



Seniors Behavioral Health Coalition 2009 Report

Partnering to Serve Seniors



4111 Minnesota Dr.
Anchorage, AK 99503
907-565-1214
www.akeela.org

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I. Introduction.

1. General. This report has been developed and is submitted to detail the activities and accomplishments of the Senior Behavioral Health Coalition (Akeela, Inc. lead agency) for fiscal year 2009. This past year has been a planning period marked by the development and refinement of the coalition, gathering and analyzing quantitative and qualitative information, acquiring and cataloging Anchorage resource information, and identifying potential interventions that are consistent with the assessment information. In this report, we will provide a brief introduction, a summary of methodology, qualitative and quantitative analyses, conclusions and plans, along with supporting documentation in the appendices.

2. Background. The overarching prevention goal of this project is to reduce the risk for, and incidence of, substance abuse and mental health problems in Alaska’s senior population—defined for the purposes of this project as anyone 60+ years of age. This issue has been referred to as the “silent epidemic” and was recently described by former SAMHSA Administrator Charlie Curie as “under-estimated, under-identified, under-diagnosed, and under-treated.”

Demographic projections indicate that the aging of the “baby boom” generation will increase the proportion of persons over age 65 from 13 percent currently to 20 percent by the year 2030. Acknowledging this trend, the first topic addressed in *Moving Forward, Comprehensive Integrated Mental Health Plan 2006–2011*, is our aging population and the need to address the emerging needs of our seniors. By the year 2030, the number of older persons with psychiatric disorders—including substance abuse disorders—will equal or exceed the number with mental illness in the younger age groups.ⁱ Furthermore, it is estimated that the number of older adults with substance abuse problems will double between now and 2020, and approximately 50 percent of persons aged 50 to 70 will be in a high-risk group.ⁱⁱ

The original proposal for this project was submitted in response to the *Comprehensive Behavioral Health Prevention & Early Intervention Services* RFP, the overall goal of which is to “promote a healthy community utilizing effective practices and partnerships.” As stated in the RFP, the prescribed outcomes which we propose to address are: (1) Alaskans are free from the harmful effects of substance use and dependency, and (2) Alaskan children, youth and adults are mentally healthy and living successfully. Although the initial proposal included a component to expand to pilots and activities in other communities, the final project is limited in scope to Anchorage and the surrounding areas.

During this past year, the primary focus was on planning with key activities centered around refinement and engagement of the coalition, information and data gathering, and review of potential actions.

II. Methodology.

1. General. During fiscal year 2009, which can be characterized as a planning period for this project, we pursued four distinct sets of activities in parallel. The first broad effort was to continue to build, refine, and engage the community coalition related to the project. The second effort was to gather data and information both through accessing of quantitative data and past studies and through a combination of focus groups, surveys, and key informant interviews. The third focus was to develop a theory of change document to help us identify the relevant risk factors and assess potential strategies. The final broad effort was to begin examining potential interventions and project activities as indicated both by the information gathering and by coalition input. Overall, the planning process followed the State Incentive Grant/Strategic Prevention Framework model, which mandates the following broad activity sequence:

- Assessment
- Capacity Building
- Development of a Strategic Plan
- Implementation of Prevention Interventions and Pilots (to be done during the coming year)
- Evaluation (ongoing this year and in subsequent years)

2. Coalition Development and Maintenance Work. The only reasonable approach to a project such as this is to work in collaboration with other agencies and individuals that either work with the senior population or have a substantial interest in issues related to behavioral health and this population. The beginning point for this organization was the initial Seniors Behavioral Health Outreach and Prevention Coalition that had formed prior to the submission of our initial proposal. During the process, we made a conscious decision to cast as “wide a net” as possible to involve individuals and organizations in the coalition. Part of the structure and design of activities was intended to elicit engagement without requiring onerous tasks and commitments that can discourage longer term participation. The resulting coalition roster is included as Appendix A to this report.

Meetings were held at least bi-monthly increasing to monthly as required to accomplish key tasks. The schedule of coalition meetings is included as Appendix B to this report. The early meetings were focused on trying to define the extent of the problems related to behavioral health among seniors, assess existing community resources, and identify other stakeholders that should be at the table. As the year progressed, the focus shifted to assessing information that had been compiled, looking at the range of interventions and options available, and planning for the upcoming fiscal year.

Meeting locations were varied in order to involve more people and avoid the appearance that this project was “all about” one single organization. Meetings were held at the Anchorage offices of the Alaska State Hospital and Nursing Home Association, the Anchorage Senior Center, Chugach Manor senior housing center, The Alaska Mental Health Trust Authority, and Akeela, Inc. Meetings were scheduled using an online scheduler that polled members to identify potential available meeting dates. Agendas and minutes were published and distributed ahead of time along with relevant supporting

material. Individual one-to-one coalition building and maintenance was accomplished by the project planner along with the Deputy Director of Akeela, Inc.

Casting a “wide net” and engaging a larger number of participants, while vastly improving the scope of input to the project, presented challenges related to managing the project, making decisions, and accomplishing much of the work. To respond to this issue, a steering committee of five members intended to manage and guide the project was formed. The steering committee members were representatives of Anchorage Community Mental Health System, AARP, Alaska Commission on Aging, Akeela, Inc., and Alaska Division of Senior and Disability Services with the project evaluator serving as an ex-officio member.

2. Data/Information Gathering and Analysis. Information and data used in assessing the nature and extent of the problem in Anchorage, existing resources, and community readiness for change was acquired through review of existing research and data from various sources, community readiness surveys, focus groups, key informant interviews, and coalition input.

Research and data gathering targeted publications and research either presented or linked at the Substance Abuse and Mental Health Administration (SAMHSA) web site, State of Alaska resources ranging from behavioral health information to Department of Labor and Workforce Development data, and relevant information from other states and programs. The population and prevalence data are presented in Section III of this report. Qualitative information from other sources is presented in section IV of this report.

The community readiness survey was based on the Tri-Ethnic Center for Prevention Research model of community readiness. We solicited appropriate contact information from the coalition members for individuals in the community that would provide objective information related to behavioral health issues and the community’s readiness to address these. The survey instrument provided as a part of this model was modified to reflect behavioral health issues. The survey was conducted online. We finished the collection and scoring of surveys in December, and made use of incentives by mailing out \$25 Barnes and Noble gift cards to each participant upon survey completion.

3. Development of Theory of Change Document. With the information and data collected we were able to fully develop the theory of change document that identifies the problem, risk factors, and potential interventions. The completed theory of change document is included as Appendix D to this report. The development of this document was accomplished by the coalition meetings and was facilitated by the Deputy Director of Akeela, Inc. The process began with the effort to clearly identify the problem and proceeded on to discussions about risk factors both generally and specific to Anchorage. The potential strategies for addressing these were checked against the list of resources developed during the information gathering stage. As a result of this step, the group identified two risk factors that they felt they could address and then began considering strategies specific to those factors. The resulting conclusions and plans related to these are presented in Section V of this report.

4. Review and Consideration of Potential Interventions and Activities. As the project entered its final three months of fiscal year 2009, the focus of the effort moved to consideration of various potential interventions and activities for the upcoming year. Potential interventions and activities were identified both by project staff (acquired in research or at various national training sessions and seminars) and through coalition input at meetings. In considering these various interventions, the group was guided by:

- The extent to which the interventions addressed the risk factors targeted
- The viability of implementation
- Potential cost and likely availability of funding
- Whether similar programs or efforts were already in place
- The extent to which the activities or interventions were evidence-based
- The preferences of the coalition and steering committee

Specific conclusions and plans are presented in section V of this report.

III. Quantitative Analysis.

Introduction. This section provides an overview of the population data including projections along with prevalence data for substance abuse and mental health disorders. This is a necessary first step in understanding the scope and impact of the problems.

In presenting this information, we will start first by looking at the population of Alaska and Anchorage and how it has changed during the past seven years. We will follow up by presenting population projections through year 2030. These presentations will be followed by prevalence data related to substance abuse, mental health, and co-occurring disorders. Within the prevalence data, we also make extrapolations to estimate Anchorage prevalence using both population and prevalence data that applies statewide and nationally.

1. Population Growth 2000-2007

Population Data

Table 11 - Population Growth 2000-2007

Alaska			
Measure/Population	2000	2007	CAGR
Total Population	626,932	676,987	1.10%
Population Age 60+	53,026	76,348	5.35%
Population Age 80+	6,329	9,945	6.67%
Anchorage/Mat-Su Valley Combined			
Measure/Population	2000	2007	CAGR
Total Population	319,605	363,879	1.87%
Population Age 60+	26,384	39,468	5.92%
Population Age 80+	3,057	5,140	7.71%
Municipality of Anchorage			
Measure/Population	2000	2007	CAGR
Total Population	260,283	283,823	1.24%
Population Age 60+	21,160	30,637	5.43%
Population Age 80+	2,542	4,102	7.08%

Data Source: Alaska Department of Labor and Workforce Development

Discussion. Between 2000 and 2007 Alaska continued to grow in terms of overall population although at a very modest 1.10% compound annual growth rate. The growth rate for the senior population is somewhat higher with the age group 60 and over growing at 5.35% and the 80 and over segment growing at 6.67%. The next two sets of data tell us that the Anchorage/Mat-Su area and the Municipality of Anchorage alone are both growing at rates exceeding the overall state growth rate. The trend of age group growth, however, is consistent across the areas. The population of older Alaskans grew at a higher rate than the population at large.

2. Projected Population Growth through 2030.

Projected Population Data. Note that, in examining population trend projections, we are using 2006 as our base year rather than the 2007 data noted in the tables above. We are doing this because the State of Alaska Department of Labor and Workforce Development projections used this in their projections. For purposes of this assessment, we are presenting projections for years 2020 and 2030. Data are also available for years 2010, 2015, and 2025.

Table 22 - Projected Population Growth 2006 - 2030

Year	Alaska			
	Total		Age 65+	
	Population	CAGR (2006)	Population	CAGR (2006)
2006	670,053	n/a	45,489	n/a
2020	771,465	1.01%	98,902	5.70%
2030	838,676	0.60%	134,391	2.21%
Year	Municipality of Anchorage			
	Total		Age 65+	
	Population	CAGR (2006)	Population	CAGR (2006)
2006	282,813	n/a	17,583	n/a
2020	322,087	0.93%	40,821	6.20%
2030	350,871	0.61%	56,206	2.31%

Data Source: Alaska Department of Labor and Workforce Development

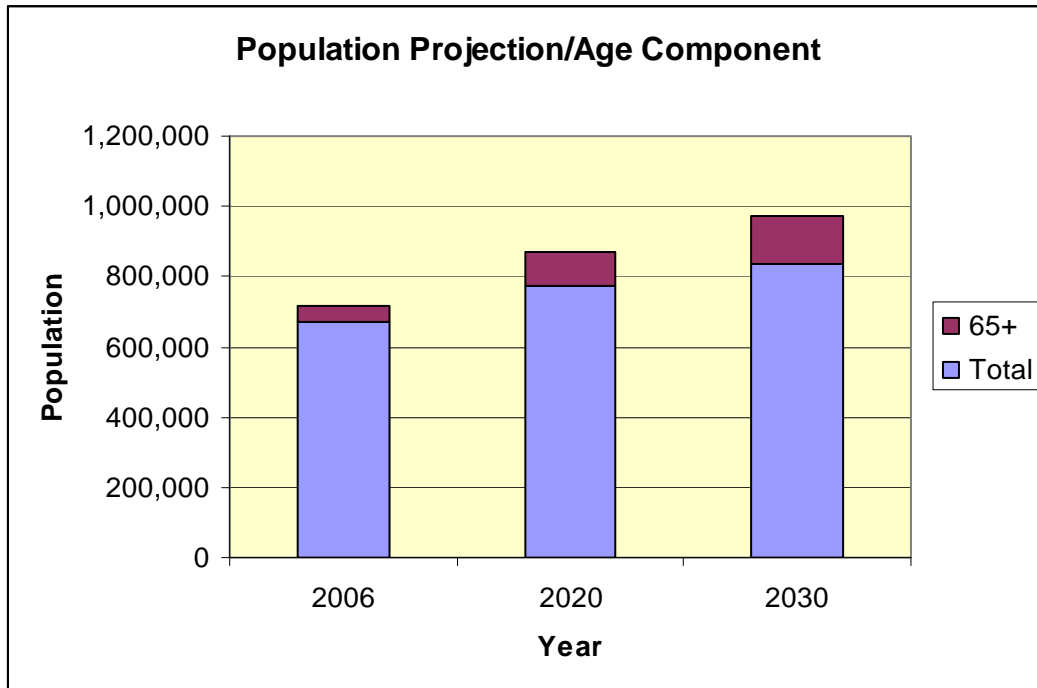
Discussion. There are several points of interest here. First, we can see that the growth projections of the population segments based on age is consistent with the 2000-2007 growth figures. We see a projected growth in the older Alaskan population greater than the population overall in the state. The second point of interest is that the rate of growth seems to hold steady through 2020 and, although growth continues after that, the rate of growth falls off somewhat between 2020 and 2030.

Presented another way, older Alaskans constituted 6.79% of the overall state population and 6.22% of the Anchorage population in 2006. By the year 2020, the Alaska Department of Labor and Workforce

Development expects older Alaskans to comprise 11.65% and 12.67% of the statewide and Anchorage total population respectively. By 2030 those percentages are projected to be 16.02% for both areas.

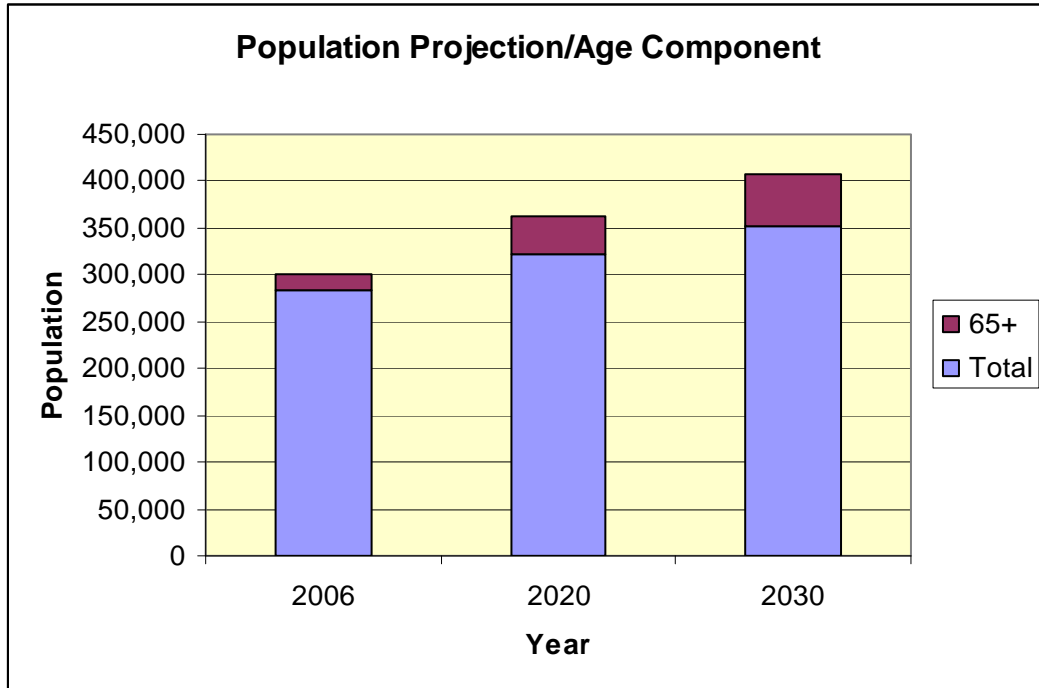
Figures 1 and 2 show the growth of the older Alaskans population relative to the overall state and Anchorage populations.

Figure 11 - Growth Projection for Older Alaskans Population Relative to Total Alaska Population.



Data Source: Alaska Department of Labor and Workforce Development

Figure 22 - Growth Projection for Older Anchorage Population Relative to Total Anchorage Population.



Data Source: Alaska Department of Labor and Workforce Development

3. Substance Abuse and Mental Health Prevalence Data. In gathering data related to substance abuse and mental health, we found ample data on overall prevalence, very good data both on prevalence by state and prevalence by age. What we found lacking is prevalence by state by age. In other words, we can know with some degree of confidence what the prevalence is in Alaska and we can know with some degree of confidence what the national prevalence is for older persons but we cannot know with any degree of confidence the prevalence for older Alaskans specifically. We will, however, extrapolate to produce estimates of prevalence for older Alaskans and, by extension, those that live in Anchorage.

One of the most reliable and consistent sources of prevalence data for substance use is the annual **National Survey on Drug Use and Health** sponsored by the U. S. Substance Abuse and Mental Health Services Administration. The following table details selected prevalence measures for Alaska and the United States based on the **2007 National Survey on Drug Use and Health**.

Table 33 - Alaska and United States Substance Abuse and Mental Health Prevalence (Percentage of Population 12 and older)

Measure	Alaska	United States
Alcohol Use Last Month	52.75%	51.37%
Binge Alcohol Use Last Month	21.58%	22.82%
Perception of Great Risk of => 5 Drinks	36.96%	41.69%
Alcohol Abuse or Dependence	7.78%	7.66%
Alcohol Dependence	4.19%	3.35%
Needing but not Receiving Alcohol Treatment	7.27%	7.30%
Serious Psychological Distress	11.34%	11.29%
Major Depressive Episode	6.82%	7.25%
Non-medical Use of Pain Relievers	5.47%	5.00%

Data Source: 2007 National Survey on Drug Abuse and Health (SAMHSA)

Overall, we can see that Alaska fares better than the national population on some items and worse on others. Generally, however, we are not that far from the prevalence seen in the rest of the country. Looked at another way, Alaskans are not fundamentally different from people in the rest of the country.

In the same survey, SAMHSA analyzed substance use by age category at the national level. Tables 4 and 5 detail the findings for alcohol and for illicit drugs, which includes the abuse of prescription medication.

Table 44 - Prevalence of Alcohol Use Among Older Americans 2006-2007

Age Group	Alcohol Use		Binge Alcohol Use		Heavy Alcohol Use	
	2006	2007	2006	2007	2006	2007
Total	50.9%	51.1%	23.0%	23.3%	6.9%	6.9%
50-54	55.9%	57.0%	22.0%	21.5%	6.7%	6.3%
55-59	53.0%	52.0%	13.8%	15.9%	4.6%	4.5%
60-64	48.0%	47.6%	12.8%	12.1%	2.7%	2.9%
65 or Older	38.4%	38.1%	7.6%	7.6%	1.6%	1.4%

Data Source: Results from the 2007 National Survey on Drug Use and Health: National Findings (SAMHSA)

What is perhaps most striking about this table is that Americans in their 50s tend to use alcohol at a higher rate than the rest of the population, although they report binge and heavy use at a slightly lower rate. We can also see that the report of use, binge use, and heavy use fall off after age 60.

Table 55 - Prevalence of Illicit Drug Use Among Older Americans 2006-2007

	Lifetime		Past Year		Past Month	
	2006	2007	2006	2007	2006	2007
Total	45.4%	46.1%	14.5%	14.4%	8.3%	8.0%
50-54	54.6%	58.9%	9.1%	10.6%	6.0%	5.7%
55-59	43.4%	51.6%	4.9%	8.0%	2.4%	4.1%
60-64	28.2%	35.0%	3.4%	4.4%	2.1%	1.9%
65 or Older	9.8%	10.7%	1.1%	1.0%	0.7%	0.7%

Data Source: Results from the 2007 National Survey on Drug Use and Health: National Findings (SAMHSA)

The big caveat here is that this particular category includes illegal substances such as marijuana as well as non-medical use of prescription medications. While these categories are analyzed separately in the report, that analysis is not stratified by age. There are several striking points in this information. First, as we might expect, the use of a substance at any time during their lives is much higher than recent use. In other words, many may have used these substances at one point in their lives but far fewer report recent use (within the last year or month). The second key point is that the age group 50-54 reports higher lifetime use but lower current use rates. Finally, being consistent with alcohol data, use falls off rapidly after age 60.

In a 2002 study SAMHSA analyzed the data from the 1999 National Household Survey and found that about 3.5% of all substance abusers were 50 years old or older, which translated into about 2.5 million nationally. Of these, 86.6% abused alcohol only while an additional 5.5% abused both alcohol and other drugs (including non-medical use of prescription drugs). They projected an increase of just over 5 million by the year 2020 with people ages 50 and older constituting 4.5% of the substance abusing population. Although not quantified, the authors also concluded that we will see a shift in substances abused to reflect a higher percentage using drugs other than alcohol.

They also noted that prevalence rates developed by different methodologies suffer from the fact that, among older persons, there are a variety of mechanisms that can mask problems. For example, over time people age out of the work place and so the work-related manifestation of substance use problems fades. Likewise, people tend to drive less and so may not be as likely to get arrested for driving under the influence. ⁱⁱⁱ

The challenge with this data and information is in trying to apply it to Alaska or even Anchorage citizens. Generally, we can see from Table 3 that Alaskans do not seem to be that far off of national trends. That being the case, can we assume that this applies to all age groups? Is drug use in Alaskan seniors comparable to that in the U. S. population at large? If we make this assumption, then we can extrapolate the magnitude of alcohol and other drug use for Older Alaskans and, more specifically, those living in Anchorage, including simple estimates of future numbers. Table 6 provides extrapolated data based on these assumptions.

Table 66 - Current and Projected Alcohol Use Alaska and Anchorage 2006-2020

Alaska						
	Alcohol Use		Binge Alcohol Use		Heavy Alcohol Use	
	Total	65+	Total	65+	Total	65+
2006	287,298	17,468	129,820	3,457	38,946	728
2020	330,324	37,978	149,262	7,517	44,779	1,582
Municipality of Anchorage						
	Alcohol Use		Binge Alcohol Use		Heavy Alcohol Use	
	Total	65+	Total	65+	Total	65+
2006	120,910	6,752	54,635	1,336	16,390	281
2020	139,387	15,675	62,984	3,102	18,895	653

Data Source: Extrapolated from National Prevalence Data and Alaska Population Data (SAMHA & Alaska Department of Labor and Workforce Development)

Note: The national data considered individuals 12 years old and older. Alaska population data for this period was broken out by age groups 10-14 and 15-29. We chose to apply the percentages to all Alaskans 10 years old and older, which would affect the results slightly. In the table above we begin to see the magnitude in numbers that Alaska and Anchorage in particular is going to work with in terms of alcohol use. What these numbers do not factor in is any changes in the attitudes and values of the age cohorts. In other words, this simple linear extrapolation assumes that values and attitudes of age groups do not change over time – that the values of any group of 40 – 50 year old individuals is the same as a group of 40 – 50 year olds that existed in the past or future. If a younger generation is more

accepting of substance use that the previous generation, it seems reasonable to assume that this acceptance will at least be partially retained as the younger generation ages giving them a higher probability of use.

Table 77 - Current and Projected Illicit Drug Use Alaska and Anchorage 2006-2020

Alaska						
	Used in Lifetime		Used Last Year		Used Last Month	
	Total	65+	Total	65+	Total	65+
2006	256,253	4,458	81,843	500	46,848	318
2020	294,631	9,692	149,262	7,517	44,779	1,582
Municipality of Anchorage						
	Used in Lifetime		Used Last Year		Used Last Month	
	Total	65+	Total	65+	Total	65+
2006	107,709	1,723	34,444	193	19,716	123
2020	124,326	4,000	39,708	449	22,729	286

Data Source: Extrapolated from National Prevalence Data and Alaska Population Data (SAMHA & Alaska Department of Labor and Workforce Development)

This table reflects the same points as Table 6.

Prevalence data for mental health issues and mental illness were also taken from results of the **National Household Survey on Use and Health**. In reviewing the reports, we found two key measures currently being tracked – individuals experiencing severe psychological stress and individuals experiencing a major depressive episode. Table 8 provides national and Alaska data from the 2006 survey related to mental health. National data provides a specific finding for persons 50 years of age and older whereas Alaska data provides only for total adults (18 and older) and adults 26 years of age and older.

Table 88 - Prevalence of Mental Health Problems 2006 National and Alaska

National Data (2006)		
Measure	All Adults	Adults 50 and over
Serious Psychological Distress Last Year	11.3%	6.9%
Major Depressive Episode Last Year	7.5%	4.2% (males) 7.2% (females)
Alaska Data (2006)		
Measure	All Adults	Adults 26 and over
Serious Psychological Distress Last Year	11.3%	10.1%
Major Depressive Episode Last Year	6.8%	6.5%

Data Source: Results from the 2007 National Survey on Drug Use and Health: National Findings (SAMHSA)

We can see that, similar to the substance abuse findings, prevalence data for Alaska is comparable to that for the national population. Because there is a strata in the national data for adults 50 years of age and older and no such strata for Alaska, making direct comparisons for older Alaskans is problematic. What seems clear is that, at the national level, reported mental health problems decline with age. The very limited data for Alaska seem consistent, although inconclusive given that the only strata for older Alaskans is included with all adults 26 years of age and older.

One final area of interest is the prevalence of co-occurring disorders. SAMHSA provides an estimate of prevalence for both abuse and dependence of substances co-occurring with serious psychological distress and major depressive episodes. The prevalence data for 2003-2004 is reflected in Table 9. The prevalence data for co-occurring disorders was not stratified by state or by age group.

Table 99 - National Prevalence of Co-Occurring Disorders 2004

Substance Abuse Problems Co-Occurring with Serious Psychological Distress		
Category of Substance	Dependence	Dependence/Abuse
Alcohol Only	9.9%	21.0%
Both Alcohol and Illicit Drugs	9.9%	33.1%
Substance Abuse Problems Co-Occurring with Major Depressive Episode		
Category of Substance	Dependence	Dependence/Abuse
Alcohol Only	11.7%	17.4%
Both Alcohol and Illicit Drugs	2.4%	4.0%

Data Source: SAMHSA Mental Health Prevalence Estimates 2003-2004

Using these national percentages and assuming that the prevalence is comparable in Alaska, we can extrapolate to estimate the number of adults in Alaska and Anchorage that would be expected to experience co-occurring disorders. This number, however, is not stratified by age group and there is little in the national data that would allow an extrapolation of this nature with any degree of confidence. Additionally, we are using 2004 prevalence estimates applied to 2006 population data for Alaska and Anchorage.

Table 1010 - Co-Occurring Disorder Prevalence Estimate for Alaskans 10 Years old or Older

Substance Abuse Problems Co-Occurring with Serious Psychological Distress		
Category of Substance	Dependence	Dependence/Abuse
Alcohol Only	55,878	118,531
Both Alcohol and Illicit Drugs	55,878	186,828
Substance Abuse Problems Co-Occurring with Major Depressive Episode		
Category of Substance	Dependence	Dependence/Abuse
Alcohol Only	66,039	98,212
Both Alcohol and Illicit Drugs	13,546	22,577

Data Source: Extrapolated from SAMHSA Mental Health Prevalence Estimates 2003-2004 and Alaska Department of Labor and Workforce Development Population Data

Table 1111 - Co-Occurring Disorder Prevalence Estimate for Anchorage Residents 10 Years Old or Older

Substance Abuse Problems Co-Occurring with Serious Psychological Distress		
Category of Substance	Dependence	Dependence/Abuse
Alcohol Only	23,516	49,884
Both Alcohol and Illicit Drugs	23,516	78,627
Substance Abuse Problems Co-Occurring with Major Depressive Episode		
Category of Substance	Dependence	Dependence/Abuse
Alcohol Only	27,793	41,333
Both Alcohol and Illicit Drugs	5,701	9,502

Data Source: Extrapolated from SAMHSA Mental Health Prevalence Estimates 2003-2004 and Alaska Department of Labor and Workforce Development Population Data

Another note of caution – these are estimates for the entire population (10 years old and older) and cannot be readily applied to the population of older Alaskans and older Anchorage residents.

IV. Qualitative Analysis.

1. General. Qualitative assessment was conducted based on the community readiness survey, key informant interviews, focus groups, and coalition input. This was combined with the assessment of prevalence and population data to help refine the problem and identify risk factors.

2. Community Readiness Results. This assessment has given us further insight into current resources, service gaps, and knowledge and perceived attitudes of community members regarding this issue. Our overall community readiness score came out to a 2.7, which falls between the *denial/resistance* stage and the *vague awareness* stage, the .7 pushing it closer to the vague awareness stage. According to the Tri-Ethnic Model, the approach for communities that are in the denial/resistance state is to raise awareness that the problem or issue exists in this community. The approach for communities in the vague awareness stage is to raise awareness that the community can *do* something. Both of these involve raising awareness, as our surveys repeatedly voiced the need for.

3. Focus Groups and Key Informant Interviews. Focus groups were conducted with providers of behavior health services for seniors, providers of other types of services for seniors, and a group of seniors. Although we hoped to have a group of family members and a group of people from the faith community, we were not able to locate enough of either group and so key informant interviews were conducted with individuals. While there were a few questions that differed between the three groups, we did use a core set of questions that applied to all three. The core questions for the focus groups are included as Appendix C to this report. The following is a summary of the relevant findings of these focus groups and interviews. The discussion is structured around the core focus group and interview questions:

- ***Extent of the Problem among Seniors*** – This was generally the first question dealt with and, as it turns out, evoked the most intense discussion. The basis of this discussion was on deciding exactly what constitutes “the problem.” For some groups, such as providers of substance abuse or mental health treatment, the problem exists when some clinical condition is present. For lay persons and, in particular, seniors, it is not so clear. As one participant succinctly put it, “It is a problem when it is a problem.” In other words, the mere fact that a person drinks or uses, even to what some might call “excess,” does not necessarily satisfy the definition of “problem.” There was more uniform agreement on the fact that when a person’s behavioral health began to have a negative impact on others (family, friends, etc.) then it begins to rise to the level of a problem. When their use begins to take a toll on their health, beyond what would normally be expected of health problems for seniors, then it becomes a problem. With this established, answering the question about prevalence was a bit more straightforward. Most participants personally knew of at least one person whose substance use or mental health status qualified as a problem, although almost all were quick to note that it was by no means the “rampant.” The responses here were not inconsistent with the prevalence findings presented in section III of this report.

- Determination of whether it is a Problem** – The response to this question was largely a reiteration of the first; the discussion of impact and effect rather than clinical diagnosis. Part of the reason for this was given as the fact that there are no good mechanisms for getting diagnoses, especially when the individual does not perceive that there is a problem. Seniors in particular cited the fact that, in this population, there are fewer opportunities for elements of society that deal with these problems to see the impact on seniors; there are fewer society checks. For example, usual intervention flags such as work-related observations, DUIs, school performance, etc. do not apply to this population. It is relatively easy for them to “stay under the radar.” The question then becomes one of, if the individual is “under the radar” and their problems have not come to anyone’s attention, to what extent is it a problem? This goes back to the initial idea that “It is a problem when it is a problem.” On the other hand, continuous drinking or ongoing depression that goes unnoticed and untreated has the real potential to erupt into substantial negative consequences without warning in this population. In the minds of the participants of these groups, it requires a balancing act as well as a focus on providing objective, non-judgmental information in a non-threatening environment. There was also a concern on the part of some individuals in interviews that, even though people might make bad choices in their lives, it is their right to make those choices. The point of conflict is the fact that the consequences of these choices have the potential to impact a wide range of people and affect service delivery organizations.
- Impact on the Lives of Seniors and Others** - Again, this topic was tied, in terms of discussion, to the two prior topics. In fact, the presence of effect on the lives of others was a primary criteria for the initial definition of the problem. The discussion focused on effect in two ways – (1) the effect on the individual and (2) the effect on others. The discussion about the effect on the individual was not as clear cut as we probably expected. There was the explicit recognition that these problems could shorten lives and deteriorate the quality of lives. On the other hand, there were mitigating factors. Some suggested that dealing with some of the problems that older people face is often easier with some use of alcohol or other substance. Another point was that, as bad as these problems might be, the potential for change may even be scarier. While this does relate more to a subsequent question (barriers to getting help), it does relate to the impact on people’s lives since, strictly looking at the individual in question, there is a trade off.

The discussion of impact on the lives of others was a bit more definite. Some of the effects (mentioned previously) were the need for specialized care that placed an additional burden on families, the deterioration of relationships within families including poor role modeling for younger people, financial impact (cost of substances and cost of medical care), health problems that affected relationships within the family, and the burden that this can place on service delivery systems (allocation of scarce resources).

- How should the problem be addressed?** The answer to this question is again tied to a criterion that, unless the issue or behavior is creating a problem other than just the consumption, there

is nothing to address. In other words, the group agreed that doing something is appropriate if it is a problem but taking action merely because a person drinks or uses may not be an appropriate thing to do.

That said, most agreed that professional help was the best approach. Some suggested counseling or programs specifically designed for seniors recognizing their special situations and problems. From a wider perspective, the groups generally agreed that more public education and awareness was a good start but that such communication should not explicitly focus on mental health or substance abuse but rather start from a general quality of life and health perspective. The reason, explained several members, is that there is often stigma associated with mental health or substance abuse that might initially discourage people from paying attention. Part of the response to this question was integrated with the next question regarding who are most trusted. Participants felt almost unanimously that the choice of initial contact points was crucial and that, among the various potential approaches, using the general health care system as a portal to assessment and services was the most likely successful approach. Seniors are likely to trust and listen to their physician and that would be an excellent starting point.

For family members, it meant having a way to get referral and resource information that was relevant and practical. This again is related to the idea of enhanced communication and promotion in a way that both informs but does not threaten. Despite the fact that it was suggested several times that a communication/promotion campaign would be useful, the discussion kept coming back to physicians and physician offices as a key point of contact with the highest chance of success.

- ***Who Seniors are most likely to Trust*** - The discussion around this question consistently came back to the physician. Because Anchorage does not have a plethora of behavioral health programs designed for seniors, it is hard for individuals or family members to know who to contact. All generally felt that the physician was the most universally accepted point of contact and was likely the most trusted. Part of this seemed due to the fact that frequent contact with the health care system is a fact of life for most seniors. Another part is that health issues overall are not as threatening and do not carry as much stigma as mental health or substance abuse issues for this group.

There was one distinction that did surface on several instances. The use of the physician as the point of entry seemed most suitable for the individual seeking help for themselves. A different question, though, is how a family member or friend might find help. This is more problematic. While discussions of this nature might be common between patient and doctor, the forum for a conversation between a system helper and a family member about problems that the individual has is less clear. Group members were not sure (and in fact asked us) who they could call to start the process of helping if they were concerned. While the social services system is set up to respond to serious and urgent problems reported by family

members, there seems little in the way of help that a family member could access to address an emerging problem that has not escalated.

So, while participants were fairly clear that the physician would be the preferred point of contact for an individual seeking help, they were unsure where a family member might seek help.

- **Barriers to Getting Help** There were a number of barriers discussed by participants; some with agreement and some with a level of disagreement.
 - *Stigma* – The willingness to even ask for help or raise this kind of topic is counter to what many seniors believe is “acceptable.”
 - *Time Availability with Physicians* – While many participants felt that seniors had access to physicians, there were differing views on how much time patients had to discuss issues with their physicians. Some felt that seniors are rushed in and rushed out of meetings with physicians and the opportunity and timing is just not right for that. Other members felt that there was ample time if the physicians could be convinced to inform themselves about the problems and be willing to have the discussions.
 - *Fear of Change* – The point was made by several participants that, for people whose lives were structured a certain way, the prospect of “a better life” had to be tempered with a fear of change. The statement was made by one group member that while the life of misery may be bad, the uncertainty of change may be worse for them.
 - *Lack of Programs/Approaches for Seniors* – There was general agreement that standard mental health and substance abuse approaches that might work well for children or young adults may be viewed as less relevant for seniors.
 - *Lack of Knowledge* – Several participants suggested that there was a general lack of knowledge about the problem, its manifestation in seniors, and approaches that work among the general population and specifically among some of the helping organizations (that are not necessarily involved with the issues). In other words, organizations that might be expected to recognize symptoms and refer people for help are not necessarily that knowledgeable about what to look for or how to find help...or even what works and what does not.

4. Coalition Member Input. During the course of our work this first year, coalition meetings typically produced some valuable insight into the nature and extent of the problems along with insights into potential interventions and activities. These were introduced and vetted in the at-large coalition meetings and discussed in greater detail in the steering committee meetings. Some of the key points brought up by Coalition members were:

- ***Abuse of Prescription Medications and the Need for a Medication Disposal Service*** – As people age, frequently they take more medications to deal with a variety of health-related issues. As might be expected, these medications sometimes expire before used and often the conditions for which they are prescribed are resolved and the individual is left with the medication in their

medicine cabinet. This gives rise to two phenomena. The first is sharing of medications where a person with leftover medications will give them to others who express a need. In addition to the issue of expiration, this also bypasses the safety features of having pharmacists and physicians involved in this process. A second phenomenon is having others (children or grandchildren, for example) surreptitiously take the medications from the cabinet for their own use or even to sell. Another potential adverse effect of this situation is that people flush medications down the toilet, which has the long term potential of introducing dangerous substances into the water table in an area. Some other states and jurisdictions have established medication disposal programs to deal with this. The project director for this coalition contacted a variety of stakeholders (local police, pharmacy board, etc.) and discovered that there was a degree of enthusiasm about the potential for such a program in Anchorage.

- ***Risk Factors for Behavior Health Problems for Alaskan Seniors*** – Coalition members spent considerable time discussing risk factors specific to seniors overall as well as those specific to Alaska. These risk factors include:
 - Generally unfavorable attitudes in our society related to seniors
 - Attitudes of seniors about mental health and substance use (exacerbated by the Alaskan culture of “rugged individualism and self reliance”)
 - The changing of identities and roles in life as we age
 - Isolation and separation from family
 - Life stage/retirement – the need to “fill the hours”
 - Alaskan specific issues related to low light, harsh climate, and sense of isolation
 - A decrease in the level of commitments and responsibilities that seniors experience (job, school, social interaction, etc.)
 - Increased availability of substances including prescription medication
 - Lack of or limited “sense of community” related specifically to seniors
 - Current economic situation that creates additional hardship and stress on seniors
 - Lack of caregivers and family
 - Family history of mental health or substance use disorders
 - Sense of loss with the aging process

These factors and accompanying discussion are presented in greater detail in the Theory of Change document that is included as Appendix D to this report.

V. Conclusions and Plans.

1. General. In this section, we present the conclusions drawn based on assessment of quantitative and qualitative information acquired during the first year of this project. Extrapolating from this, we present our tentative recommendations and plans for moving this project forward during fiscal year 2010 and beyond.

2. Conclusions.

- a) Based on data from SAMHSA from 2006 and 2007, the prevalence of use as a percentage of the age groups is mixed with some groups increasing slightly while others decrease. Overall use as a percentage of the elderly population is increasing very slightly.
- b) Based on data from the Alaska Department of Labor and Workforce Development, the senior population of Alaska (including Anchorage) is increasing dramatically and is projected to continue through at least 2020.
- c) Based on conclusions (a) and (b) above, we conclude that the number of seniors experiencing substance use and mental health problems will continue to increase significantly through 2020 (the absolute number; not the percentage).
- d) There is nothing to indicate that Alaskan trends in prevalence are remarkably different from those in the United States in general. While some risk factors identified apply specifically to Alaska, others reflect risk factors that are not geographically bound.
- e) In addition to alcohol and illegal drugs, prescription medication abuse is a problem with the senior population, which is exacerbated by the phenomena of expired medications being exchanged without regard to prescription or physician recommendations and prescription medications being taken from medicine cabinets by persons other than the person for whom they were prescribed.
- f) Substance use and mental health problems in seniors are viewed as “problems” due more to the negative impact on the individual and others around them than by a clinical diagnosis or the mere fact of using substances (“it is a problem when it is a problem.”)
- g) Accessing services and help for behavioral health issues for seniors is perceived to be easier and more likely when the access point is a physician or service provider not necessarily related to substance use or mental health. In other words, the negative connotation associated with substance use and mental health issues by seniors serves as a barrier to accessing these services directly compared to the broaching of these topics by general health care providers.
- h) Information about substance use and mental health is more readily accepted by seniors when introduced as a part of a more holistic look at wellness.

3. Recommendations and Plans. In the development of recommendations and plans, we based our decisions on the conclusions as well as the array of existing services and activities to try and introduce interventions and plans that fill existing gaps.

- a) **Medication Disposal Program** – This initiative seems to be a missing piece in the current array of services, however, implementation of such an undertaking is far more complex than presentation of an education program. We intend to pursue this issue by gathering additional specific information from stakeholders such as public safety, the medical community, and the legal community to determine the best approach to dealing with the issue given the resources available.
- b) **Information and Education about substance use and mental health for Seniors** – We propose to implement a curriculum-based program targeted to seniors and delivered in key locations (for example, Chugach Manor senior housing). Several different sets of content are being considered by the coalition as of the end of fiscal year 2009. The current intention is to finalize a decision, conduct necessary facilitator training, acquire materials, and begin presentations by the end of the second quarter.
- c) **Replicability of Programs** – As this project has progressed, we have attempted to consider approaches that might be replicated in other communities. While this project has been specific to Anchorage, we intend to make our materials and results available to other communities that may desire to implement similar initiatives.

Appendices.

Appendix A: SBH Coalition Roster

Appendix B: SBH Coalition Meeting Dates

Appendix C: Focus Group Core Questions

Appendix D: Populated Project Theory of Change

Appendix E: Coalition Mission, Vision, and Core Values

Appendix A: SBH Coalition Roster.

Name	Organizational Affiliation
Rebecca Busch	Planner, AMHB/ABADA
Randall Burns	ASHNA
Theresa Brisky	Marlow Manor
Rebecca Carlson	Akeela, Inc. (Initial Project Planner) (Steering Committee)
Maria Contreras	Director, OPAG
Denise Daniello	Executive Director, Commission on Aging (Steering Committee)
Bob Dreyer	Long Term Care Ombudsman
Nick Gonzales	Aleela, Inc. (Smokefree Alaska Project)
Steven Hamilton	Evaluator, C & S Management Associates (Ex officio, Steering Comm.)
Michelle Holloway	Geriatric Education Center
Liz Hunt	Anchorage Community Mental Health Services (Steering Committee)
Carol Jackson	Salvation Army Older Alaskans Program
Maria Johnson	Geneva Woods Pharmacy Services
Mary & George Jones	St. Patrick's Senior Group
Jocelyn Liebig	Volunteers of America, Grand Families Program
Amanda Lofgren	Division of Seniors and Disabilities Services (Steering Committee)
Pat Luby	AARP (Steering Committee)
Connie Mason	Salvation Army Older Alaskans Program
Lynda Meyer	Anchorage Department of Health and Human Services
Brenda Moore	Director, Faith Based and Community Relations Programs
Andi Nations	Executive Director, Statewide Independent Living Council
Diane Ogilvie	Deputy Director, Akeela, Inc. (Steering Committee)
Marti Pausback	Team Leader, Akeela inc. Tobacco Prevention
Kathy Roberts	Director of Senior Services, Anchorage Senior Activity Center
Rosellen Rosich	Geriatric Education Center
Alberta Rust	Community Member
Anna Sappah	Executive Director, Substance Abuse Directors Association
Larry Spellens	Community Member
Mary Sullivan	Akeela, Inc., Project Planner (Steering Committee)
David Wilson	Alaska Primary Care Association
Sheila Wright	Geriatric Education Center, UAA

Appendix B: SBH Coalition Meeting Dates.

Coalition Meeting Dates

9/30/2008

12/2/2008

2/2/2009

3/18/2009

5/14/2009

6/11/2009

7/14/2009

Steering Committee Meeting Dates

12/18/2008

2/5/2009

4/29/2009

6/30/2009

Appendix C: Focus Group Core Questions.

General Questions for each group:

- From your experience, how much of a problem is substance abuse/mental health issues among seniors?
- In what ways does this affect peoples' lives?
- How would you go about addressing this?

In addition to these core questions, the following questions were included that were specific to the group being conducted.

Older Persons

- If you had a problem, who would you most likely trust?
- What do you think is the biggest barrier to folks getting help?

Mental Health/Substance Abuse Providers

- Do people in the field tend to get training specific to seniors, or are they just considered "adults?"
- What are some approaches that might work well with this population?

Other Types of Service Providers

- In your experience, when face with these situations, what's the patient's reaction to the discussion?

Appendix D: Populated Project Theory of Change.

Theory of Change:								
When a community comes together and implement multiple strategies to address older adults and alcohol/substance abuse, older adults will likely use less and live healthier lives.								
Problem Statement			Strategies	Activities (evidence-based practices)	Resources	Outcomes		
Problem	But Why?	But Why Here?				Short-term	Intermediate	Long-term
Adverse effects of substance abuse and mental health issues among seniors 60+.	Unfavorable attitudes toward seniors	Median Age/younger state; many seniors returning to AK	Increase positive senior visibility	-Develop positive media coverage on the contributions and value of seniors in the community (PSAs, regular column coverage of seniors) - Intergenerational mentoring programs (Across Ages)				
	Senior view of mental health and substance abuse -Character flaw -Not a real issue -No confirmed definition	Rugged individualism -Cultural norms -Attitude toward social programs including SA treatment	Increase positive messages about seniors, recovery, wellness and mental health	Develop positive media coverage on the role of recovery and wellness as it relates to seniors in the community (PSAs, etc)	The Trust you know me campaign			
	Change of identity, roles	Many seniors returning to or staying in AK	Increase opportunities for meaningful community involvement	-Maintain a centralized resource and referral capacity -Promote volunteerism through the coordination of a senior volunteer service	ADRC, AK 2-1-1 VOA RSVP			

Theory of Change:								
When a community comes together and implement multiple strategies to address older adults and alcohol/substance abuse, older adults will likely use less and live healthier lives.								
Problem Statement			Strategies	Activities (evidence-based practices)	Resources	Outcomes		
Problem	But Why?	But Why Here?				Short-term	Intermediate	Long-term
Adverse effects of substance abuse and mental health issues among seniors 60+.	Isolation	Lack of family "Ruralness" Rugged individualism	Increase opportunities for meaningful community involvement	-Maintain a centralized resource and referral capacity -Promote volunteerism through the coordination of a senior volunteer service	ADRC, AK 2-1-1 VOA RSVP			
	Life Stage- Retirement Boredom/filling time	Weather/light are leaving Lack of family/Young Lack of obligations that would notice problems Harsh/challenging environment	Increase opportunities for meaningful community involvement	-Maintain a centralized resource and referral capacity -Promote volunteerism through the coordination of a senior volunteer service	ADRC, AK 2-1-1 VOA RSVP			
	Availability of alcohol and medications	Community norms regarding use	Decrease availability of medications	-Establish a medication disposal program for Anchorage. -"pharming" awareness campaign -Implement WISE programming through senior centers				
	Criteria for diagnosis (addiction/use)	Limited prevention and treatment \$; focus is on the acute (youth and	Increase knowledge of problem	Multi-tiered education outreach/media ed				

Theory of Change:								
When a community comes together and implement multiple strategies to address older adults and alcohol/substance abuse, older adults will likely use less and live healthier lives.								
Problem Statement			Strategies	Activities (evidence-based practices)	Resources	Outcomes		
Problem	But Why?	But Why Here?				Short-term	Intermediate	Long-term
Adverse effects of substance abuse and mental health issues among seniors 60+.	different	problem adults)	Increase advocacy for senior services related to problem	effort to include: -consumer -Anchorage community -medical and behavioral health providers -policy makers and legislators				
	Lack of community	Limited senior housing options as well as services including transportation	Increase advocacy efforts for safe, affordable senior housing and collateral senior friendly services.	Engage and prepare vocal advocates for seniors services that change community practices/systems	AARP			
	Current economic situation	Workforce/sustainability Cost of living is high in AK	Increase advocacy efforts for policies to improve senior economic wellbeing	-Engage and prepare vocal advocates for seniors services that change community practices/systems	AARP			
	No caregivers for family, lack of connection with family	Young leaving state	Increase advocacy efforts for programs that provide senior specific quality care.	Engage and prepare vocal advocates for seniors services that change community practices/systems	AARP			

Theory of Change:								
When a community comes together and implement multiple strategies to address older adults and alcohol/substance abuse, older adults will likely use less and live healthier lives.								
Problem Statement			Strategies	Activities (evidence-based practices)	Resources	Outcomes		
Problem	But Why?	But Why Here?				Short-term	Intermediate	Long-term
Adverse effects of substance abuse and mental health issues among seniors 60+.	Perception of financial situation <ul style="list-style-type: none"> Limited options Pension usually w/male s 	AK cost of living	Increase advocacy efforts for policies to improve senior economic wellbeing	Engage and prepare vocal advocates for seniors services that change community practices/systems	AARP			
	Family History	High rates of alcoholism/addiction in AK	Increase early identification	MH/SA Screening as part of a doctor's visit				
	Spousal loss, widow, divorce	SAD, inclement weather	Increase early identification	MH/SA Screening as part of a doctor's visit				

Appendix E: Coalition Mission, Vision, and Core Values.

MISSION - To promote a comprehensive and coordinated behavioral health services system responsive to seniors in Anchorage, with an eye towards demonstrating the applicability of the developed system to other Alaska communities.

VISION- The senior population of Anchorage maintains optimal behavioral health, and well-being free from the effects of addiction.

VALUE STATEMENTS:

To achieve our vision and mission statements, we intend to:

Build partnerships and relationships based on mutual respect and dignity.

Educate and increase community awareness of the need for senior responsive behavioral health services

Mobilize community partners to advocate for strength-based, senior responsive behavioral health services.

Empower seniors to make informed decisions to maintain their health, well-being and maximum life satisfaction.

Collaborate with community partners to provide a comprehensive and coordinating system of needed services for seniors.

References & Notes

ⁱ Older Americans Substance Abuse and Mental health technical Assistance Center. (2005). Substance Abuse and Mental Health Among Older Americans: The State of the Knowledge and Future Directions. Rockville, MD. SAMHSA

ⁱⁱ Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *Substance Use by Older Adults: Estimates of Future Impact on the Treatment System*. OAS Analytic Series #A-21, DHHS Publication No. (SMA) 03-3763, Rockville, MD, 2002

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