

# **Executive Summary**

## **2013 Report from the Legislative Work Group on Senior and Disability Mental Health and Addictions**

In 2011, Senator Laurie Monnes-Anderson and the Senate Health Care and Human Services Committee agreed to form the Legislative Work Group on Senior and Disability Mental Health and Addictions to look into mental health and chemical dependency problems, as well as the lack of access to needed services, for seniors and people with disabilities. Co-Chaired by Senator Monnes-Anderson and Dr. Jim Davis, the Work Group began its work in April 2012.

Senior advocates had pushed unsuccessfully for the development of a statewide task force to examine the serious mental health and chemical dependency problems experienced by Oregon seniors and people with disabilities after the state DHS/SDSD senior mental health and addiction projects were eliminated by the recession of 2001.

### **Problem**

Seniors and People with Disabilities experience a wide range of life adjustments, including serious physical and emotional health problems, changes in finances, loss of loved ones, changes in physical appearance, changes in relationships, and the stress of caregiving. As a result, they are at high risk of developing mental health difficulties such as depression, anxiety, sleep disturbances, obsessive concerns about health, and mild paranoia. These symptoms are often exacerbated by the effects of complex medical problems, multiple medications and the use and abuse of alcohol and prescription medications.

The misuse and abuse of alcohol and medications among seniors and people with disabilities is a serious problem that can devastate relationships, choice, and independence. Alcohol is the most abused substance by seniors and people with disabilities, followed by prescription and over the counter medications. Seniors purchase around 30 percent of all the prescription drugs purchased in the US. Senior and disability alcohol and drug-related concerns are frequently underreported, misdiagnosed, and often overlooked by clinicians and other providers.

Suicide among seniors and people with disabilities is often the consequence of ignoring, minimizing or misdiagnosing these serious mental health impairments. While seniors represent only 13.7 percent of the population, they account for anywhere between 17-30 percent of all successful suicides. The problem is more pronounced in Oregon than elsewhere in the U.S. Elder white males and older vets have the greatest suicide risk.

### **Service Access and Needs**

Elders and people with disabilities experience many roadblocks in accessing mental health and addiction services, including: the stigma attached to mental health; access barriers to elders receiving appropriate mental health treatment; limited funding for aging and mental health; lack of collaboration and coordination on the local or state level; gaps in mental health and addiction services; significant shortage of geriatric health and social service professionals; and few local, state or national advocacy groups that identify senior mental health as an issue priority. This lack of attention is equally prevalent in the public and private mental health systems, where the

emphasis is on a younger, more mobile clientele. Older minority populations experience greater health problems and shorter life spans than other seniors group. One of the principle reasons is that they tend to underuse health services, in part because of physical, economic, cultural and institutional barriers.

Fewer than 3 percent of the total clientele served by Community Mental Health Programs are age 65 and over, and less than 1 percent of the clientele served by alcohol and drug providers are age 65 and above. For decades, the mandated emphasis of public mental health services has been on the chronically or severely mentally ill population.

Services in the private sector also ignore the special mental health needs of the elderly. Treatment of the elderly is almost non-existent. Psychologists, counselors, psychiatrists and clinical social workers have historically been reluctant to treat older persons. In addition, their education and training does not prepare these professionals to respond adequately to the older population.

It is far more likely that elders, people with disabilities and their families will turn to their primary care physicians before seeking help from mental professionals. However, there are concerns that primary care providers are not adequately responding to these mental health needs of their elder patients, given their lack of training in these areas.

### **Work Group Recommendations**

The Legislative Work Group on Senior and Disability Mental Health and Addictions developed a comprehensive set of policy and program recommendations concerning a wide range of senior and disability mental health and chemical dependency issues and concerns. Strategies were geared toward the creation of a basic system of mental health and alcohol and drug services for seniors and people with disabilities, coordinated through the state Department of Human Services' Aging and People with Disabilities Division and the Oregon Health Authority. The recommendations call for utilizing creative mental health and chemical dependency intervention and treatment approaches to underserved seniors and people with disabilities, many of whom would not have qualified for or accessed services through existing mental health and alcohol and drug service systems. They also place a strong emphasis on greater provider education and community outreach activities, as well as strong advocacy efforts on behalf of these disadvantaged populations. There were eleven major areas identified:

- 1) Create **greater access to mental health and addiction services geared to the needs of seniors and people with disabilities** within the senior/disability and community mental health systems and other public and private mental health and addiction services. Develop local **preventive service options** within the senior, disability, health care and mental health care communities, including counseling, education, outreach, suicide prevention, and case management.
- 2) Increase the capacity of the Oregon Health Authority (OHA)/Addictions and Mental Health Division (AMH) and their mental health and addiction systems to **serve severely impaired seniors and people with disabilities** with such disorders as schizophrenia, bi-polar, and clinical depression in need of services and supports.

- 3) Clarify the role that senior and disability mental health and addictions will play in the **health care transformation process**, particularly regarding collaboration between the Coordinated Care Organizations and the Department of Human Services/Aging and People with Disabilities. Develop best practices in dealing with the **dual-eligible populations**.
- 4) Create greater understanding and enhanced outreach around the **impact of prescription misuse and abuse by seniors and people with disabilities** on seniors and people with disabilities in terms of prescription drug misuse and abuse.
- 5) Establish the role that senior and disability mental health and addictions will play in the **redefinition of community-based long term care** through APD/DHS.
- 6) Provide greater **geriatric training** for current and future health professionals. Create more geriatric in-service training for APD/Area Agencies on Aging and Disabilities (AAAD) and OHA workers, as well as health professionals within the community, particularly emphasizing geriatric training of physicians and nurses in primary care.
- 7) Establish a **statewide advocacy and education campaign** to create greater public awareness and support of the mental health and addiction issues of seniors and people with disabilities and to identify how best to respond with programs, services and policy.
- 8) Develop a **gatekeeper program** that involves critical people in the lives of seniors and people with disabilities, including trusted people in their everyday lives such as neighbors, service providers, postal workers, grocery clerks, banking employees, and auto workers.
- 9) Develop an adequate network of support services and respite care for **family care providers**. Respond effectively to caregiver-related depression.
- 10) Reach out to **elder veterans** with mental health and addiction services that are geared to their needs.
- 11) Create a strong alliance with the **volunteer service** community to provide needed volunteer support within the senior and disability communities.

**Membership**  
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**Senior and Disability Mental Health and Addictions**

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