Greg Link  
Administration for Community Living  
U.S. Administration of Aging  
Department of Health and Human Services  
Washington, DC 20201

RE: Request for New Information Collection for a Program Instruction on Guidance for the Development and Submission of State Plans on Aging, State Plan Amendments and Intrastate Funding Formula

Dear Mr. Link:

We are submitting this letter in response to the Notice published in the Federal Register on June 21, 2016 regarding the inclusion of a provision in the Administration for Community Living’s (ACL) Program Instruction that would provide guidance regarding the obligation of State Units on Aging to target resources to older adult populations that have the “greatest economic and social need.”

On behalf of the American Psychological Association (APA), the largest association of psychologists in the United States, we commend ACL for this constructive proposal. With over 122,500 members, APA comprises clinicians, researchers, educators, consultants, and students nationwide and uses psychological practice and science to promote health, education, and human welfare.

The Older Americans Act (OAA) defines “greatest social need” as caused by “physical and mental disabilities” and by “cultural, social or geographic isolation.” We are appreciative of the broad range of populations of greatest social need specified in the Notice, including older individuals who are low-income, ethnic minorities, those with limited English proficiency, those residing in rural areas, American Indians, Holocaust survivors, refugees, or those who face religious or political discrimination. We would like to call your attention to two populations that should be further addressed and clarified within the Notice: older adults living with mental health and substance use disorders and cognitive impairments; and those with diverse sexual orientations and gender identities.

**Older Adults with Mental and Substance Use Disorders and Cognitive Impairments**

Statistics show that over 20% of adults age 60 and older experience disorders such as anxiety, depression, substance use, and dementia; due to stigma and underdiagnosis, the actual figure is likely higher.¹ These numbers will continue to grow as the U.S. population ages; by 2030, the number of older people with mental health and substance use disorders is expected to increase by 80 percent² and a growing number of these older adults will require mental health and substance use services across a range of settings.³ These disorders adversely affect physical health and ability to function, especially in older adulthood. For example, untreated...
depression in an older person with heart disease can negatively affect heart disease outcomes. In 2010, at least 5.6 to 8 million older adults had one or more mental health and/or substance use conditions. A recent study found that illicit drug use nearly doubled among people age 50-59 between 2002 and 2007, increasing from 5.1 percent in 2002 to 9.4 percent in 2007. In addition, individuals age 65 and older have a significantly higher rate of death by suicide than the general population. Non-Hispanic white men age 85 and over are at the greatest risk for suicide, with a rate of 49.8 suicide deaths per 100,000. Tragically, many of these suicides are preventable. Depression in a major risk factor for suicide and 20% of older adults who commit suicide see a doctor the day they die, 40% the week they die, and 70% the month they die. Yet, depression frequently goes unrecognized by physicians. Moreover, for reasons of stigma and access, older adults are less likely to receive mental health treatment than younger adults.

Another major mental health problem, largely unique to older adults, is dementia. People with dementia often suffer from depression, paranoia, and anxiety. Current estimates suggest that 1 in 8 persons over 65 has Alzheimer’s disease; a total of approximately 5.4 million older Americans.

Mental health conditions, substance misuse, and dementia have implications for family caregivers as well. As many as 8.4 million Americans are providing care to an adult with an emotional or mental health issue. Caregivers in more complex, demanding care situations—including those caring for someone with a mental health issue—are more likely to report worsening health. In addition, the supply of family caregivers is unlikely to keep pace with the future demand.

The Institute of Medicine in its 2012 Report, “The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?” states that the Administration on Aging (AoA) has noted the importance of increasing awareness of mental health disorders, providing mental health screening, removing barriers to diagnosis and treatment, and coordinating mental health services for older adults with community health centers and other public and private organizations. The OAA identifies mental health projects that the agency is authorized, but not required to implement, and AoA funds a number of states to deliver services for older adults with mental health and substance use conditions. However, to date, AoA has not funded such projects on a wide scale nor has this high risk population been identified as one of greatest need in the Notice.

Given the data cited above, early identification of older adults (and their caregivers) with mental health and/or substance use and/or dementia should be a top priority for State Units as should connecting them with needed services. This effort could have a demonstrable positive impact on quality of life and health outcomes, and result in fiscal savings.

Lesbian, Gay, Bisexual, and Transgender (LGBT) Populations

We welcome your recognition that sexual orientation and gender identity “can limit the degree to which older adults experience full inclusion in society and are able to access available services and supports.” ACL’s own statistics estimate that there are 1.8 to 4.0 million LGBT adults age 60 and older, which may double as more ‘Baby Boomers’ reach retirement. While the proposed guidance requires the States to describe approaches for assessing the needs of isolated populations, we are concerned that it does not unambiguously require the States to assess the need of LGBT older adults.
LGBT older adults are more likely to report poor health, and have higher rates of disabilities and some diseases. They have higher rates of exposure to violence, and are at increased risk of psychological and emotional distress. LGBT elders are also more likely to be isolated than heterosexual and cisgender elders. Many report limited opportunities to socialize and are more likely to be single and without children. Most LGBT elders have primary caregivers who do not have a legal relation to them, and compared to the general population, are less likely to have traditional sources of caregiving. Overall, LGBT elders have smaller social networks which are not always able to provide needed supports.

LGBT elders report having many unmet needs relating to physical and mental health care, legal concerns, housing, family issues, and social concerns. However, we know that LGBT elders underutilize health and social services. A 2010 Administration on Aging study found that LGBT older adults are 20 percent less likely than other older adults to access government services such as housing assistance, meal programs, food stamps, and senior centers. This may be due in part to the stigma of being both LGBT and older, reflected in an unwelcoming climate at service providers. In a national survey, nearly 80% of LGBT elders and their caregivers felt that they could not be ‘out’ in long-term care facilities; others have expressed concerns about disclosing their sexual orientation and/or gender identity with their service providers. LGBT elders have indicated that they would like service providers to undergo training on LGBT aging issues.

Finally, LGBT elders are diverse in terms of race, ethnicity, socioeconomic status, geographic region, and urban/rural location. Each of these characteristics impacts the experiences of LGBT elders in the United States, their access to services, and their decision to seek services. Consequently, it is important to consider these intersecting identities when designing programs that will meet their needs.

At present, most State Units on Aging are not making any systematic effort to assess and address the needs of older adults with mental and substance use disorders and cognitive impairments or LGBT older adults. We believe that only a Federal mandate requiring State Units on Aging to assess and address the needs of older adults with mental and substance use disorders and cognitive impairments and LGBT older adults will ensure the maximum inclusion of these populations in programs funded under the OAA. We therefore urge ACL to modify the proposed guidance to expressly require States to describe the actions taken to assess the needs of LGBT older individuals, and to ensure that staff receive the training they need to carry out the required needs assessment. We further believe that, by targeting these populations, States will ultimately save resources by allowing more older adults to live independently with improved quality of life. The APA welcomes the opportunity to assist in this effort.

Sincerely,

Gwendolyn Puryear Keita, PhD
Executive Director
Public Interest Directorate
American Psychological Association
