



National Coalition on Mental Health and Aging
Draft Meeting Minutes
March 24, 2016

Welcome and Update

Kimberly Williams, NCMHA Chair and Geriatric Mental Health Alliance of New York Representative recognized the Aging in America conference participants who were present at the meeting and thanked them for attending. There were 18 members present onsite and 14 members via conference call.

The minutes from October 2015 meeting were then approved. Kimberly then updated NCMHA on recent efforts related to SAMHSA's National Certified Community Behavioral Health Clinics (CCBHC) 223 Demonstration Program. As reported at the NCMHA meeting in July 2015, Alixe McNeil drafted and submitted NCMHA comments on the 223 criteria requesting more attention be given to older adults. In October, SAMHSA awarded planning grants to 23 states to integrate behavioral and physical health and improve access to services. Some of the awardees, e.g. California, North Carolina, Oklahoma and New York have mental health and aging coalitions. It was discussed how we should provide some guidance to these states so they might better incorporate older adult mental health needs when they submit their formal program proposals in this October. Alixe McNeil offered to take the lead in drafting guidance for states and Mike O'Donnell (IL), Jennifer Glick (RI), and Deborah Allen (PA) agreed to help. Of the 23 states selected for the planning grants, only 8 will receive program grants. It was noted that David Morriset is the SAMHSA contact.

NCMHA's Priority Committee Reports

Kimberly reminded the Coalition how the areas for NCMHA strategic growth were developed followed by Committees being established in each of the four areas. Committee chairs updated NCMHA about their recent efforts.

Membership Development: Viviana Criado reported that the Committee reviewed the current membership list to assess the rates of regular, sporadic and non-participation. They also updated the list of State and Local Coalitions to make it current and considered opportunities to strengthen and expand our membership. A draft work plan for member recruitment and retention for 2016-2017 was completed. They developed a draft member survey and are planning to conduct phone interviews with a sample of members to inform, educate and gather information about members' interest. The goal is to increase NCMHA membership by 12% within the next two years. Members were asked to give input on the draft survey to potential members, and complete the survey when received.

Website Development: Marcia Marshall stated that the NCMHA website is archaic and out of date. It needs to be completely revamped. As part of the membership survey, they will include questions asking for feedback on the website. Ideas related to having another organization host the website as part of their own site were discussed.

Public Awareness: Jennifer Glick stated that we have a key role in enhancing consciousness and fostering public policy changes related to mental and behavioral health of older adults. On a conference call earlier this month, five objectives were developed: 1) increase understanding of behavioral health disorders in older adults and the implications on quality of life and health care costs when not identified and treated; 2) promote knowledge about specific methods of prevention, screenings, and treatment for behavioral health disorders in older adults – particularly evidenced-based practices; 3) increase awareness of the factors related to high rates of suicide among older adults in the U.S. – particularly white men aged 70 and older – and effective methods of prevention and intervention; 4) reduce the existence of age-related prejudice and discrimination against older adults experiencing behavioral health disorders; and, 5) increase awareness and understanding of systems-level factors that create barriers to the delivery of effective behavioral health services to older adults, as well as policy solutions. The Committee’s initial public awareness activity will occur in May in conjunction with Older Americans Mental Health Week. A twitter chat will be hosted by NCMHA and the National Council for Behavioral Health. The NCMHA Member Resources list will also be updated and disseminated widely. The Committee will track hits received by the web products and twitter chat participation and reach.

Coalition Development: Willard Mays reported that groups interested in establishing new coalitions come to us and existing ones want technical assistance. The Committee’s goal is to promote the development and continued success of state and local mental health and aging coalitions. They have three objectives: 1) promote the coalition concept through all available opportunities; 2) provide information and technical assistance to state or local entities wishing to develop a mental health and aging coalition, and 3) provide information and technical assistance to existing state and local coalitions to improve and maintain their effectiveness. Over the next two years they will: 1) Respond to requests from individuals and/or organizations interested in developing a mental health and aging coalition by providing materials and further assistance as needed.; 2) Respond to requests from existing mental health and aging coalitions for technical assistance in improving the effectiveness and/or achieving sustainability of their coalition by providing materials and further assistance as needed.; 3) Provide educational articles and presentations about coalition building and the successes that have been achieved in publications, and at major conferences such as the annual Aging in America Conference.; 4) Update the coalition building materials on the NCMHA website.; 5) Partner with the NASMHPD Older Persons Division to survey state mental health agencies to determine the status of older adult mental health services and mental health and aging coalitions in their respective states and whether there is interest in developing a coalition if one doesn’t exist; and, 5) Work with other established NCMHA workgroups. They will be coordinating with other committees to move forward.

Kim thanked the Committee members and chairs for their good work. Please contact Martha Randolph at mrandolph@apa.org if you would a copy of the Committees’ full reports.

Report on NCMHA/Mental Health and Aging Network (MHAN) Policy Day at ASA’s Aging in America Conference

Willard Mays provided a summary of how NCMHA traditionally partners with MHAN to do two, all day sessions at Aging in America. Monday focuses on policy issues and Tuesday focuses on clinical issues. A peer group is also convened on Sunday for those interested in behavioral health. The all day sessions this year were well attended and feedback on the quality of the sessions and speakers was positive. The MHAN Leadership Council discussed what to do next year and decided to again have policy and clinical days. NCMHA will take the lead on the policy day. It was also noted that ASA’s Winter Issue of *Generations* focuses on what the new U.S. President needs to know about aging which is relevant to next year’s planning.

A comment at the ASA convention, led Willard to next initiate a discussion regarding the terminology “mental health” vs “behavioral health”. Some assume that mental health is not inclusive of substance abuse. Others feel behavioral health is more inclusive of dementia and brain health. Some feel that social determinants (poverty, housing) of health also seems to be more fully included within behavioral health. Should NCMHA change or expand its name, e.g. National Coalition of Behavioral Health and Aging? There was a significant difference of opinion on this issue and it was decided to allow adequate time on a future agenda to discuss this issue.

Integrating Older Adult Behavioral Health into Long-Term Care (LTC): Reports from State Coalitions

Kimberly Williams began the discussion by noting the work of NCMHA to foster LTC rebalancing, especially as states transition individuals from LTC institution based settings into the community. NCMHA received a one year grant from the Retirement Research Foundation to work collaboratively with mental health and aging state coalitions to develop a structure to facilitate integration. Last summer a needs assessment was conducted with 8 states to look at their rebalancing efforts and if they are addressing the mental health needs of older adults within the state initiatives going on. They have established a virtual learning community to learn via webinar about programs such as the work of the CMS Innovations Center and ways to fund evidence based interventions. They are digging deeper into what has been successful. The next phase is to provide specific guidance to states. NCMHA member state coalitions then described their efforts in this arena.

Jennifer Glick with the Connecticut Older Adult Behavioral Health Workgroup began by describing their programs. Their work group began in late 2012 and in 2014 they began an Asset Mapping Project as very little data about older adult services was available. They worked with the University of Connecticut’s Center of Aging who leveraged funds to support the Asset Project. It took a year to complete. After the release of the Asset Mapping Report, they are developing an action plan, focusing on key recommendations where they can accomplish integration by not spending a lot of money. First they are working to Increase Education, Awareness, & Access. They will focus on integrating state initiatives around a “No Wrong Door” (NWD) access point for LTSS. The NWD approach allows users to address their total wellness needs in one location for information on both physical and mental health services. Regarding the Integration of BH, Physical Health & Aging Services recommendation, they have already integrated SBIRT into assessments conducted by ADRC staff, Money Follows the Person (MFP) efforts, Senior Outreach, and Gatekeeper Programs. Their State Department of Aging (SDA)’s SHIP Program partners with NAMI to provide Mental Health 101 training to senior center staff, municipal agents, resident care coordinators in housing programs, etc. SDA’s also issued grants to 3 organizations to implement Healthy IDEAS. They are also actively working with the Department of Mental Health and Addiction Services (DMHAS)’s Behavioral Health Homes leadership on education around serving OAs with behavioral health needs. DMHAS also plans to implement elements of SWELL, which is a compression of Senior Wellness, through coordinating and strengthening three existing programs that serve older adults (Nursing Home Diversion and Transition Program, Senior Outreach, and Gatekeeper) and linking them with other community resources. The SWELL idea should enhance their ability to identify and collaborate. Under their MFP Project, they are demonstrating an addiction support system that will, pre and post-transition out of an institution, assist the client with coordinating substance abuse community services as well as other medical services, along with peer supports, transportation to support activities, and employment supports. This program is open to all age groups. Their state has also offered competitive grants to nursing homes in order to diversify their business models to community-based services, such as increasing the community-based workforce for older adults, which not only benefits the physical health of older adults, but also their behavioral health.

Cynthia Dunn with the Georgia Coalition on Older Adults and Behavioral Health reported how in Georgia they are working with three groups, Emory University, the Department of Behavioral Health and Developmental Disabilities, and the Department of Aging Services. They had observed a drop off of

individuals over 55 who use community mental health centers. There is a lot of confusion over Medicare billing and the definition of recovery for older adults – how it differs and what is achievable. They are expanding their initiatives beyond their Medicaid funded waiver programs. They are involving family members and older adult consumers in developing a “NWD” approach. They are also embarking on a new project to develop six regional forums to connect Area Agencies on Aging and Community Service Boards to review services with an eye to care coordination and regional planning. They want to make sure both aging and mental health practitioners understand what resources are available to the community and conduct more trainings in aging. The mental health and behavioral provider of choice is established in an individuals’ health care plans, and aging and mental health entities develop business arrangements to coordinate care. This also creates a forum to bring professionals together to look at difficult cases.

Kim Burton with the Mental Health Association of Maryland began her remarks by noting that their coalition has been around awhile and that the new RRF grant with NCMHA awakened some new interest in its work. Through the Maryland Coalition on Mental Health and Aging, efforts to integrate behavioral health into long term care are happening on many levels. Coalition members have offered constructive comments in the review of both nursing home and assisted living regulations to require enhanced education and training requirements for staff and to standardize practices around facility based behavioral health services. As Maryland is a state engaged in rebalancing efforts such as MFP, Coalition members have been pushing for the reinvestment of rebalancing savings into building better behavioral health consultation and services. The Coalition recently convened a “Long Term Care Behavioral Health Workgroup” to bring diverse stakeholders together for education about geriatric behavioral health needs across the spectrum of long term care settings. “Issue Action Groups” are forming around such issues as workforce development, community providers, discharge planning, assisted living, PASARR and public education. The specially focused “Action” groups allow people to concentrate time and efforts into those topics that are of personal and professional interest. If anyone is interested in more information contact Kim Burton at kburton@mhamd.org or 443-901-1550 x 210.

Deborah Allen, Pennsylvania Department of Human Services, Office of Long Term Living (utilizing the Power Point Presentation prepared by Virginia Brown) reported that they are just starting to work toward seamless transitions. In Pennsylvania they have carved out behavioral health from long term services and supports. Their current LTSS System consists of five home and community-based waivers serving discreet target populations. Some individuals receive physical health benefits through Health Choices, other do not. Individuals residing in nursing facilities are carved out of Health Choices and there is very little coordination of LTSS and Medicaid/Medicare benefits. There are two Medicaid waivers. 1915 (b) waivers allows for the use of managed care in the Medicaid program through MCOs and makes the program mandatory for eligible participants to receive services, and 1915 (c) allows the provision of home and community-based services to people who would otherwise need institutional care. In addition, Medicare Section 1859 allows Medicare Advantage plans to create specialty plans targeted to special needs individuals, including those who are dually enrolled in Medicare and Medicaid. Under this authority, states can use their The Medicare Improvements for Patients and Providers Act (MIPPA) agreements to link Medicare services to Medicaid Managed Long Term Services and Supports (MLTSS) programs. Populations included in the 1915(b) Waiver Application are adults age 21 or older who require Medicaid LTSS (whether in the community or in private or county nursing facilities) because they need the level of care provided by a nursing facility and dual eligibles age 21 or older whether or not they need or receive LTSS. The 1915(c) waiver allows for the delivery of Long-Term Services and Supports (LTSS) in the home and community. During the three-year phased implementation of Community Health Choices (CHC), Pennsylvania will operate a 1915(c) CHC waiver in CHC regions, while continuing to operate existing 1915(c) waivers in fee-for-service regions. The OBRA waiver will continue to operate across the state. The COMMCARE Waiver (waiver for individuals with traumatic brain injury) has been selected as the vehicle for CHC for the following reasons: it is the smallest OLTL waiver, with

the fewest people to transition; the nursing facility level-of-care eligibility criteria aligns with CHC and other OLTL waivers, easing transition; it is similar to Independence waiver, which can serve as transitional waiver for COMMCARE participants, and its expiration date allows for a longer transition period than other existing waivers. As part of this transition, two services will need to be added to the Independence to make the packages equivalent: Residential Habilitation and Structured Day Habilitation. The transitions involved in this change should be seamless to program participants.

Mike O'Donnell, President of the Illinois Coalition on Mental Health and Aging discussed rebalancing long term care in Illinois. It is a broad effort by the State to provide an opportunity to persons with disabilities and older adults to choose to live in appropriate, permanent, integrated settings in the community, and moving out of institutional settings. Illinois was awarded a 223 demonstration planning grant of \$982,373. Rebalancing long term care links a number of initiatives and has profound impact on the long standing infrastructure serving older adults and persons with disabilities. Rebalancing long term care also addresses adjustment to the allocation and investment of resources from institutional to community-based care. Rebalancing efforts have been driven by a combination of federal incentives under the Affordable Care Act, legal mandates based on Olmstead consent decrees, long standing advocacy, best practice outcomes for older adults and persons with disabilities, and the realization of potential savings through closure of costly state facilities. Uniformly, implementation of rebalancing efforts is based on core principles of choice, maximum independence in a safe environment, and quality community-based services for individuals. In all instances, a successful transition will include housing and services that meet an individualized plan. Mike reviewed his handout that summarized the impact of the Illinois five rebalancing initiatives. They are the MFP, Williams Consent Decree which impacts Institutes for Mental Disease (IMDs), Colbert Consent Decree, which impacts skilled nursing facilities, the Ligas Consent Decree which impacts intermediate care/developmental disability facilities, and State Closures which impacts state operated developmental disability and mental illness facilities.

For a complete copy of any of the above State coalitions presentations, please contact Martha Randolph at mrandolph@apa.org.

Federal Policy Update

Joel Miller, Executive Director & CEO, American Mental Health Counselors Association provided the policy update. He summarized the five approaches to mental health that are reflected in five pieces of legislation currently before Congress: The Mental Health Awareness and Improvement Act (S. 1893), The Helping Families in Mental Health Crisis Act (H.R. 2646), The Mental Health Reform Act (S. 1945), The Mental Health and Safe Communities Act (S. 2002), and The Mental Health Access and Improvement Act (S. 1830 & H.R. 2759). S. 1893 authorizes funding for training programs to educate the public about signs and symptoms of mental illness and addictions, including strategies for de-escalating a crisis situation and helping persons connect to appropriate treatment services that are strikingly similar to those taught in Mental Health First Aid courses. H.R. 2646 authorizes funding to train law enforcement officers, paramedics, emergency medical services workers and other first responders to recognize and properly intervene with individuals in crisis. Another bill, S. 2002 (in Sec. 108) requires MH awareness and crisis de-escalation training for the federal uniformed services under the Departments of Defense, Homeland Security and others. H.R. 2646 and S. 1945 include numerous provisions designed to move identification and treatment more upstream – that is, to support prevention and intervention at an early stage before a patient's MH/SU conditions worsen. These two bills establish grants to support innovative approaches to treatment while disseminating information about proven, evidence-based interventions. Both codify the 5 percent set-aside for early intervention activities in the Mental Health Block Grant (MHBG). Each include an important provision clarifying that providers may bill Medicaid for MH and physical health services provided on the same day. This small but far-reaching clarification will remove a common barrier to the integrated care initiatives now burgeoning throughout the country; it ensures providers may receive reimbursement for primary and behavioral health services that are co-located within the

same clinic. In addition, S. 1945 reauthorizes and modifies existing grant funding to support states in scaling up their integrated care activities, including by authorizing integrated care training and technical assistance provided through a National Center. Gun control and gun violence often mixed in here. It's unfortunate as it brings added politically charged issue into mental health.

Efforts are also underway to reauthorize key SAMHSA programs. These bills include: The Garrett Lee Smith Memorial Act suicide prevention activities; the National Child Traumatic Stress Network; Projects for Assistance in Transition from Homelessness; comprehensive community mental health services for children with serious emotional disturbances; jail diversion programs and more. These are longstanding, successful programs providing important sources of assistance and support to Americans considering suicide, those who are homeless or involved with the criminal justice system, and children with serious emotional disturbances. In addition, strengthening Parity Enforcement is another issue particularly important to consumers. The landmark 2008 parity law was further strengthened by provisions in the Affordable Care Act extending parity's protections to millions of additional consumers. Many groups are pleased to see improved parity compliance measures receiving attention in H.R. 2646 and S. 1945.

Bolstering the Mental Health and Addiction Workforce is another issue receiving attention on the Hill. S. 1945 and H.R. 2646 also support programs that strengthen and diversify the mental health and addictions health workforce, allowing for better access to needed treatment and culturally competent care for those in need. Both bills maintain funding for the Minority Fellowship Program, which recruits minorities to the mental health and addiction workforce to aid in reducing health disparities and improving health care outcomes for racial and ethnic minority populations. Additionally, each bill maintains funding for the National Health Service Corps (NHSC) and expands the eligible provider pool to include pediatric mental health professionals. There is growing recognition by Congress' of the role peers play in helping individuals along the path to recovery that is recognized in the bill.

Another major theme that is garnering a lot more interest in Congress is addressing justice-involved populations. People with mental illness and addiction are more likely than others to be victims of crime; yet they are disproportionately represented in jails and prisons, primarily as a result of nonviolent offenses. Over 65 percent of inmates meet the criteria for a SUD (a rate 7 times higher than the general population). More than half have a behavioral health condition. Inmates with mental illness or addiction often become trapped in a revolving door of arrest, release, poverty, deterioration of health, and re-arrest. Legislators are turning to mental health and addiction reform as a way for addressing these health needs and reducing recidivism. S. 2002 includes provisions designed to support justice-involved individuals including grants for law enforcement crisis intervention teams; a program for federal drug and Mental Health courts; assistance for addressing mental health and addictions as part of offender reentry, and mental health and drug treatment alternatives to incarceration.

As the U.S. health care system moves quickly into the digital age, mental health and addiction treatment providers face major challenges to their adoption and use of health information technology (HIT). But these groups were not included in HIT grants. H.R. 2646 includes expansion of federal Meaningful Use incentives to previously ineligible mental health and substance use treatment providers and facilities. H.R. 2646 also authorizes grants for telehealth services provided to individuals with mental illnesses, an important means of expanding access to care in areas suffering a shortage of mental health & addiction professionals.

Most attention of late has been focused on the Senate HELP Committee. Just this week, Senator Alexander (R-Tenn.), the Chairperson, and Senator Murray (D-Wash), the Ranking Member, together with several other Senators, presented a discussion draft of a new bipartisan bill, the Mental Health Reform Act of 2016. This discussion draft has been very well received by the mental health community over the past week. Of considerable importance, this new draft bill represents a good-faith, bipartisan

effort to craft a bill that will receive broad support from Democrats and Republicans, and can receive support from the Administration. The bill is seen as improving coordination between federal agencies and departments that provide services for individuals with mental illness, and will improve accountability and evaluation of mental health programs. It would ensure that federal dollars support states in providing quality mental health care for individuals suffering from mental illness by updating the CMHS BG for states. The bill also requires that the federal agencies and programs involved in mental health policy incorporate the most up-to-date approaches for treating mental illness, and requires agency leadership include mental health professionals who have practical experience. Finally, the bill increases access to care for individuals including veterans, homeless individuals, women, and children. It also helps improve the training for those who care for those with mental illnesses. It promotes better enforcement of existing mental health parity laws. Joel noted a few shortcomings in the Bill. First, it would leave largely unaddressed the need to direct more resources to serving the mental needs of older adults. Second, Licensed Clinical Mental Health Counselors and Marriage and Family Therapists are excluded from participating in the program. These two groups represent 40 percent of the licensed Mental Health workforce and are fully qualified to deliver Behavioral Health services in all 50 states, but their services are not covered under Medicare due to their more recent recognition for independent practice by the states.

A question was posed whether mental health issues are on the radar of the Presidential election. The answer is no. Clinton supports ACT. Sanders supports a single payer system. But mental health is lost in the shuffle and the gun issue muddies this. Another question was raised regarding the needs of Latino older adults who have so many needs and it's the fastest growing aging population. What is the best channel to address this? The response was unfortunately a shortcoming of all these bills is that the older adult needs are not really addressed. A final question was how then can we give older adult mental health issues a voice? These are all issues our Public Awareness and Web development committees should consider. It's important to meet with our policy makers about diverse groups of older adults.

Joel's PowerPoint presentation was distributed to members. If you would like a copy contact mrandolph@apa.org.

Member Updates

[Administration on Community Living](#) – Shannon Skowronski reported on the Chronic Disease Self-Management [Resource Center at NCOA](#) that provides support to the eight chronic disease self-management education grantees funded by the Administration for Community Living (ACL). It has many offerings including webinars. Kim Williams, Mike O'Donnell, and Eve Byrd recently did a webinar, Achieving Collaboration between Mental Health and Aging Services through Coalition Building for which 1400 people registered. The next webinar will be in May. They are also working with the National Council for Behavioral Health on the integration of behavioral health into aging services. In the last Older Americans Act reauthorization after each mention of mental health, "behavioral health" has been added. ACL and SAMHSA have a contract to look at ADRCs and "no wrong door" efforts to see how they are serving older adults with mental health needs and how best to do this.

[American Mental Health Counselors Association](#) – Joel Miller reported that they continue to advocate for Licensed Clinical Mental Health Counselors and Marriage and Family Therapists status as independent Medicare providers. They are also developing standards for mental health counselors and a code of ethics. They are currently engaging their state chapters for a conference celebrating the 40th anniversary of the Association.

[American Psychological Association](#) – Deborah DiGilio noted that her Office on Aging has become much more involved in social media including producing regular blogs on aging issues. There are 20 thus far with one to be released tomorrow on ageism. All blogs on aging can be found [here](#).

[American Society on Aging](#) – Anita Rosen announced that ASA and MHAN are both looking for individuals to write blogs.

[California Elder Mental Health and Aging Coalition](#) – Viviana Criado discussed their advocacy training for promotores, health promoters that engage with members of their own local community and conduct health education. They are also developing a new coalition focusing on advocacy for aging Latinos that will be broad in its focus, not only mental health but topics such as legal issues. All of their programs are data-driven.

[Department of Veteran Affairs](#) - Michele Karel reported on the renewed efforts on Veterans' suicide with both older and younger veterans. There is a recognition that many receive services at the VA but they should also be doing more to link with community agencies and groups. VA is also devoting a lot of attention to those with complex comorbidity. It is very hard to get appropriate community placements for some of these veterans. Other major initiatives include integrated mental health care in primary care, homebased primary care and the dementia intervention, STAR within VA community living centers (long-term care settings).

[Illinois Coalition on Mental Health and Aging](#) - Mike O'Donnell reported that that it took nine months to pass the state budget. Some AAAs have laid off staff and community based health center providers. They have an active Medicare/Medicaid partnership but providers are not participating due to low Medicaid reimbursement. They also have a strong core of advocates for disability rights who are prevailing in courts.

[Indiana Mental Health and Aging Coalition](#) – Willard Mays reported that Indiana had a program prior to PASSR that covered all individuals going into long-term care settings. Unfortunately options counseling went away. They then partnered with AAA to advocate for reestablishing options counseling. They surveyed all of their area agencies on aging and community mental health services to learn if they are providing evidence based services.

[National Association of Social Workers](#) – Chris Herman invited all to their biannual national conference in Washington, on June 22-25. NASW is working with Senator Debbie Stabenow on the Improving Access to Mental Health Act. Related to Medicare, efforts are underway to have social workers reimbursed by Medicare as independent clinical mental health providers in skilled nursing facilities. They are currently developing messaging materials about the bill and will send to NCMHA when available.

[North Carolina Mental Health and Aging Coalition](#) – Debbie Webster reported on how their Coalition is working with the North Carolina Institute of Medicine's Task Force on Mental Health and Substance Abuse to create a state-wide plan to address adolescence and older adult mental health issues. They have three working groups: the cross-cutting group, the adolescent group, and the older adults group. The overall Task Force will address topics affecting the whole population, including the array of services available, workforce needs, integrated care, and tele-behavioral health. The older adult working group will look specifically at the need to develop a continuum of services for the older adult population.

[Pennsylvania Behavioral Health and Aging Coalition](#) – Deborah Allen reported that Pennsylvania has not passed a budget either. They have a small staff that is doing their best. They recently convened two forums on older adults and behavioral health and did a virtual dementia training and are also working on hoarding.

Rhode Island Elder Mental Health and Addiction Coalition – Janet Spinelli reported that in partnership with CCBC via a grant they have convened a hoarding task force. They are also collaborating on homeless initiatives and expanding substance abuse services with other collaborators.