

**Report to the 2013 Oregon Legislature**

**Oregon Legislative Work Group on  
Senior and Disability Mental Health and Addictions**

**in cooperation with the  
Senate Health Care and Human Services Committee**

Prepared by

James Davis, Ed.D., Work Group Co-Chair  
Oregon State Council for Retired Citizens, United Seniors of Oregon  
Oregon Alliance for Retired Americans, Parkinson's Resources of Oregon  
Marylhurst University

## **Introduction**

After the 2011 Oregon Legislature, Senator Laurie Monnes-Anderson and the Senate Health Care and Human Services Committee she chaired 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 and concluded in the spring of 2013.

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 in Oregon after the state DHS/SDSD senior mental health and addiction projects were eliminated by the recession of 2001. The projects were started by the 1987 Legislature and managed by the state Senior and Disabled Services Division/DHS and the Governor's Commission on Senior Services, with local coordination of services and programs through Area Agencies on Aging and community mental health centers. They utilized creative mental health and A & D early-intervention approaches such as individual, group and peer counseling and education, reaching out to thousands of seniors, most of whom would not have qualified for services through the established mental health and alcohol and drug service systems. The projects brought a large return for seniors in 13 counties facing mental health problems such as depression, anxiety, mild paranoia, and the abuse of alcohol and drugs, helping them lead happier, more fulfilled lives, and avoid much more costly interventions such as institutionalization. Some of the project services remain, funded through other sources.

In the 2005 Oregon Legislative Session, advocates won approval of legislation that recognized the importance of delivering appropriate services and supports to elders and people with disabilities, both of whom experience high rates of mental health and addiction problems, but low rates of service utilization. It was the first time Oregon Statutes had referred to mental health and chemical dependency problems among people with disabilities. Oregon Revised Statutes Section 410.720 now states that it is "the policy of this state to provide mental health and addiction services for all Oregon senior citizens and persons with disabilities through a comprehensive and coordinated statewide network of local mental health services and alcohol and drug abuse education and treatment." It goes on to discuss DHS and OHA facilitating "the formation of local partnerships between the senior, disability, mental health, alcohol and drug abuse and health care communities by supporting the development of program approaches", including screening, outreach, multilingual and multicultural services, education and training, and consultation.

Advocates and providers continued to believe that something must be done to reach out to seniors and people with disabilities with mental health and addiction services that meet their special needs. They were pleased, when in the spring of 2012, the Work Group held its inaugural meeting with interested and involved advocates, providers and policy-makers from the senior and disability communities to discuss solutions for these critical underserved demographics and their mental health and addiction needs.

In the end, the Work Group developed strategies 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 plan calls for utilizing creative mental health and chemical dependency intervention and treatment approaches that will hopefully reach out to thousands of underserved seniors and people with disabilities who have not been able to access services through existing mental health and alcohol and drug service systems. Another emphasis is on greater education and community outreach activities, as well as strong advocacy efforts on behalf of these disadvantaged populations.

With the Work Group recommendations and Final Report now complete, the real work begins. The Work Group has proposed a Budget Note to the Ways and Means Committee that both DHS and OHA review the recommendations and report back to the 2015 Legislature on how they plan to respond with services and supports. Meetings will be held with departmental and legislative leadership and staff to strategize future programmatic directions. A future public forum is being planned to gather more public input.

The Work Group wishes to thank Senator Laurie Monnes-Anderson and the Senate Committee on Health Care and Human Services for supporting the establishment of the Work Group. Special thanks as well to the original Work Group advocacy/organizational co-sponsors, Oregon State Council for Retired Citizens, United Seniors of Oregon, Parkinson's Resources of Oregon, and Oregon Alliance of Retired Americans, as well as the many more senior, disability and mental health groups that endorsed and participated in the effort.

**Membership**  
**Legislative Work Group on**  
**Senior and Disability Mental Health and Addictions**

**Co-Chairs:**

Senator Laurie Monnes Anderson  
Chair, Senate Health Care and Human Services Committee

Jim Davis, Ed.D.  
Marylhurst University, United Seniors of Oregon, Oregon State Council for Retired Citizens, PRO, Oregon Alliance for Retired Americans, GCSS

**Work Group Members**

Jon Bartholomew, Alzheimer's Association, Oregon Chapter,  
Governor's Commission on Senior Services (GCSS)  
Rick Bennett, AARP,  
Campaign for Oregon's Seniors and People with Disabilities (COSPwD)  
Peggy Brey/Nicole Armstrong, Oregon Association of Area Agency on Aging  
and Disabilities  
Leah Craft, Addictions and MH Division, Oregon Health Authority  
Bob Joondeph, Disability Rights Oregon  
State Representative Bill Kennemer  
Jim McConnell, OCSRC, United Seniors of Oregon  
John Mullin, Oregon Law Center, HSCO  
Bill Olson, Advocacy Coalition for Seniors and People with Disabilities  
Dale Penn, Oregon Health Care Association, COSPwD  
Ana Potter, Office of the Long Term Care Ombudsman  
David Schneider, Parkinson's Resources of Oregon  
Jane Ellen Weidanz/Nathan Singer, Aging and People with Disabilities, DHS  
Steve Weiss, United Seniors, OSCRC

**Research Assistants**

Jane O'Brien, Psychology Student, Marylhurst University  
Glenna Wilder, Gerontology/Interdisciplinary Studies Student, Marylhurst

# **Executive Summary**

## **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 and concluded in the spring of 2013.

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.

## **Guiding Principles**

**Before tackling the arduous task of developing the recommendation around senior and disability mental health and addiction services, the Work Group agreed upon the following Guiding Principles for this important task:**

1. The system for addressing Mental Health and Addiction problems for the elderly and persons with disabilities will:
  - Promote independence and dignity for each person
  - Honor the rights of each person with psychosocial disabilities to have equal dignity and freedom to make decisions that affect them
  - Promote prevention and recovery without bias against age, disability, race, gender, religious preference, sexual orientation, or presenting problem
  - Be “person-centered” and support the person to achieve full potential
  - Make services available, timely and easily accessible with the least possible barriers in local communities
  - Assure that services are provided as a “seamless system” from multiple agencies
  - Provide opportunities for professional, consumer and government organizations to work together to improve the availability and quality of mental health preventive and treatment strategies to elderly and persons with disabilities.
  - Deliver services in a culturally competent manner
  
2. The system will address all of the following Key Elements:
  - Systems development to improve services to older people and persons with disabilities
  - Easy access to information, Services and Supports in each community
  - Prevention/early intervention and community education
  - Service/care coordination across disciplines and agencies
  - Levels and scope of services and treatment appropriate to individual needs:
    - Community mental health services and treatment

- Specialized services
  - Community support services, including peer support
  - Acute services
  - Protective services
3. The system will be adequately funded to address the mental health and addiction needs of the state's elderly and disability populations
  4. All partners in the service and supports system will pursue equity in the distribution and delivery of mental health and addiction services

**Special thanks to Jim McConnell of the Oregon State Council for Retired Citizens and United Seniors of Oregon for his invaluable assistance in developing the Guiding Principles.**

# **Program and Policy Recommendations**

## **Legislative Work Group on Senior and Disability Mental Health and Addictions**

The Legislative Work Group on Senior and Disability Mental Health and Addictions worked from April of 2012 to April 2013 to develop a comprehensive set of policy and program recommendations on a wide range of senior and disability mental health and chemical dependency issues and concerns. There were eleven major areas identified: greater access to mental health and addiction services; clarify the role within the health care transformation process; the impact of medications; role within the redefinition of community-based long term care; geriatric training for health professionals; statewide advocacy and education; gatekeeper program; family care providers; outreach to elder veterans; and alliances with the volunteer service. Multiple policy and program recommendations were developed for each area.

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.

### Policy/Program Recommendations:

- ✓ Create evidence-based senior/disability mental health and addiction preventive and early to middle intervention services and programming through the long term care services and supports system within Aging and People with Disabilities (APD) within the Department of Human Services (DHS), Aging and Disability Resources Centers (ADRCs) and the area agencies on aging and disability (AAAD), with cooperative arrangements between APD and AAADs with the community mental health system, including counseling, peer counseling, support groups, client screening, case management, outreach, telephone reassurance, community education, information and referral, consultation, and provider training.
- ✓ Provide mental health and addiction services and supports to Medicaid-eligible populations that are not currently receiving long term care services, emphasizing preventative approaches.
- ✓ Incorporate innovative, evidence-based clinical and care practices to provide the most effective mental health and addiction options for seniors and people with disabilities.

- ✓ Develop and strengthen cooperative arrangements between APD/AAADs, the CCOs, and the community mental health system, placing an emphasis on early and middle intervention and treatment approaches.
- ✓ Support the placement of geriatric and disability mental health and addiction specialists in all community mental health centers to facilitate outreach and services to seniors and people with disabilities experiencing mental health and addiction problems.
- ✓ Create greater capacity for care of severely mentally ill seniors and people with disabilities within the long term care system, including in-home services, assisted living facilities, adult foster homes, residential care facilities, and skilled care facilities, through clinical and staff training and support consultation from mental health professionals.
- ✓ Provide mental health and addiction services and supports to Medicaid-eligible populations that are not currently receiving long term care services.
- ✓ Develop more comprehensive referral networks within the APD/AAA system to be able to effectively connect seniors and people with disabilities with appropriate mental health and addiction services and supports that provides the most appropriate level of intervention and treatment for seniors and people with disabilities, through collaborations between APD/DHS and the Oregon Health Authority (OHA)/Addictions and Mental Health (AMH).
- ✓ Create a resource guide to mental health and addiction services and programs that reaches out to elders and people with disabilities.

2) Increase the capacity of the OHA/Addictions and Mental Health Division 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.

- ✓ Create evidence-based services and supports for severely mentally ill seniors and people with disabilities within the community and long term care facilities (assisted living facilities, adult foster homes, residential care facilities, and skilled care facilities), including: specialized therapy and treatment approaches; crisis programs; targeted case management; in-home services; respite care; day treatment; enhanced care; clinical and staff training; and support consultation from mental health professionals.
- ✓ Create an effective process for screening and responding to senior and disability clients with mental health and chemical dependency/addiction problems to enable the most appropriate treatment plan and options.

- ✓ Implement appropriate, evidence-based public and private service options for crisis response to seniors and people with disabilities, responding to the high suicide rates within these populations and incorporating the recommendations of the Oregon Older Adult Suicide Plan: A Call to Action, particularly regarding measures for suicide prevention.
- ✓ Work closely with OHA Office of Equity and Inclusion to establish a system of data collection and analysis around creating culturally competent and inclusive access to senior and disability mental health and addiction services.
- ✓ Create on-going public reporting that measures, evaluates and monitors mental health and addiction service capacity and delivery for seniors and people with disabilities.

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 (CCOs) and APD/DHS. Develop best practices in dealing with the **dual-eligible populations**.

Policy/Program Recommendations:

- ✓ Establish and monitor within the memoranda of understanding between the CCOs and long term services and supports appropriate and thoughtful planning and strategizing for evidence-based, collaborative programs, services and supports the benefit elders and people with disabilities experiencing mental health and addiction problems.
- ✓
- ✓ Create an effective and appropriate monitoring system to measure the mental health and addiction service delivery and support systems within the CCOs.
- ✓
- ✓ Create cooperative processes of communication, information sharing, strategizing and planning between the AAA advisory councils and CCO advisory councils. Ensure adequate consumer representation on CCO advisory panels, as well as the boards of directors.
- ✓ Use CCO connected training specialists to raise awareness and competency levels of those in the field dealing with geriatric, disability and cross-cultural populations.
- ✓ Develop an enhanced network of mental health and addiction treatment and services for senior and disability populations that do not qualify for Medicaid, through potential co-payment arrangements and enhanced capacity of health plans to serve elders and people with disabilities.

- ✓ Ensure that CCOs have strategies for addressing the special needs of persons with dual diagnosis of mental illness or addiction and any form of cognitive impairment such as Alzheimer's disease or specific diseases such as Parkinson's disease and Multiple Sclerosis.
- ✓ Expand CCO consultation and crisis services to include the needs of elders and people with disabilities for dual eligible clients.
- ✓ Create greater accountability by requiring annual reporting to the Oregon Legislature and stakeholders that measures consumer outcomes to reflect service capacity and delivery and how seniors and people with disabilities were served in the DHS and OHA systems.
- ✓ Gain a better understanding of the effects, role and application of the changing service provisions within the Affordable Care Act, Medicare mental health parity, and private health insurance.

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.

Policy/Program Recommendations:

- ✓ Create evidence-based senior/disability preventive and early to middle intervention services and programming through APD/DHR and AMH/OHA that addresses prescription drug misuse and abuse, including chemical dependency counseling, support groups, case management, outreach, community education, information and referral, consultation, and provider training.
- ✓ Develop programs, treatments and services that respond specifically to seniors' medication misuse and abuse.
- ✓ Develop and strengthen cooperative arrangements between APD/AAADs, the CCOs, and the community mental health system, placing an emphasis on early and middle intervention and treatment approaches for seniors and people with disabilities dealing with addictions to prescriptions and other drugs.
- ✓ Create an effective process for screening senior and disability clients for prescription and other drug problems to enable the most appropriate treatment plan.

- ✓ Create greater capacity for monitoring medication misuse and abuse by seniors and people with disabilities within the long term care system, including in-home services, assisted living facilities, adult foster homes, residential care facilities, and skilled care facilities, through clinical and staff training and support consultation from chemical dependency professionals.
- ✓ Work collaboratively with the addiction services community to create intergenerational, culturally competent and inclusive access to addiction services and supports for the senior and disability populations.
- ✓ Senior and disability clients should be required to have a designated pharmacy that would have centralized records that would have up-to-date data on the medications prescribed.
- ✓ Develop drug safety training statewide with particular emphasis on training consumers, health professionals and providers.
- ✓ Establish a statewide consultation model or hot-line for seniors and people with disabilities through OHA or DHS where they can ask important questions about the medications they are taking.
- ✓ Develop an effective on-line patient record keeping system to track drug intake and measure the use of medications by seniors.

5) Establish the role that senior and disability mental health and addictions will play in the **redefinition of community-based long term care** through Aging and People with Disabilities/DHS.

Policy/Program Recommendations:

- ✓ Work closely with APD/DHS to incorporate within the rethinking of Oregon's long term care system a stronger emphasis on senior and disability mental health and addictions needs through a comprehensive mind-body approach.

6) Provide greater **geriatric training** for current and future health professionals. Create more geriatric in-service training for APD/AAA and OHA workers, as well as health professionals within the community, particularly emphasizing geriatric training of physicians and nurses in primary care.

Policy/Program Recommendations:

- ✓ Work with OHSU and other universities with professional health programs to expand the emphasis on geriatric training in the curriculums and practicums of the medical, dental, nursing and social work schools to better prepare their graduates

to deal with seniors and people with disabilities and their physical and mental health care issues and support services, particularly in primary care.

- ✓ Work with public and private universities and colleges to expand the emphasis on geriatric/gerontology training in the curriculums and practicums of their health-related academic programs to better prepare their graduates to deal with seniors and people with disabilities regarding their physical and mental health care needs.
- ✓ Create access to more fellowships and other incentives in geriatric mental health to attract physicians, nurses and physician assistants into geriatric medicine.
- ✓ Develop greater geriatric emphasis and specialization for health professionals, as well as the training of more health providers in geriatric medical issues.
- ✓ Create training that assists elders and people with disabilities to return to the workforce.
- ✓ Reach out to professional organizations to create geriatric training for local and regional training conferences and continuing education events, particularly primary care health professionals.

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.

Policy/Program Recommendations:

- ✓ Establish a statewide education and training program to create greater public awareness of senior/disability mental health and addiction.
- ✓ Create community-based education events in key demographic locations around the state to highlight senior and disability mental health and addiction issues.
- ✓ Develop a statewide collaborative effort with interested state and local advocacy and provider organizations.
- ✓ Increase advocacy and policy efforts statewide around senior and disability mental health and addictions. Work with APD and area agencies on aging and disabilities, the Oregon Legislature, senior advocacy community, etc.
- ✓ Develop a statewide coalition on senior and disability mental health and addictions.

- ✓ Create a statewide conference to showcase the recommendations of the Legislative Work Group and to organize collaborative efforts within the senior and disability communities.
- ✓ Establish a statewide educational campaign to reduce the stigma of mental health and addiction within the senior and disability communities.

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.

Policy/Program Recommendations:

- ✓ Develop gatekeeper programs within each AAA district.
- ✓ Develop outreach and training to appropriate gatekeepers in the community, such as Meals on Wheels, postal workers, bank employees, etc.
- ✓ Create innovative collaborative efforts with local police and neighborhood watch groups to assist in outreach to seniors and people with disabilities in local communities.

9) Develop an adequate network of support services and respite care for **family care providers**. Respond effectively to caregiver–related depression.

Policy/Program Recommendations:

- ✓ Provide greater incentives and support for family caregivers.
- ✓ Protect and expand respite care for family caregivers.

10) Reach out to **elder veterans** with mental health and addiction services that are geared to their needs.

Policy/Program Recommendations:

- ✓ Create greater links and partnerships between APD/DHS and the Veteran’s Administration.
- ✓ Develop specialized treatment programs for older veterans facing mental health problems, particularly related to post traumatic stress disorder (PTSD), including depression and/or chemical dependency issues, as well as the increased chance of dementia.

- ✓ Respond to medication-related addictions experienced by elder vets with appropriate treatment, supports and training.
- ✓ Create specialized suicide prevention approaches and options that respond to the critically high suicide rates among older veterans.
- ✓ Reach out to homeless elder vets.

11) Create a strong alliance with the **volunteer service** community to provide needed volunteer support within the senior and disability communities.

Policy/Program Recommendations:

- ✓ Better utilize Senior Corps programs like Senior Companions and RSVP to provide needed support to elders and people with disabilities in their homes and other long term care settings.
- ✓ Expand teleassurance programs throughout the state.
- ✓ Develop local services banks that allow for a community-based system of collaborative community supports and services.

**January 31, 2013**

## **Overview of Problem/Review of Literature**

### **SENIOR AND DISABILITY MENTAL HEALTH AND ADDICTIONS**

In this section, the Legislative Work Group on Senior and Disability Mental Health and Addictions wants to provide an overview and review of current literature for major areas affecting senior/disability mental health and chemical dependency, including: demographic trends; life transitions/emotional hurdles; emotional problems; effects of chemical dependency; suicide; mental health and addiction service response; mental health in long term care facilities; role of primary care physicians, barriers to accessing services; and cultural competency.

**Although the Work Group remains equally dedicated to the mental health and chemical dependency needs of both elders and people with disabilities, and despite our extensive research efforts and searches, we have found little research on the mental health and addiction problems and issues of adults with physical disabilities as represented in Oregon's disability community served by the Department of Human Services/Aging and People with Disabilities, compared to the extensive research on senior-related issues. We have, however, received anecdotal evidence of higher rates of mental health and addiction and certain contributing life hurdles within the disability community, and have incorporated that thinking into this review of the problem wherever possible.**

#### **Demographic Trends in Aging**

Oregon is aging along with the rest of the nation. In 2010, approximately 15 percent of the population was aged 65 years or older. This percentage will increase to increase to 20 percent in 2020 as the baby boomers begin their historic demographic explosion (Oregon Health Division, 2012). Nationally, the 65+ population will reach 72 million by 2030. This population explosion will have a great effect on seniors and people with disabilities with mental health and addiction problems. National figures show that 15 percent to 25 percent of those over 65 already are estimated to have mental health problems requiring intervention, and 10 to 15 percent of seniors have alcohol and drug-related problems requiring intervention. With the senior population expected to double by 2030, the social service system will be seriously impacted.

#### **Life Transitions and Emotional Hurdles**

The physical and lifestyle changes that accompany growing old or dealing with disabilities can seriously affect the emotional health of elders and people with disabilities. The transition from one phase of life to another can be a difficult process at any age. Loss and change are predominant themes in the emotional experiences of older people.

People with disabilities also face serious life adjustments and mobility problems while trying to cope with their physical disabilities. As a result, they experience higher levels of anger and depression, but are often afraid to seek help due to fear of a double stigma of physical and mental disabilities.

Coping with life adjustments can be a great challenge for seniors and people with disabilities. How one deals with these changes can make the difference between mental stability and emotional difficulties.

**Changes in Finances.** Financial challenges are common among both seniors and people with disabilities. They are much more likely to be lower income and experience poverty; and, as a result, have a heavier reliance on Social Security income. They face a variety of financial problems. In many cases, they may not have enough money to purchase adequate health/medical care. Mobility may be affected. They may have to sell their home or let the home they live in run down. Not surprisingly, physical and emotional problems may result from the multiple stresses brought on by strained finances. Studies also show that financial problems are a major cause of dissatisfaction and morale problems.

**Changes in Relationships.** Human relationships have a critical affect on the retirement years. Relationships undergo changes and strains as retirees face new roles as an elder spouse, parent, grandparent, or friend. Couples must learn to reconcile two lives, having occupied different worlds and functioned more or less independently of the other for decades, and now must confront these hurdles and come to terms with them. Many deal with being single and re-establishing new relationships and starting to date again. Relationships with adult children, as well as their spouses and in-laws, are constantly changing.

**Loss of Loved Ones.** The longer a senior lives, the more he or she must come face-to-face with the loss of loved ones, close friends and associates; the most stressful loss often being the death of a spouse. Widowhood means dealing with the tremendous loss of a partner, lover and confidant. Lifelong roles are changed overnight. Social interactions are altered. It is a trying time of rebuilding one's life.

**Changes in Health and Physical Appearance.** Significant changes in health and physical appearance are an inevitable part of growing old. Although the majority of seniors continue to lead active and independent lives, aging nevertheless takes its toll. Most seniors face some form of chronic illness; often in multiple forms and requiring progressively more medical care and medication. They face lessened resiliency and loss of strength. People with disabilities must deal with serious health issues on a consistent basis. In addition, on-going changes in physical appearance serve as constant reminders to seniors and people with disabilities of the aging and disability processes and the limitations that they present.

**Stress on Caregivers.** Recognition is finally being given to the tremendous emotional investment by caregivers who are providing full or partial care for a loved one. The stress is caused by endless hours of work, often without necessary respite, and the financial burden and emotional cost of seeing the physical and mental decline of a spouse, relative or friend. The pressure and strain can take a tremendous physical and emotional toll on care providers, who are often not physically able to maintain the necessary level of caregiver responsibilities.

## **Mental Health Problems**

Given the tremendous number of losses, adjustments and transitions faced by seniors and people with disabilities, it is no surprise they are at high risk of developing mental health difficulties such as depression, anxiety, sleep disturbances, obsessive concern about health, and mild paranoia. These symptoms are often exacerbated by the effects of complex medical problems and the use and abuse of alcohol and prescription medications.

In their study, *The State of Mental Health and Aging in America*, the Centers for Disease Control estimated that 20 percent of people aged 55 or older experience mental health concerns. The most common conditions noted were anxiety, severe cognitive impairment, and mood disorders such as depression. They also noted that mental health impacts suicide rates, with older men being the hardest hit, particularly those males 85 years of age or older, who have a suicide rate of 45 per 1000 compared to the average rate of 11 per 1000 for all ages (Centers for Disease Control).

**Anxiety.** It is common for seniors and people with disabilities to experience anxiety, a complex physical and emotional response to stressful situations. It can be triggered either by external circumstances or internal conflict and may be experienced chronically or in intermittent episodes. There are a variety of reasons for an older person to feel anxious. Anxiety may be rooted in a generalized fear of growing old, particularly if one's independence is threatened. Anxiety is also a common response when faced with a changing world or a massive onslaught of new situations/information. Anxiety may be accompanied by a variety of physical symptoms, including muscular tenseness, rapid heart rate, sweating, and high blood pressure. Outward manifestations include pacing, chain smoking, nervous mannerisms and restlessness.

**Depression.** According to the World Health Organization, depression is the second most common health disorder worldwide among all ages. But for many seniors and people with disabilities, it is more than just a fleeting occurrence. Studies show that depression is the most prevalent mental health disorder for seniors and people with disabilities and they are more likely to suffer frequent and debilitating depressive episodes (CDC). There are numerous causes of depression, but many can be related to life adjustment problems and the significant changes and losses experienced by elders and people with disabilities.

Depressive states range from mild to severe. Victims of depression may feel listless and discouraged. They may be unable to perform daily tasks as effectively as normal and may

show decreased interest in their usual activities. They may also experience physical symptoms such as indigestion, achiness, dizziness, loss of appetite, fatigue, constipation, sexual impotence and sleep disturbances.

Proper and timely response to depression is critical. The major goal of treatment is to restore a sense of confidence and the ability to cope. Involvement in activities that are intellectually and physically challenging can often do the trick. Psychotherapy also has proven to be an effective treatment approach. Of course, no approach is sustainable unless there is regular and meaningful contact with other people. Marked improvement can be seen simply from having someone with whom to share feelings and experiences.

**Sleep disturbances.** Difficulties maintaining an appropriate sleep regimen can be troubling for seniors, particularly for those suffering from depression. They may have trouble getting to sleep, awake too frequently after falling asleep, or sleep restlessly. Anxiety-producing life transition situations are often a major cause of sleep disturbances. Sleep disturbances can also be rooted in disability, isolation, loneliness or even changes in sleep patterns like daytime napping. One major problem that is associated with sleep problems is the overuse of sleeping pills as a sleep aid. Not only does this have serious health implications, but it also leads to larger and larger doses as the individual develops a tolerance for the overused medication.

**Mild paranoid reactions.** Seniors can develop mild paranoid reactions in their later years that range from elaborate well-organized paranoid beliefs to brief, mild episodes with no lingering effect, but almost always involve a persecution complex. Symptoms vary greatly. There is a tendency to latch their fears and misfortunes on to nearby figures such as the mailman, neighbors, children, relatives, or others in their immediate environment. Paranoid reactions may be precipitated by such factors as social isolation, solitary living and feelings of insecurity. Probably the largest single cause, however, is sensory defects, particularly hearing and vision problems, which make seniors feel that they have lost control over the world around them and, as a result, become insecure or suspicious.

**Anxious Concern Over Health.** Seniors and people with disabilities suffer from a wide range of health problems, often poorly treated. It is not uncommon for them to develop significant anxiety or depression about health difficulties, especially in the absence of social support systems. It can be a vehicle for gaining sympathy, concern and attention that is not being received when healthy and well. Social isolation and lack of stimulating interests are major reasons seniors can develop an inappropriate preoccupation with their bodies.

## **Severely Mentally Ill Elders**

Although it is estimated that the severely mentally ill, often with clinical depression, bipolar, and schizophrenia, die decades before their normal life expectancy, more people with these disorders are living into their senior years. The Department of Human Services/Oregon Health System estimates that around 2 percent, or 10,436 older Oregonians, have a serious mental illness. Elders with serious mental illness can end up in the state hospitals or residential/enhanced care settings, which can include nursing homes or residential care facilities, where staff are often ill-prepared to deal with them. Recent data on senior admissions to the state hospitals indicates an increase from 52 senior admissions in 2009 (7.3 percent) to 59 senior admissions in 2011 (7.9 percent) (OHA-DHS, 2012).

## **Chemical Dependency**

The chemical dependency problems of seniors and people with disabilities are complex, typically falling into two major categories, alcohol and prescription drug use and abuse.

The misuse and abuse of alcohol and medications among seniors is a serious problem that can devastate relationships, choice and independence. Although it is very much a hidden problem, conservative estimates are that 10 to 15% of the senior population has alcohol and drug-related problems requiring intervention.

Faced with significant losses, adjustments and transitions, coupled with the high risk of developing mental health problems such as depression and anxiety, sleep disturbance, and hypochondria, seniors and people with disabilities are at risk of abusing alcohol and prescription drugs.

The special needs of seniors and people with disabilities are being ignored by the alcohol and drug abuse system in the state of Oregon. Less than 1 percent of the chemical dependency services of the Oregon Health Authority and the Department of Human Services Chemical Dependency Services were devoted to seniors. As a matter of fact, only 516 seniors were served during the fiscal year 2010-2011, and nearly 70 percent of those clients were being assessed after a DUII. Historically, more than 90 percent of the chemical dependency clients have been under the age of 50 (OHA/DHS, 2012).

## **Alcohol Misuse and Abuse**

Alcoholism and aging are two conditions that are surrounded by stereotypes, stigmas, intolerance, fear, and a general misunderstanding by society at large. Alcohol is the substance most abused by seniors and people with disabilities, followed by drugs obtained legally through prescriptions and over the counter. Alcohol can be particularly toxic in seniors and exacts a very high physical, emotional and social toll. A growing number of seniors with alcohol-related problems are being admitted to long term care facilities.

Conservative estimates are that alcohol addiction affects around 10 percent of seniors, or more than four million Americans or 70,000 Oregonians over the age of 60 who have alcohol-related problems. Data is not available for people with disabilities.

Senior alcohol-related concerns are frequently underreported, misdiagnosed and overlooked by clinicians. The problem is often hidden as large numbers of seniors and people with disabilities drink in isolation in their homes. The rate of alcoholism among seniors is expected to grow. With the boomers expected to double the senior population, life and health problems related to alcohol will grow exponentially, which will seriously strain limited resources available to treat alcoholism and its attendant disorders.

### **Prescription Drug Abuse**

The senior years are often a time of chronic health problems that keep physicians searching for answers to help ease their older and disabled patients' discomfort. Eighty-six percent of the elderly must deal with a chronic ailment, such as heart disease, arthritis, hypertension, and prostate disease. Chronic health problems amongst the disability population would likely be at similarly high levels, as are emotional problems for both groups.

Seniors purchase three times as many medications as the general population, around 30 percent of all the prescription drugs purchased in the US. They also purchase a disproportionate amount of over-the-counter medications. Eighty-three percent of older adults age 60 and over take prescription drugs. Older adult women take an average of five prescription drugs at a time, and for longer periods of time, than men. Studies show that half of those drugs are potentially addictive substances, like sedatives, making older females more susceptible to potential abuse issues (Basca, 2008).

Because they may have a number of diseases or disabilities at the same time, it is common for seniors and people with disabilities to simultaneously take many different drugs. Studies show that more than two-thirds of all physician visits for patients over 65 result in a new prescription. Approximately 30 percent of those 75 or older with two or more chronic conditions take at least 5 prescription drugs regularly, with the average elderly person commonly taking 4 or more prescription medications.

There are also serious questions being raised about whether some the medications prescribed for senior and disability patients are inappropriate. Although in the vast majority of cases seniors and people with disabilities take medications that are correctly prescribed for legitimate health problems. There is concern that a significant number of prescriptions written to these groups are incorrect or unnecessary. Coordinating medications among multiple physicians is difficult, and without coordination, seniors and people with disabilities are put at increased risk for adverse drug interactions. The vast majority of adverse drug reactions in elder patients are the result of preventable dosage-related factors.

Misuse of drugs - the inappropriate use of drugs intended for therapeutic purposes - is far more common among the elderly than blatant abuse. This may include the mixing of prescription drugs, over-the-counter medications and/or alcohol in ways that are dangerous and outside the knowledge or approval of the prescribing physicians, trading medications with friends and loved ones and taking higher doses of medications than recommended. These and other examples of drug misuse are common among seniors, most often due to a lack of education on how to responsibly use the medications.

Senior services and care providers may confuse the physical and emotional symptoms of substance misuse or abuse with the normal process of aging, resulting in a failure to intervene in a timely or appropriate manner. This situation points to the great need for adequate educational programming for seniors and their service/care providers on the importance of responsible use of all medications.

The most common prescription medications that are abused include opiates, central nervous system depressants, and stimulants, particularly due to their addictive qualities, as well as benzodiazepines for anxiety and insomnia, pain relievers for arthritis and hip fractures, and various over-the-counter (OTC) medications, all of which can have adverse reactions when mixed with other drugs or alcohol (Basca, 2008).

Chemical dependency issues are changing as the baby boomers age, with a marked increase in the use of drugs such as marijuana, cocaine, heroin, and other illicit drugs. Alcohol is expected to remain the substance of choice among boomers, but marijuana use is expected to increase, along with other "street" drugs.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that approximately 5 million or 5.2% of adults aged 50 and older used illicit drugs in the past year. Marijuana was the most commonly used substance, followed by the nonmedical use of prescription drugs. SAMHSA also found the proportion of treatment admissions for people aged 50 and older nearly doubled in treatment facilities that receive some public funding between 1992 and 2008 (Reardon, 2012).

### **The Impact of Chemical Dependency**

Addiction to chemicals such as prescription drugs and alcohol can lead to the same types of symptoms as seen in psychiatric illnesses. The pattern of symptoms of such dependency frequently includes depression, sleep disorders, mental confusion, hypochondria, paranoia and/or anti-social behavior. Medical implications can include cirrhosis, gastro-intestinal disease, hypertension, fractures due to frequent falls, and cognitive and neurological damage. Social implications caused by senior addictions include untold pain to family and other loved ones.

Older addicts need to be in a treatment program that, if not specializing in senior/disability addiction, can at least effectively consider aging and disability issues along with the chemical dependency problems. Seniors and people with disabilities in specialized addiction programs respond better to treatment than those in mainstream programs.

## **Gambling Addiction**

More and more elders are being drawn into an addiction to gambling, especially as seniors are encouraged to gamble by easy access to and discounts at casinos. Erickson (2005) evaluated the prevalence of problem and pathological gambling in 343 older adults aged 60 and older in Connecticut. About 10% of the sample had gambling problems, with 6.4 percent classified as problem gamblers and an additional 3.8 percent classified as pathological gamblers. Problem and pathological gamblers evidenced significantly greater physical and mental health problems than non-problem gamblers (Erickson, 2005), with a commensurate need for specialized services and supports.

## **Suicide**

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 Alliance for Aging Research found that in 2005, seniors comprised 12 percent of the population yet accounted for 17 percent of all suicides: in all, more than 7,000 older Americans committed suicide that year. But the actual figures are likely much higher than reported, given that families are often reluctant to report an elder loved one's death as a suicide.

Suicide among the elderly is particularly pronounced in Oregon. In 2005, Oregon DHS released a comprehensive report on the problem of elder suicide. It noted that nationally elder suicides are around 15 to 20 per 100,000 nationally, but around 20 to 30 per 100,000 in Oregon, which is among the highest rates in the nation. The study found that of those seniors that committed suicide, 99 percent were white, 86 percent were males, and 79 percent used a firearm. Both physical and mental health problems appeared to be major causal factors. According to the data, 76 percent of the males and 72 percent of the females were facing physical health problems, while 50 percent and 61 percent, respectively, suffered from depression and mood disorders. DHS recommended steps be taken to ameliorate this problem, including: improve clinical care and services; implement evidence-based suicide prevention practices; improve information gathering, evaluation and research; and collaborate with local and state partners (DHS, 2005).

Other research confirms these findings. A study conducted by David Clark, a psychologist at Rush-Presbyterian-St. Luke's Medical Center in Chicago, found mental health problems

to be the principal reason for seniors' taking their own lives. Of the group of 54 senior suicide victims studied, 65 percent were depressed and 19 percent were alcoholics. Surprisingly, only 13 percent had fatal diseases; 24 percent had chronic disease. Few had received psychiatric treatment.

A large percentage of senior suicides stem from depression, alcohol and/or organic brain diseases. Suicide can be an escape from social isolation, loneliness, a chronic illness that will never improve, a feeling of uselessness, inactivity, and loss of loved ones and close friends. Seniors who attempt suicide have the highest success rate of any age group. When seniors choose suicide they usually fully intend to die. White elderly males are most at risk, as are widowers from low socio-economic classes.

The already startlingly high elder suicide rate will likely not see much change with the boomers unless there is a serious investment in senior mental health and addiction services. The Center for Disease Control and Prevention found that between 1999 and 2005, there was a 20% increase in suicide rates among boomer adults between age 45 and 54. (Chopivsky, 2011)

Despite these frightening statistics, seniors remain underserved by prevention and treatment programs and resources. SPAN USA outlined three strategies to prevent senior suicide: 1. Optimize function and reduce isolation, 2. Restrict access to lethal means, and 3. Diagnose and prevent depression (Alliance for Aging Research, 2009).

### **Mental Health and Addiction Service Response**

The lack of attention to mental health and addiction needs of seniors and people with disabilities is equally prevalent in the public and private mental health systems: both place their emphasis on a younger, more mobile clientele. Local and state senior/disability services have also traditionally focused little attention on the mental health needs of the elder and disability populations.

Nationally, statistics show that fewer than 3-5 percent of the total clientele served by the 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. In Oregon during the fiscal year 2010-2011, 4,855 elders received mental health services from the State of Oregon, either through DHS or OHA. Of those served, 2.9% were in state hospitals and 4.7 percent were in residential or enhanced care. OHA/DHS data indicates that of the 59,009 individuals that are dually eligible for both Medicaid and Medicare, 20 percent had a serious or persistent mental health illness diagnosis, but only 28 percent of those individuals received any long term care support services, let alone mental health support (OHA/DHS, 2012).

There is little if any data on the particular mental health and addiction problems of people with physical disabilities. Yet, limitations to access appear to be the norm, with few options for outreach services.

The lack of publicly-funded mental health options for the elderly has placed an increased burden on state senior and disability services, which have few specific programs or specially trained personnel to address mental health needs of their senior clientele. Oregon's senior and disabled service system has focused its services on meeting the functional needs of the elderly, without resources or mandate to give adequate attention to the emotional and alcohol/drug problems which occur in the senior and disability populations.

The Medicare Improvements for Patients and Providers Act will help move toward mental health equity for seniors with Medicare copayments for mental health care reduced from 50 percent to 20 percent, the Medicare co-pay for other outpatient care. This should increase elders' access to mental health services and medications, but reimbursement rates will remain a very real problem, as well as limitations on the therapy/counseling services that qualify for reimbursement.

Services in the private sector also ignore the special mental health needs of the elderly. 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. As a result, only 2 to 5 percent of private psychiatric services have any experiences serving seniors. Psychiatrists who specialize in geriatrics are even more scarce. Money also can be a consideration in the exclusion of seniors from mental health care. Private therapy and counseling services are typically between \$80 and \$150 per hour, which is out-of-reach for most seniors.

There is a significant national shortage of mental health professionals who have any expertise in geriatric mental health care, including counselors, gero-psychologists, board-certified geriatric psychiatrists, geriatric nurses, and geriatric social workers. There is typically very limited geriatric training in most medical, nursing and social work schools. Most graduates say they are not prepared to deal with the specialized needs of elders.

The graying of America will only exacerbate this situation. The National Institute of Health's Institute of Medicine's congressionally-mandated report, *Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?*, points out the "silver tsunami" of health care needs expected to accompany the explosion of the senior population and the demand that it will place on the health care profession. The report noted that the key to handling the upsurge in seniors with mental health issues and/or substance use issues will be organizing a better health care workforce that is more able and qualified to respond the needs of seniors and people with disabilities. The report also cites the need for better provisions such as funding and training of professionals to

care for this population, including primary care providers, nurses and nursing-home assistants (NIH/NOM, 2011).

### **Mental Health Issues in Long Term Care Facilities**

Compared with seniors living in the community, residents of long term care facilities such as nursing homes or assisted living facilities, (most of whom are 80 years or older), have much higher rates of mental health problems and a much greater need for mental health services, especially for cognitive impairment and behavioral difficulties.

Although much is written about the high prevalence of dementia in long term care facilities such as nursing homes, there also are pervasive mental health problems in such long term care facilities as assisted living facilities and adult foster homes. In addition to a high prevalence of depression, anxiety and behavior-related disorders, long term care facilities, particularly nursing homes, are likely to have to deal with the most severely mentally ill residents, including those with chronic clinical depression, bipolar disorder, or schizophrenia. A growing number of severely mentally ill clients are living into their senior years, and, if not living within a supportive family or community environment or in a mental health institutional setting, will have a much greater likelihood of ending up in the long term care system. Long term care staff are often ill-prepared to deal with seriously mentally ill residents. Psychotherapeutic and counseling services are not nearly as available in nursing homes as psychopharmacological interventions.

The American Geriatrics Society (AGS), American Association for Geriatric Psychiatry (AAGP) and a number of other national organizations issued a consensus statement on improving the quality of mental health care in nursing homes in the United States. Recommendations include: policies affecting long term care for older adults should promote mental health services compliance with existing regulations concerning screening, assessment, and referral should be more rigorously enforced; nursing home payment systems should reward facilities for providing appropriate mental health care; and consumers should have access to information about nursing home quality that includes well-designed mental health measures. (AGS, AAGP, 2003).

### **The Role of Primary Care Providers in Senior Mental Health Care**

It is far more likely that elders and their families will turn to their primary care physicians before seeking help from mental health professionals. Gerontologist Gene Cohen noted that primary care physicians have an important role in provision of mental health services in that seniors and their family members prefer to talk to them rather than psychiatrists or psychologists. "Primary care physicians have the opportunity to advise staff about developing a plan for dealing with mental health problems in their facilities." (Cohen, 2003)

An American Psychological Association (APA) study indicated that 50-70 percent of all primary care medical visits are related in some way to mental health issues such as anxiety, depression, and stress.

Other studies suggest, however, that these primary care providers are not adequately responding to the mental health needs of their elder patients. One study of 35 primary care physicians in Midwest and Southwest medical clinics and 366 of their patients aged 65 and older (mean age 74) videotaped 385 office visits covering 2,472 topics to assess how primary care is delivered for senior mental health problems. Fifty percent of patients had mental health scores suggesting major depression. Of these patients, mental health discussions occurred in only 25 percent of the visits. Referrals to mental health specialists were rare, even for severely depressed and suicidal patients. (Tai-Seale, 2007)

Data also shows a strong overlap between physical and emotional health. In a study of the effects of expanded mental health services to HMO patients, the "high utilizers" of outpatient medical services aged 55 and older sought expanded mental health services at more than three times the rate (11.5 vs. 3.4 visits) of usual care patients (Hass, Spendlove, and Silver, 2001).

In its study, the APA recommended addressing these issues by: an increase in the availability of and access to effective senior mental health services; overcoming barriers to treatment, particularly around poor diagnosis, reimbursement, lack of specialized programs, stigma, and the reluctance of providers to refer to mental health; increased funding through Medicaid, the Older Americans Act, and the Community Mental Health Services Block Grant; and increased collaboration between mental and physical health care providers (APA).

### **Barriers to Accessing Services**

Key roadblocks to accessing mental health and addiction services for elders and people with disabilities:

***Stigma.*** Many elders, particularly from the greatest and silent generations, won't seek psychological treatment because of the stigma they and their loved ones attach to mental health. They often don't want to be identified with the mental health system, which they associate with "asylums," and extreme treatments like electroshock. As a result they may deny or overlook the need for treatment. If they seek help, it will most likely be in the form of emotional support from their family doctor, clergy, or a family member. Many mental health experts agree that the baby boomers are far less likely to carry stigmas about mental health and are much more open to therapy and counseling options.

**Access barriers.** There are many barriers to mental health treatment and few mental health options available for elders. Transportation to services can be limited. For those not on public assistance, the cost of private mental health and addiction services can be prohibitive.

**Funding issues.** Funding for aging services generally and mental health specifically are usually limited and not a priority for funders. What funding that is available through such public programs as Medicare and Medicaid is inadequate.

**Lack of collaboration and coordination.** The mental health and aging services communities do not interact or collaborate much on local or state levels. Coordination between the two service networks is critical to the successful development of senior mental health and addiction services.

**Gaps in services.** Local or state aging units are usually ill-prepared to respond to the mental health conditions of their clients. There are few targeted monies. Staff has typically not been trained to deal with mental health.

**Workforce issues.** With the pending boomer aging upsurge, there is a significant nationwide shortage of health and social service professionals who have any expertise in geriatric mental health care. Particular specialties in short supply include geropsychologists, board-certified geriatric psychiatrists, geriatric nurses, and geriatric social workers. Geriatric training is limited in most medical, nursing and social work schools. When providers graduate, they are not prepared to deal with the specialized needs of elders.

**Organized consumer support.** There are few local, state or national advocacy groups that have senior mental health as an issue priority. Lawmakers and funders need to hear from the grassroots that this is a priority or little will be done. (Administration on Aging, 2001)

**Attitudes.** A critical obstacle to the delivery of adequate senior mental health services are seniors' own negative attitudes toward mental health care. Many older people still equate mental health care with a one-way ticket to an institution. They tend to view such care as being for people who are more seriously ill; those who are "senile" or "crazy." Born of a generation that emphasized independence and self reliance, some elders feel that seeking mental health care represents a character flaw or a moral failure. The popular acceptance of counseling and therapy is a recent phenomenon. As a result, seniors are less likely than younger persons to seek assistance for their own mental health and alcohol and drug problems, but, ironically, stand to benefit as much or more from the services.

For seniors and people with disabilities in rural, remote, or disadvantaged areas, particularly ethnic minority seniors, the hurdles can be much greater. There are fewer

supportive services and even fewer specialized services. Transportation is a barrier with limited subsidized transportation options.

The Institute of Medicine Committee on the Mental Health Workforce for Geriatric Populations (2012) noted that "millions of baby boomers will likely face roadblocks gaining access to diagnoses and treatment for their mental health and substance abuse problems unless there is a major initiative to significantly boost the number of health professionals and other service providers with geriatric training and experience. The magnitude of the problem is so great that no single approach or isolated changes in a few federal agencies or programs will address it." The report calls for a redesign of Medicare and Medicaid payment rules to guarantee coverage of counseling, care management, and other types of mental health and addiction services. (Committee on the Mental Health Workforce for Geriatric Populations, 2012).

### **Cultural Competency**

Minority elderly populations, including African Americans, Hispanics, Asian Americans, and Native Americans, are growing by leaps and bounds, predicted to increase from 10 percent in 1990 to 25 percent by 2030. Hispanic elderly will experience the greatest growth levels, with the 75+ age cohort increasing 61 percent from 1989 to 2000.

Older minority populations experience greater health problems and shorter life spans than other senior groups. One of the principle reasons is that these populations are even more likely to underuse health services, in part because of physical, economic, cultural and institutional barriers. To address this problem, providers must become aware of cultural beliefs, practices and traditions of their patients. Culturally-competent mental health screening and treatment services, culturally sensitive health and disease prevention education and location of health care facilities in accessible public locations (particularly underserved areas), will be required to address the high rates of mental illness and addiction problems among ethnic and racial minorities and gay, lesbian and bisexuals who are elders or people with disabilities.

A large-scale study of older adults in California was undertaken to determine racial and ethnic differences in the prevalence of mental health issues and use of mental health services. The sample comprised 16,974 people aged 55 and older, with 13,974 non-Hispanic whites, 719 African Americans, 1,215 Asians, and 1,066 Latinos. African Americans, Asians, and Latinos were more likely to have mental health problems than whites (21.2–24.2 percent vs. 14.4 percent) and a higher prevalence of serious mental illness (4.1–7.7 percent vs. 2.5 percent). After adjustment for age, sex, birthplace, marital status, education, limited English proficiency, chronic health conditions, and insurance status, older African-American adults still had greater odds of mental health problems than whites. All three groups had more limited access to mental health services than whites (Sorkin, Pham, and Ngo-Metzger, 2009).

The substantial increase in the number of Hispanic elders requires particular focus on this population. A study published in the *Community Mental Health Journal* assessed the need for mental health services among Latino older adults in San Diego, California and found the primary mental health issue to be depression. They found that the primary organizational barriers to accessing services were language and cultural barriers, a lack of translators, inadequate information on available services, and few Latino providers, a lack of transportation and housing, and the need for greater socialization and social support.

There is little research available on the mental health and addiction problems of gay, lesbian, and bisexual elders. D'Augelli (2001) examined mental health among 297 male and 119 female lesbian, gay, and bisexual older adults aged 60-91 (mean age 68.5), evaluating their current mental health status and how it had changed in the past 5 years. A total of 37 percent rated their overall mental health as excellent, 47 percent said good, and 14 percent said fair. Only 2 percent said their mental health was poor, and less than 1 percent said it was very poor. Compared with women, men reported significantly more alcohol abuse and suicidal tendencies related to their sexual orientation (D'Augelli, 2001).

## **Older Veterans**

Although the trauma of war is now being more widely discussed, the emotional impact on older veterans of World War II, the Korean War and the Vietnam War is less likely to be acknowledged and dealt with, although more than 50 percent of the veterans are age 60 and over. Older veterans have faced various levels of post traumatic stress disorder (PTSD), which creates serious problems in their lives. Studies show that the more prolonged, extensive and horrifying the exposure to war, the greater chance of negative emotional effects (National Center for PTSD, 2006). There is often a dual diagnosis of PTSD with depression and/or chemical dependency issues, as well as increased chance of dementia.

One study of 10,481 veterans over the age of 65 showed that older veterans with PTSD were twice as likely to get dementia; although, interestingly, much less likely if they had received the Purple Heart (Healthinaging.org). There seems to be a link between PTSD and how veterans were received when they got home. WW II vets, who were received as heroes, had lower rates of PTSD than Korean War vets, who received a lackluster welcome, and Vietnam War vets, who faced a negative response back home.

Suicide rates among older vets are much higher than among non-veteran seniors. A 2013 study released by the US Department of Veteran Affairs showed that 69 percent of all veteran suicides were vets aged 50 and over, with 49 percent 60 and over. Older vets are three times more likely to commit suicide than their non-veteran peers (DVA, 2013).

Although most older vets are part of the Veteran's Administration, there is often overlap in service provision between the VA and local social services. Therapeutic approaches, especially those geared to vets, are proving to be effective in dealing with PTSD and other mental disorders faced by vets. With the recent wars in the Middle East, the VA has stepped up its efforts to develop mental health approaches and older vets have benefited. But not enough is being done to provide mental health and addiction support to older vets.

## **Conclusion**

Strong support needs to be given to the development of local community partnerships between the senior, disability, ethnic minority, mental health, alcohol and drug abuse, and health care communities to develop such program approaches as: mental health and alcohol and drug assessment; supportive outreach to seniors in their homes; clinical services, including individual and group therapy; support groups; treatment services for senior clients coming out of hospital settings; education and training for consumers, advocates, health professionals, and providers; peer counseling; and consultation.

In a joint report, the Substance Abuse and Mental Health Services Administration (SAMHSA) and Administration on Aging (AoA) recognized the importance of strong partnerships for addressing seniors' behavioral health issues "through planning and coordination of aging and behavioral health services for older adults, particularly in the areas of suicide, anxiety, depression, alcohol and prescription drug use and misuse among older adults, and partnering with AoA to get these resources into the hands of aging and behavioral health professionals" (Administration on Aging).

Strategies need to be developed that are geared toward the creation of a basic system of mental health and alcohol and drug services for seniors and people with disabilities, potentially coordinated through the state Department of Human Services/Aging and People with Disabilities, area agencies on aging and disabilities, Oregon Health Authority, Oregon Health Plan, and community mental health programs, utilizing creative mental health and alcohol and drug early-intervention approaches to reach out to thousands of underserved Oregonians, many of whom would not have qualified for or accessed services through the established mental health and alcohol and drug service systems.

**A very special thanks to our research assistants Jane O'Brien and Glenna Wilder from Marylhurst University for their excellent research efforts.**

## Bibliography

Administration on Aging, U.S. Department of Health and Human Services. (n.d.). Older Americans Behavioral Health: Issue brief 1: Aging and Behavioral Health Partnerships in the Changing Health Care Environment. *Administration on Aging*. [www.aoa.gov](http://www.aoa.gov)

Administration on Aging, U.S. Department of Health and Human Services. (2001). Older adults and mental health: issues and opportunities. *U.S. Department of Health and Human Services*. [www.globalaging.org/health/us/mental.pdf](http://www.globalaging.org/health/us/mental.pdf)

Alliance for Aging Research (2009). Raising Awareness: The First Step in Preventing Senior Suicide. *Alliance for Aging Research*. Spring 2009. [www.agingresearch.org/content/article/detail/2354](http://www.agingresearch.org/content/article/detail/2354)

American Geriatrics Society and American Association for Geriatric Psychiatry Recommendations for Policies in Support of Quality Mental Health Care in U.S. Nursing Homes." *Journal of the American Geriatrics Society* 51.9 (2003): 1299-304. Print.

American Psychological Association (n.d.) Psychology and Aging: Addressing Mental Health Needs of Older Adults. APA; [www.apa.org](http://www.apa.org)

Barrio, C., Palinkas, L.A., Yamada, A.M., Fuentes, D., Criado, V., Garcia, P., Jeste, D.V. Unmet needs for mental health services for Latino older adults: perspectives from consumers, family members, advocates, and service providers. *Community Mental Health Journal*.; 44(1): 57-74, doi: 10.1007/s10597-007-9112-9.

Basca, B. (2008). The elderly and prescription drug misuse and abuse. *Prevention Tactics* 9 (2). [www.ca-cpi.org](http://www.ca-cpi.org)

Becker, Marion, Paul Stiles, and Lawrence Schonfeld. "Mental Health Service use and Cost of Care for Older Adults in Assisted Living Facilities: Implications for Public Policy." *Journal of Behavioral Health Services and Research* 29.1 (2002): 91-8. Print.

Brenne, J., Curtis, R., Hubert, D., Lawrence, M. (2001). A study of the mental health and addiction needs of Oregon's baby boomers. *Oregon Governor's Commission on Senior Services, Senior Mental Health and Addictions Committee*. [www.oregon.gov/dhs/spd/adv/gcss/mh\\_boomers.pdf](http://www.oregon.gov/dhs/spd/adv/gcss/mh_boomers.pdf)

Centers for Disease Control (n.d.) The State of mental Health and Aging in America. *Centers for Disease Control*. [www.cdc.gov](http://www.cdc.gov)

Chopivsky, L. (2011). Baby boomers and their mental health care needs: can Medicare rise to the challenge? *Yale Journal of Medicine and Law*, Vol. VIII, (1). <http://www.yalemedlaw.com/2011/12/>

Cohen, Gene D., et al. "Mental Health Problems in Assisted Living Residents: The Physician's Role in Treatment and Staff Education." *Geriatrics* 58.2 (2003): 44. Print.

Committee on the Mental Health Workforce for Geriatric Populations. (2012). Baby Boomers Likely to Face Inadequate Care for Mental Health, Substance Abuse; IOM Report Recommends Ways to Boost Work Force, Fund Services and Training. *National Academy of Sciences, National Institute of Medicine*.  
[www.nationalacademies.org/onpinews/newsitem.aspx?RecordID-13400](http://www.nationalacademies.org/onpinews/newsitem.aspx?RecordID-13400)

"Consensus Statement on Improving the Quality of Mental Health Care in U.S. Nursing Homes: Management of Depression and Behavioral Symptoms Associated with Dementia." *Journal of the American Geriatrics Society* 51.9 (2003): 1287-98. Print.

D'Augelli, A. R., et al. "Aspects of Mental Health among Older Lesbian, Gay, and Bisexual Adults." *Aging and Mental Health* 5.2 (2001): 149-58. Print.

Dupree, Larry W., Mary Ann Watson, and Myra G. Schneider. "Preferences for Mental Health Care: A Comparison of Older African Americans and Older Caucasians." *Journal of Applied Gerontology* 24.3 (2005): 196-210. Print.

Erickson, Lauren, et al. "Problem and Pathological Gambling are Associated with Poorer Mental and Physical Health in Older Adults." *International journal of geriatric psychiatry* 20.8 (2005): 754-9. Print.

Everett, A., Mahler, J. Biblin, J., Gangull, R., Mauer, B. (2008). Improving the health of mental health consumers: effective policies and practices. *International Journal of Mental Health*, 37 (2), 8-48. doi: 10.2753/IMH0020-7411370201

Hass, Leonar J., David C. Spendlove, and Michael P. Silver. "Expanding Mental Health Services to Older High-Utilizing HMO Patients: A Pilot Study." *Journal of Clinical Psychology in Medical Settings* 8.3 (2001): 189-97. Print.

Huffpost Healthy Living. "Older Veterans Also Have Mental Health Needs."  
<http://www.huffingpost.com/michael-friedman-lmsw/veterans-mental> (2012)

Karlin, Bradley E., and Michael Duffy. "Geriatric Mental Health Policy: Impact on Service Delivery and Directions for Effecting Change." *Professional Psychology: Research and Practice* 35.5 (2004): 509-19. Print.

Lagana, Luciana, and Sheri Shanks. "Mutual Biases Underlying the Problematic Relationship between Older Adults and Mental Health Providers: Any Solution in Sight?" *International Journal of Aging and Human Development* 55.3 (2002): 271-95. Print.

Molinari, Victor, et al. "Mental Health Services in Nursing Homes: A Survey of Nursing Home Administrative Personnel." *Aging and Mental Health* 13.3 (2009): 477-86. Print.

National Center for PTSD. PTSD and Older Veterans. *Psych Central*.  
<http://psychcentral.com/lib/2006/ptsd-and-older-veterans/all/1/>  
National Institutes of Health(2012). Aging boomers' mental health woes will swamp health system: report. *Medline Plus*.  
[www.nlm.nih.gov/medlineplus/news/fullstory\\_127086.html](http://www.nlm.nih.gov/medlineplus/news/fullstory_127086.html)

Oregon Public Health Division. State Health Profile September 2012.  
Retrieved from <http://public.health.oregon.gov/About/Documents/oregon-state-health-profile.pdf>

Preville, Michel, et al. "Physical Health and Mental Disorder in Elderly Suicide: A Case-Control Study." *Aging and Mental Health* 9.6 (2005): 576-84. Print.

Qureshi, Salah, M.D., et al. "Increased Prevalence and Incidence of Dementia in Older Veterans with Post-Traumatic Stress Disorder." *Journal of the American Geriatrics Society* (2010).

Reardon, C. (2012). The changing faces of older adult substance abuse. *Social Work Today*, 12 (1). [www.socialworktoday.com/archive/012312p8.shtml](http://www.socialworktoday.com/archive/012312p8.shtml)

Robb, C., et al. "Attitudes Towards Mental Health Care in Younger and Older Adults: Similarities and Differences." *Aging and Mental Health* 7.2 (2003): 142-52. Print.

Robison, Julie, et al. "Mental Health in Senior Housing: Racial/ethnic Patterns and Correlates of Major Depressive Disorder." *Aging and Mental Health* 13.5 (2009): 659-73. Print.

Sorkin, Dara H., Pham, E., Ngo-Metzger, Q. "Racial and Ethnic Differences in the Mental Health Needs and Access to Care of Older Adults in California." *Journal of the American Geriatrics Society* 57.12 (2009): 2311-7. Print.

Tai-Seale, Ming, et al. "Two-Minute Mental Health Care for Elderly Patients: Inside Primary Care Visits." *Journal of the American Geriatrics Society* 55.12 (2007): 1903-11. Print.

# Table of Contents

Introduction .....	pg. 1
Work Group Membership .....	pg. 3
Executive Summary .....	pg. 4
Guiding Principles .....	pg. 7
Program and Policy Recommendations .....	pg. 9
Overview of Problem/Review of Literature .....	pg. 17
Bibliography .....	pg. 33