adults in Minnesota?

2. What models or practices exist that are specifically for older adults experiencing mental health needs?

Methodology

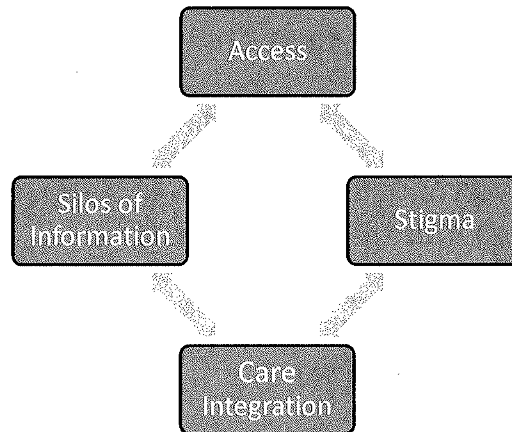


- Current landscape
- Barriers
- Models of mental health care

- 25 interviews
- Mental Health and Primary Care Providers
- Area Agencies on Aging
- Community Resources

- Analysis of data from state demographer's office
- Ratios of mental health & primary care providers per county
- Population trends

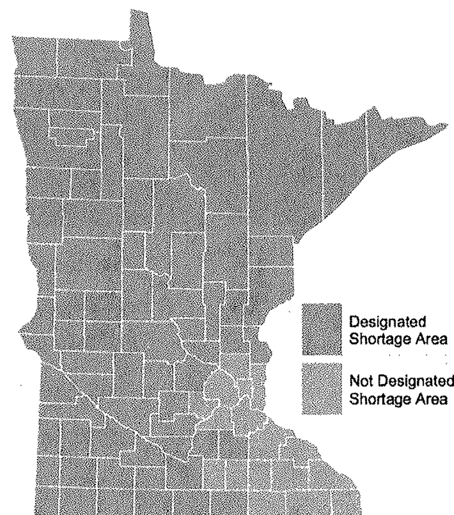
Current Landscape and Barriers



Access

- Mental Health Provider Shortages
- Use of Primary Care Physicians
- Transportation
- Funding & Reimbursement Rates

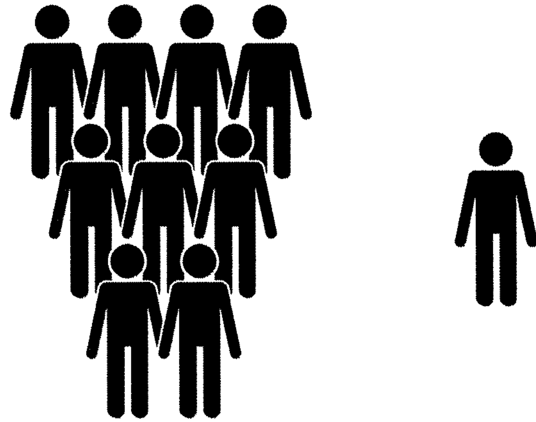
9 out of 11 geographic areas in Minnesota are designated as Mental Health Professional Shortage Areas



Minnesota Department of Health: Office of Rural Health, 2016

Stigma

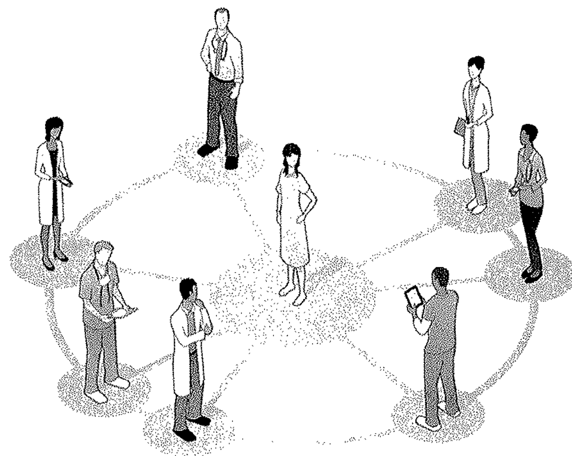
- Ageism
- Cultural Factors
- Awareness and Education



Depression is not part of the normal aging process; it's a treatable medical condition. (5)

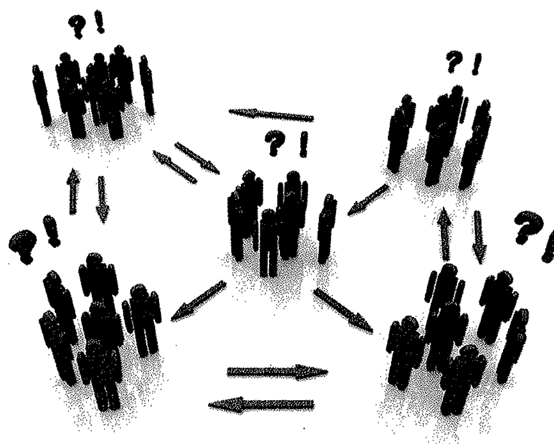
Care Integration

- Integrated Mental and Physical Care
- Holistic Care
- Handoff and Communication Amongst Providers
- Early Intervention



Silos of Information

- Stakeholders have their own unique perspective
- Leadership is needed to start the conversation and provide coordination



Models of Mental Health Programs

PEARLS (Program to Encourage Active and Rewarding Lives)

Evidence-based practice that teaches depression management techniques to older adults with depression.

- In-home counseling sessions (problem solving and recognizing symptoms)
- Physical and social activity planning
- Pleasant evening planning and scheduling

ECHO (Economic, Clinical, and Humanistic Outcomes)

A collaborative model of medical education and care management that empowers clinicians everywhere to provide better care to more people. Training geared towards primary care physicians and provides education, mentoring, and consultation.

- Use of teleconference (or other technology)
- Benefit of reaching rural parts of the state

Recommendations

Education
- Expand existing stigma campaigns to have a geriatric and cultural focus
- Create targeted and accessible educational resources for patients, families, caregivers and medical professionals

Integration
- Train existing primary care physicians on mental health needs and available resources
- Explore existing evidence based community and integrated care models

Collaboration
- Create a backbone organization to coordinate the complexities surrounding this issue and the needs of multiple stakeholders

Recognizing Limitations

- Recommendations and potential solutions will not assist all older adults equitably.
- Further input from older adults, families/caregivers, and diverse populations will be needed as part of future solutions.

2030 is Coming...

There are many stakeholders working on this simultaneously but not collaboratively.

To address this topic "you have to embrace complexity." – Stakeholder Interview

Thank you!

University of Minnesota, Humphrey School of Public Affairs
Sarah Berns, Alyssa Dotson, Amanda Jensen-Stahl, Jen Moberg

Citations

(1) Centers for Disease Control and Prevention (CDC). (2008). The State of Mental Health and Aging in America Issue Brief 1: What Do the Data Tell Us?; Karel, M. J., Gatz, M., & Smyer, M. A. (2012). Aging and mental health in the decade ahead: What psychologists need to know. *American Psychologist*, 67(3), 184.

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