HEALTHY MINDS POLICY INITIATIVE

Aging and Mental Health in Oklahoma

Meeting the needs of older Oklahomans with treatable illness

Mental illnesses are not part of the normal aging process – they can and should be treated. As Oklahoma's population ages, the need for effective behavioral health systems and services for older Oklahomans will continue increasing. Although Oklahoma has taken steps to prioritize older adult mental health in recent years, the state still ranks 46th in the nation for depression among those 65 and older. It has a relatively high prevalence of suicide, depression, and other poor mental health outcomes among older adults, and services and practices specific to this population are often overlooked and underutilized.

This paper provides an overview of the older adult behavioral health landscape in Oklahoma for treatable mental illnesses, such as depression and anxiety (excluding dementia), with considerations for policy and practice next steps.

Key Findings

- **Mental health is worsening for older Oklahomans, especially since the start of the pandemic in 2020.** Suicide and unintentional overdose rates are on the rise, and prevalence of depression and frequent mental distress are higher among older Oklahomans than their counterparts nationally.
- **Older Oklahomans face treatment barriers similar to other Oklahomans,** including rural accessibility, cost, stigma related to seeking help, and unique cultural needs for some populations (such as Native Americans and those with limited English proficiency).
- **The Oklahoma health care workforce that specializes in older adults is severely limited.** Oklahoma lacks a sufficient number of health care professionals with the training and expertise needed to effectively address the mental health needs of older adults.
- To meet the needs of older Oklahomans, **the state must build a health care system that promotes whole-person health, integrated care, and appropriate supports to age in place when possible**. We present several considerations, including:
  - Specialized workforce training
  - Expanding the abilities of primary care practices to treat mental illness
  - Capitalizing on federal funding and waivers to strengthen home-based services
  - Continued and strengthened state agency coordination
  - Expanded use of community-level best practices for older Oklahomans with intensive needs, such as the Assertive Community Treatment (ACT) team model, and skill empowerment for older adults

Aging and Mental Illness: A Background

Mental health issues are not a normal part of the aging process. If this were true, the prevalence of mental disorders should increase with age. However, data reveal this is not the case. For example, the prevalence of depression in 2020 was highest among those aged 25-44 (36.5%), followed by those aged 45-64 (32.5%), those aged 65 and older (17.0%), and then those aged 18-24 (14.0%).[1] Exacerbating the problem of treating mental illness as a normal part of aging is the notion that older people will not benefit as much from intervention as younger people. Studies have shown that many mental health providers believe older adults with mental illness are either difficult to treat or untreatable.[2] According to the Substance Abuse and Mental Health Services Administration (SAMHSA), evidence-based treatments can reduce the severity of symptoms in older adults with mental illness by as much as 80%.[3] It should be noted that although symptoms of depression and dementia share similarities, they are not the same condition. While there is significant potential to treat depression and other mental illnesses in older adults, dementia is a disorder characterized by cognitive decline and currently has no cure.[4] The notion that developing mental illness is a natural part of aging is a misconception – **older adults experiencing mental illness can and should be treated**.

While mental illness is not a natural consequence of aging, older people are at risk of experiencing certain behavioral health issues related to life events that tend to coincide with aging. For instance, it is more likely for an older adult to experience the loss of a friend or spouse than it is for a younger person. The aging process can also increase difficulty communicating, perceiving the environment, and moving freely in the community. Additionally, older adults are more likely to have chronic illnesses and other physical health concerns that can negatively interact with behavioral health conditions.

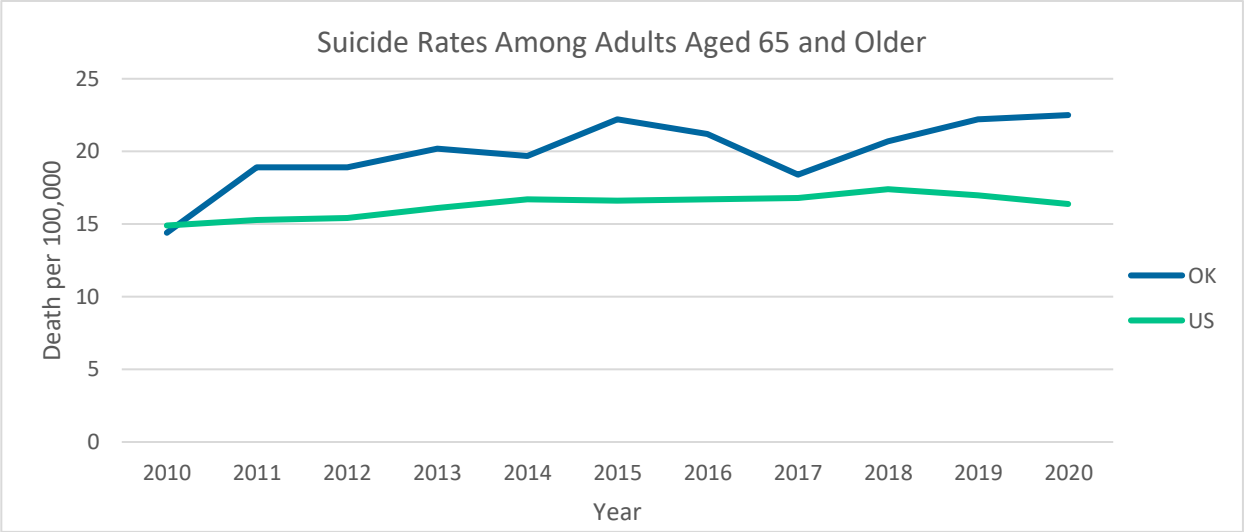
The State of Older Oklahomans' Mental Health

The older adult population has been growing exponentially in recent years. As of 2020, nearly 620,000 adults aged 65 and older live in Oklahoma, accounting for 15.7% of the total population.[5] By 2030, the U.S. Census Bureau estimates this population will increase to over 757,000 (17.8% of the population).[6] Similar increasing trends can also be seen at the national level.[7] Moreover, the racial demographics of this population are rapidly changing, becoming more ethnically diverse. From 2010 to 2020, the number of older adults in Oklahoma who identified as non-white increased from more than 64,000 to more than 98,000.[5,6]

As the older adult population increases and diversifies, so does the need for culturally competent and accessible behavioral health systems. As many as one in five older adults suffer from any mental illness, substance use disorder, or both, and approximately 1 million older adults in the U.S. will specifically suffer from a serious mental illness (SMI).[8,9] The life expectancy of those suffering from SMI is reduced by as much as 11 to 30 years compared to the general populace.[10]

As of 2022, Oklahoma ranks 46th in America's Health Rankings Annual Senior Report, which evaluates 62 unique measures of older adult health, including rates of suicide and frequent mental distress.[11] According to the Centers for Disease Control and Prevention, Oklahoma's suicide rate among those aged 65 and older has been substantially higher than the national average for most of the past 10 years (Figure 1).[12] This trend has been increasing gradually. As of 2020, older adults in Oklahoma die from suicide at a rate of 21.8 per 100,000, which is higher than the national average of 16.9 per 100,000. Similarly, the unintentional drug overdose rates among older Oklahomans have historically been much higher than national averages and continue to increase (Figure 2). Older adults in the state die from drug overdose at a rate of 8 per 100,000, which is higher than the US rate of 7.4 per 100,000.[12] The latest prevalence of both frequent mental distress (9.7%) and depression (15.8%) among Oklahoman older adults was also considerably higher than the national prevalence (8.1% and 14.3%, respectively).[13]

Figure 1: Comparing National and State Death Rates for Adults 65 and Older



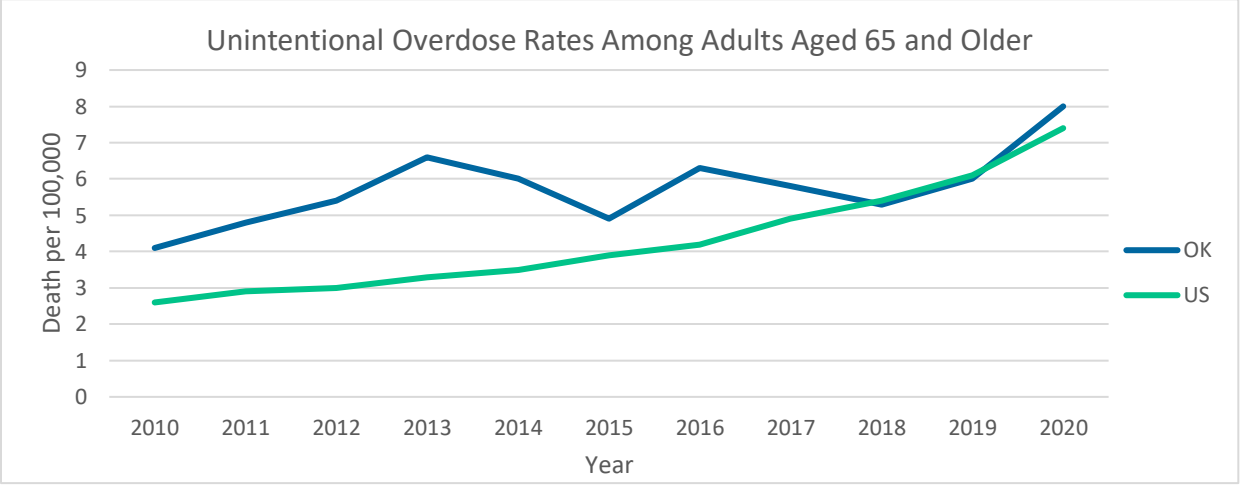
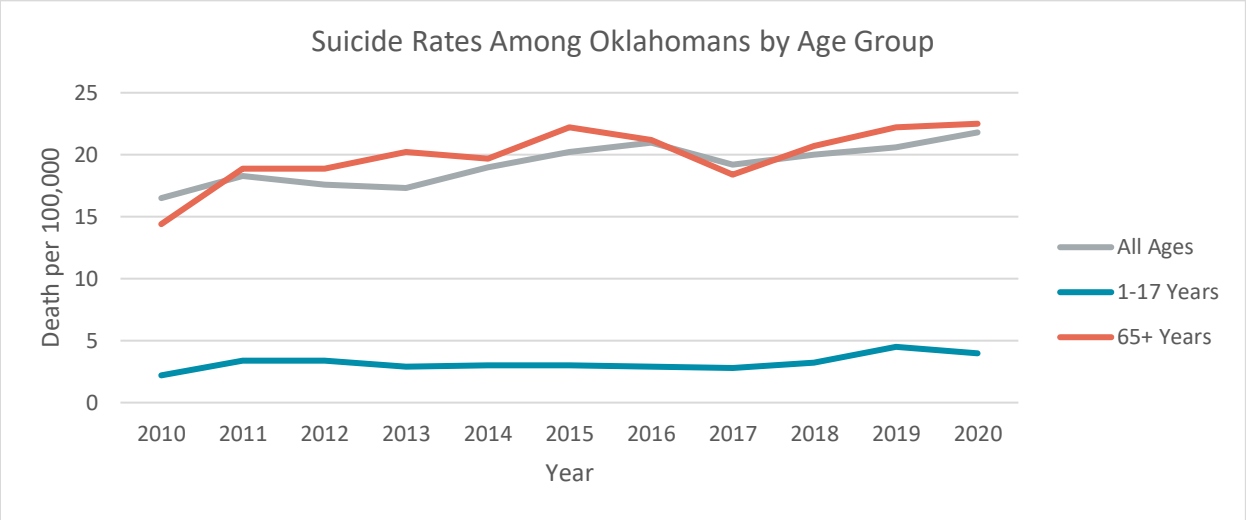


Figure 2: Comparing Suicide Death Rates of Oklahomans



The COVID-19 pandemic has also exacerbated behavioral health issues among older adults. To date, more than 81,497 (71.3%) of all reported Oklahoma COVID-19 deaths since March 2020 are adults aged 65 and older.[14] Although older adults have shown remarkable resilience throughout the pandemic, feelings of anxiety, depression, and isolation among older adults still increased.[15] All of these variables combined can lead to strong, difficult feelings for a population that might not have ever experienced these symptoms before.

Treatment Access Challenges

Lower Service Utilization

Studies have found that most older adults with symptoms of mental illness or substance use disorder often do not access behavioral health services.[16,17,18,19] In 2020, the National Survey on Drug Use and Health (NSDUH) found that only approximately 48% of U.S. adults aged 50 or older with any mental illness received treatment. Although 9.3% of U.S. adults aged 50 or older have a substance use disorder, only 1.1% of U.S. adults aged 50 or older received substance use treatment in 2020.[9] Low service utilization among older adults has been attributed to several factors, including, but not limited to, cost, the belief they do not need help, lack of knowledge of services, stigma, and an inability to recognize how mental illness symptoms present in older adults.[20] In Oklahoma, 4.8% of older adults avoid care due to costs, which is higher than the U.S. average of 4.2%.[9] The number one reason for avoiding mental health care in Oklahoma is due to cost. Although most older U.S. adults have some form of behavioral health care coverage through Medicare, reports by the Commonwealth Fund have found that U.S. Medicare beneficiaries are more likely to skip care and experience economic hardship compared to older adults from other high-income countries despite reporting higher needs, indicating cost is likely a major barrier.[21]

Leaving mental health conditions untreated in older adults leads to higher utilization of physical health care and emergency services, as well as an increased financial cost when compared to older adults who are not experiencing mental health issues. Older adults with mental illness are more likely to visit a doctor or emergency room, use more medication, have higher outpatient costs, and have more hospital utilization compared to older adults without mental illness.[22] If mental health conditions are treated early, this additional strain on hospital systems can be avoided.

In terms of cost, one study that used a population health survey for adults aged 65 and older found the excess annual adjusted healthcare costs of depression, anxiety, and comorbid depression and anxiety reached $27.4 million, $80 million, and $119.8 million per 1 million population of elderly people, respectively.[23] For older adults with serious mental illness, health care utilization costs are even higher. A study that looked at samples of older patients with schizophrenia compared to adults of comparable age without schizophrenia over the course of 10 years found Medicaid costs specifically were significantly higher for patients with a schizophrenia diagnosis.[24]

Geographic challenges

In addition to common barriers to mental health treatment such as stigma and cost, older adults in Oklahoma face specific challenges. For example, Oklahoma is primarily rural, with the highest percentage of elderly residents found in rural counties.[25] In general, older adults in rural areas are found to have less access to health care across the board because most providers tend to be concentrated in urban parts of the state. This is due in part to a lack of transportation, which has been well-documented as a major barrier for older adults to receive any type of health care.[26,27,28]

Many older adults may require special needs or wheelchair-accessible vehicles or simply need help being transported. Even with free or low-cost transportation options available, such as SoonerRide, it may be difficult to coordinate times for drop-off and pick-up, especially if an individual has several different doctors' appointments consecutively. Moreover, although telehealth has been proposed as a solution to increase behavioral health accessibility, many rural parts of Oklahoma still do not have access to reliable, high-speed broadband internet. Even if they do have access to high-speed internet, many older adults may be unfamiliar with video calls and need extra support when accessing telehealth.

Cultural needs

These challenges are further complicated by the cultural implications of a diverse and growing population. There are significant racial and ethnic disparities among mental health and mental health care. According to the American Psychiatric Association, although prevalence of depression is lower among racial/ethnic minority groups compared to white Americans, depression was more likely to persist among specific racial/ethnic groups, such as Black

Americans and Hispanics.[29] The same report also stated that American Indians/Alaskan Natives, which make up a large percentage of Oklahoma's population, had the highest rates of post-traumatic stress disorder (PTSD) and alcohol use disorder compared to any other ethnic/racial groups. To reduce these healthcare disparities within the aging population, it is important to build a culturally competent system that aims to address the diverse needs of patients with different values, beliefs, and racial/ethnic backgrounds. It will also be important to implement programs and policies that address these challenges, including language barriers and the ability to tactfully navigate cultural beliefs.[30,31,32]

Detecting mental illness in older adults

Approximately 63.7% of adults 65 and older have two or more chronic conditions.[33] These chronic illnesses include, but are not limited, to arthritis, cancer, chronic obstructive pulmonary disease, coronary heart disease, current asthma, diabetes, hepatitis, hypertension, stroke, and weak or failing kidneys. With co-occurring physical health conditions, it is not uncommon for physicians to focus on physical symptoms and attribute them all to a physical ailment instead of investigating whether it could be linked to a mental health condition. Providers treating someone in poor physical health might also prioritize stabilizing someone's physical health before addressing mental health concerns.

Even if a patient is willing to bring up mental health concerns, receiving the correct diagnosis can be difficult. For example, in older adults, the way symptoms present do not always meet criteria in number or severity for a formal diagnosis of something like major depression. However, individuals with fewer symptoms can still experience a negative impact on day-to-day living, or subsyndromal depression.[2] When older adults experience depression, they are more likely to exhibit physical changes like body aches, insomnia, or lack of appetite instead of feeling sad or losing interest in normal activities, which can make it even harder to recognize as depression. Another challenge with older adults is the number of medications one person can be taking, increasing the chance for a negative drug interaction. As people get older, it also becomes more difficult for bodies to metabolize drugs. This can lead to new, or more intense, side effects.

The necessity of a holistic approach

Physical and chronic diseases can also contribute to mental illness. A serious, chronic, or terminal diagnosis can lead to anxiety or depression. Nearly 40% of cancer patients experience anxiety, depression, or PTSD, and people with diabetes or rheumatoid arthritis are six times more likely to experience depression when compared to people without a diagnosis.[34] The increased likelihood of exhibiting mental health symptoms can stem from fear of the unknown, psychological or physical reactions to treatments, not having the energy to go through life the same as before a diagnosis, stress around finances with medical bills in combination with an inability to work, and feeling like a burden to loved ones. Therapy, psychiatric medication, and/or

support groups comprised of people with similar conditions can all be helpful to people experiencing co-occurring physical and mental health conditions.

Just as physical health can impact mental health, mental health is often associated with poorer physical health. People with mental health disorders are more likely to engage in risky behaviors that could compromise their physical health, including smoking, a sedentary lifestyle, and non-compliance with prescribed medication.[35] Individuals experiencing depression are two to three times more likely to have diabetes.[36] And mental health conditions such as anxiety, depression, stress, or PTSD have been linked to heart disease due to higher levels of the stress hormone (cortisol), higher heart rates and blood pressure, and reduced blood flow to the heart.[22] One study found adults with a serious mental illness like schizophrenia had higher rates of congestive heart failure, chronic obstructive pulmonary disease, hypothyroidism, and dementia.[37] With the high chance of overlap between physical and mental health conditions, it is imperative that health care professionals and systems have protocols in place to coordinate the care of older adults with complex comorbidities.

Considerations for policy and practice

Behavioral health workforce

Oklahoma has a shortage of behavioral health providers in high-need areas, including psychologists, social workers, and licensed marriage and family therapists (LMFTs).[38] **Oklahoma exceeds the national average for availability of licensed professional counselors (LPCs), but unlike Medicaid, Medicare does not reimburse for services rendered by an LPC.**[39] Since Medicare is federally regulated, Congress would need to act in order for older adults to reap the benefits of Oklahoma's strong LPC workforce. Psychologists specifically can help cover some ground with education and training on identifying and addressing the behavioral health needs of older adults. The Council of Professional Geropsychology Training Programs has developed online training for psychologists who work with older adults but don't necessarily specialize in their care. The training includes addressing attitudes and biases on aging, the aging process, and basic behavioral health assessment and intervention for older adults.[40]

Training new providers will be key to meeting the unique needs of Oklahoma's older adults. Higher education institutions and healthcare systems can focus on cross-training between mental health and physical health, as well as educating behavioral health professionals and primary care providers on the unique needs of older adults. As the population shifts and becomes older and more racially diverse, training for culturally and linguistically appropriate care is also essential.

Additionally, increasing the number of peer recovery support specialists (PRSSs) with an older adult specialty certification could help address the geriatric workforce shortage. The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) offers a specialty track

for already certified PRSSs.[41] The additional training covers the aging process, cultural and environmental factors, the impact of physical disease, medication, suicide, ageism, and unique risks for developing a behavioral health disorder in older age. Not only does this help expand the number of workers for peer resources and interdisciplinary teams, but having an older peer with lived experiences related to mental illness, having children or grandchildren, and learning new technologies can be an integral form of support for older adults with mental illness that might not be possible with a more traditional provider.

Expanding the role of primary care physicians

Primary care providers are another type of provider that can help alleviate the strain on the behavioral health workforce. When considering providers with prescribing power, **Oklahoma has a critical shortage of psychiatrists but a robust pool of primary care doctors**.[37] As many as 60 to 80% of mental health conditions can be treated in the primary care setting.[42] Primary care providers can use an integrated care model to incorporate mental health care more prominently into their preexisting practices. More advanced models use a multi-disciplinary team to cohesively address physical health, behavioral health, and social determinants of health, which is especially useful for older adults who often have complex needs. By routinely screening patients and discussing mental health with them, primary care doctors can detect and address the behavioral health concern themselves, refer the patient to a higher level of care or direct them to specialty services. The following are evidence-based integrated care models that have been shown to work specifically with the older adult population:

- **The Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)**, also known as the collaborative care model, is used to treat older adults with depression and has been proven to decrease suicidal ideation and depression symptoms.43
- **Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT)** helps primary care physicians reduce depression symptoms, suicidal ideations, and deaths by detecting depression and suicidal ideations, applying a treatment algorithm for geriatric depression, and treatment management by an interdisciplinary team.

Aging in place and long-term care facilities

While Medicare covers adults over the age of 65, an older adult can be dual eligible with Medicaid if they also have a low income. Nearly 90% of Americans older than 50 want to age in their homes, but advocacy groups representing older adult interests have argued that Oklahoma's Medicaid favors placing older adults in long-term care settings as opposed to providing the resources to keep older adults in their communities of choice.[44] The Oklahoma Department of Human Services (OKDHS)' Aging Services Division (ASD) is the state's primary agency for addressing the needs of aging Oklahomans.[45] ASD is responsible for administering the programs and funds of the 1965 Older Americans Act and the Home and Community Based ADvantage Waiver, both of which aim to keep seniors living in their homes and in their communities by providing social services and

supports. ASD delivers many of its services through 11 area agencies on aging and more than 200 partners statewide. Services include adult day services, long-term care services at home, meal delivery, legal services, volunteer opportunities, personal care assistance, respite services, credits to purchase fresh food, solutions for long-term care facility complaints, transportation services, and medication management.

Strengthening home and community-based services will allow more adults with mental illness to age in place and avoid institutional care. Medicaid waivers offer states more flexibility by allowing them to provide services that might not otherwise be covered or offer specialized benefits to a specific segment of the Medicaid population.[46] Oklahoma currently has six 1915(c) waivers and one 1115 waiver.[47] Both types of waivers are subject to federal approval, the estimated cost for the time period the waiver is enacted cannot exceed what the federal cost would have been without the waiver, and would otherwise require institutional care. One of Oklahoma's 1915(c) waivers, the Advantage waiver, provides home- and community-based services for older adults aged 65 and older and those 21 and older with a physical disability. Oklahoma does have the opportunity to expand its 1115 waivers to target services to people with mental health conditions.[48] Aside from waivers, states can also change their Medicaid plans with a state plan amendment. The 1915(i) state plan option allows states to provide home- and community-based services to people who need assistance but do not meet criteria for an institutional level of care, while the Communities First Choice 1915(k) is a state plan option providing enhanced federal matching dollars to support those in the community who would otherwise require institutionalization.[49]

Raising reimbursement rates for Medicaid would lessen the barriers older adults with mental illness face in finding a long-term solution for their care. For adults who are not able to age in place in their desired community, living options include residential care, assisted living, and nursing facilities. However, there is a gap in facilities that can meet both physical and mental health needs of individuals in Oklahoma. About 70% of all nursing facility residents in Oklahoma rely on Medicaid.[50] Since Oklahoma as a state has low Medicaid reimbursement rates, facilities may be less likely to admit an individual with co-occurring mental and physical health needs because those patients are costly compared to other patients.

Inter-agency coordination

While multiple state agencies provide vital services that impact the health and wellbeing of older adults, no single agency specializes entirely on older adults' mental health. **The expertise of multiple agencies is necessary to wield an appropriate, comprehensive response to older Oklahomans with mental health needs.** In addition to OKDHS and the Aging Services Division, ODMHSAS focuses on helping Oklahomans with behavioral health needs; the Oklahoma Health Care Authority provides care for older adults who are dually eligible through Medicare due to age

and Medicaid through income or disability; and the Oklahoma Department of Veterans Affairs supports the needs of veterans, with older veterans being especially at risk of suicide.[51]

With an eye for interagency coordination for older adult behavioral health in the state, OKDHS' Aging Services Division contracted with the Oklahoma Mental Health and Aging Coalition in 2013 to create Oklahoma's Older Adult Behavioral Health State Plan.[52] State agencies approved the plan in 2017, and a smaller executive team comprised of agency representatives developed guidance for implementation.[53] The plan outlines several potential partnerships across agencies, but there is not a mechanism that tracks progress, and many experts expressed these partnerships are very relationship-based. Further intentional focus on formalizing partnerships through interagency agreements and building infrastructure to support data sharing across agencies could help gauge progress in the older adult behavioral health space.

Evidence-based interventions for older adults

Expanding access to evidence-based practices will help older adults with physical and behavioral health symptoms and outcomes, maintain their independence, learn new skills, decrease emergency service utilizations, increase adherence to treatment plans, and enhance quality of life, all of which will allow more older Oklahomans to age in place in their desired communities instead of in higher levels of care that can be avoided.

There are several evidence-based interventions that have been proven effective for older adults. These interventions have either been adapted to serve older adults' needs or created with the specific intention of addressing older adults' needs. Additionally, the interventions listed below cover a variety of care settings including in the community, long-term care facilities, outpatient services, or inpatient services:

- **Assertive Community Treatment (ACT)** is a model developed for the general adult population, but there has been success in using it with older adults. ACT employs a multi-disciplinary team to provide intensive case management and address the holistic needs of the client.
- Skills training like **Cognitive Behavioral Social Skills Training (CBSST)** or **Functional Adaptation Skills Training (FAST)** teaches behavioral techniques to help older adults with mental illness manage their symptoms, improve skills that help them live independently, and aid in interpersonal social skills.
- **Integrated Illness Management and Recovery (I-IMR)** improves skills in managing both physical and behavioral health conditions, which includes training on illnesses and treatments, approaches to promote consistent medication usage, relapse prevention, coping skills for dealing with chronic symptoms, and social skills.[54]

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