Mat-Su Older Adult Behavioral Health Needs Assessment

Prepared for the Alaska Mental Health Trust Authority
by Actionable Data Consulting, 11/15/2023

Trust

Alaska Mental Health
Trust Authority

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ABBREVIATIONS

ACEs
Adverse Childhood Experiences

ACoA
Alaska Council on Aging

ACS
American Community Survey

ADRD
Alzheimer's disease and related dementias

AHAVRS
Alaska Health Analytics and Vital Records Section

AKHMIS
Alaska Homeless Management Information System

AHHA
Alaska Health and Hospital Association

AKDOLWD
State of Alaska Department of Labor and Workforce Development

AN/AI
Alaska Native/American Indian

APS
Alaska Protective Service

ATR
Alaska Trauma Registry

BH
Behavioral Health

BRFSS
Behavioral Risk Factor Surveillance System

CoCM
Collaborative Care Management

COPD
Chronic Obstructive Pulmonary Disease

DOLWD
State of Alaska Department of Labor and Workforce Development

DBH
Division of Behavioral Health

ED
Emergency Department

EMS
Emergency Medical Services

FQHC
Federally Qualified Health Center

Healthy IDEAS
Identifying Depression and Empowering Activities for Seniors

MAT
Medication Assisted Treatment

Mat-Su
Matanuska Susitna Borough

MHFA
Mental Health First Aid for Older Adults

MSHS
Mat-Su Health Services

MSRMC
Mat-Su Regional Medical Center

NCCDPHP
National Center for Chronic Disease Prevention and Health Promotion

NEMS
National Elder Mistreatment Study

NIAAA
National Institute on Alcohol Abuse and Alcoholism

NIDA
National Institute on Drug Abuse

NSDUH
National Survey on Drug Use and Health

OAS PACT
Older Adult Services Program for Assertive Community Treatment

PEARLS
Program to Encourage Active Rewarding Lives

PTSD
Post Traumatic Stress Disorder

RIS
Restorative Integral Support

SUD
Substance Use Disorder

US Census
United States Census

VNPCC
Valley Native Primary Care Center

65+
65 years of age and older

Acknowledgments

We extend our sincere thanks to the individuals, agencies, and organizations that made this report possible. They not only go above and beyond the call of duty to provide services to Mat-Su older adults, but they gave of their time for this report. Thank you. You are vital to our community.

Executive Summary

Background

This report was commissioned by the Alaska Mental Health Trust Authority and coordinated with the Mat-Su Council on Aging and the Mat-Su Health Foundation. Actionable Data Consulting was hired in March of 2023 to do a Mat-Su Older Adult Behavioral Health Needs Assessment. This report will focus only on the behavioral health (BH) needs of older adults and does not include the needs of older adults with dementia even if they have behavioral health challenges. For this report, behavioral health is defined as mental health and substance use disorders, life stressors and crises. In this report, adults 65 and older will be referred to as "older adults" or "65+". The term "Elders" or "Alaska Native Elders" will be used when referring specifically and only to Alaska Native/American Indian (AN/AI) persons 65 or older. The original usage will be retained when this report cites organizational or program names or titles of articles or direct quotes that use "seniors" or "elder" for older adults.

Methods

For this report, the following different types of data were used:

Quantitative Data

- Census data
- Online survey
- Phone surveys
- Vital statistics data
- Service utilization data

Qualitative Data

50 interviews with 76 individuals with:

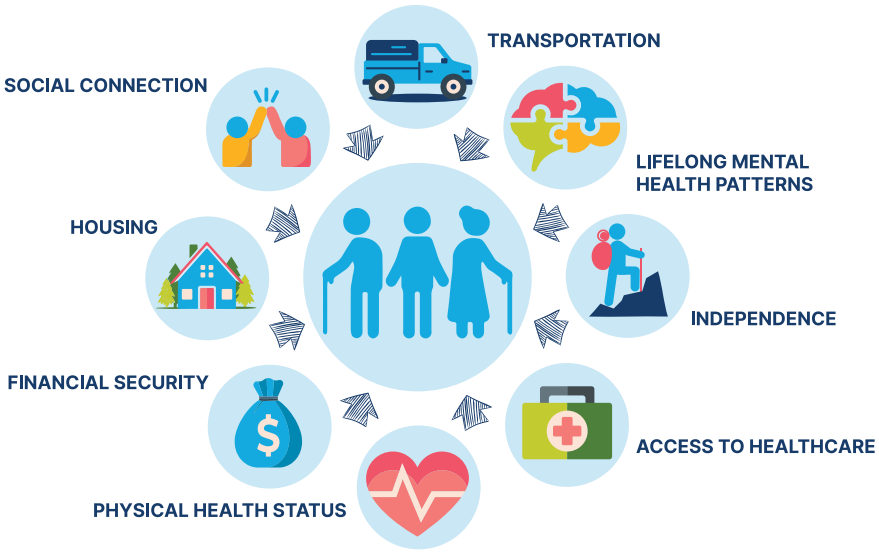
- State agency staff
- Local providers to older adults
- Church leaders and staff
- Older adults

Methodological limitations include surveying techniques that may not reach all older adults and using a convenience sampling technique for the older adult interviews. While the survey results may reflect an underrepresentation of low-income or isolated individuals, the interviews may overrepresent these groups.

Determinants of behavioral health for older adults

Being a human at any age can be complex and challenging, depending on one's life circumstances. This is especially true for older adults. Several factors can make things easier or harder for an individual. In this study, the providers, church staff, and older adults who were interviewed all mentioned at least one of the eight determinants shown in Figure 1 as affecting an older adult's mental health and well-being.

FIGURE 1.
DETERMINANTS OF BEHAVIORAL HEALTH FOR OLDER ADULTS



Older resident demographics

In 2022, 18% of the Mat-Su population (20,224) were aged 50-64, and 14% (15,975) were 65 or older. Of those 65 years+, 69% are between 65-74 years, 25% are between the age of 75-84 years and 6% are aged 85+ years. The total Mat-Su population of older adults aged 65+, is projected to increase from 14,907 in 2021 to 25,806 in 2050, a change of 73%. While older adults made up 14% of the population in 2021, this will increase to 17% of the population in 2050. With this fast rate of population growth among older adults in Mat-Su, it will be especially important to address the needs identified in this report, not only for the current population but also for an even larger population of older adults in the future.

The Mat-Su areas with the largest percentages of older adults were:

1. Knik-Fairview 14.4% (2,300)
2. Wasilla 9.2% (1,477)
3. North Lakes 8.3% (1,322)
4. Meadow Lakes 7.9% (1,259)
5. Tanaina 6.3% (1,000)

In Mat-Su in 2022, the older adults had the following characteristics:

White 90%
Alaska Native 6%
Black 2%
Native Hawaiian Pacific Islander . . . . . <1%
Hispanic 2%
Asian 2%
Disabled 65-74 yrs. 28%
Disabled 75+ yrs. 54%
Veterans 27%

The mental health status of Mat-Su older adults

There was limited data on the prevalence of behavioral health issues among older adults in Mat-Su, and the survey data had significant limitations. Therefore, the picture constructed in this report used interview data from those who work with older adults, older adults themselves, and service utilization data, along with survey data. Those interviewed reported that mental health issues and substance use disorders in older adults were intertwined with:

1. Fear of stigma of having a behavioral health issue
2. Resistance to seeking treatment
3. Social isolation
4. Failing health or cognition
5. Limited mobility
6. Financial insecurity
7. Difficulty with the long, dark, and snowy Alaska winter
8. Misuse of prescribed medication
9. Self-undermedication to prompt a medical visit

Survey data revealed the following behavioral health behaviors and conditions:

Used opioids in the last year 10% (1,598)
Used marijuana in the last year 8% (1,278)
Binge drank in the last year 7% (1,118)
Drank heavily in the past year 9% (1,438)
Poor mental health in last 2 weeks 8% (1,278)

Interviewees identified the most common behavioral health conditions they saw as:

- Depression
- Suicidal ideation
- Anxiety/stress
- Grief
- Pain medication misuse
- Alcohol misuse

Service data revealed that few older adults seek outpatient care, and a much larger number are seen in an acute care setting with a primary or secondary behavioral health-related diagnosis.[1]

Wasilla/Palmer Federally Qualified Health Center patients (2022)

Psych care 90
Clinical care 84
Case management 20
Medication assisted treatment 90

Hospital inpatient discharges (2021)

BH-related 985
Drug-induced 517
Alcohol-induced 62

Emergency department discharges (2021)

BH-related 639
Drug-induced 327
Alcohol-induced 64

Mat-Su EMS calls (2018-2019)

Altered mental status or psychiatric problems 163

Suicide deaths (2021)

Deaths 5

Determinants of behavioral health

PAST BEHAVIORAL HEALTH STATUS

Older adults have past behavioral health experiences that can impact them as they age, such as having experienced intimate partner violence (11%), sexual assault (16%), or depression (13%). Alaska Native Elders experienced the historical trauma of colonization, including being sent to boarding schools.

Access to Care

Access to physical health care can provide a pathway into access to behavioral health care, especially if there is integrated care in a clinic or the provider refers a patient to a behavioral health provider. During 2015-2021, 81% of Mat-Su older adults reported having a personal health care provider. Close to 100% of Mat-Su older adults had health insurance coverage. Major access barriers that were found were:

1. A lack of behavioral health providers who accept Medicare (1 provider to every 614 older adults)
2. There are only two substance use disorder (SUD) outpatient treatment providers locally that bill for Medicare and only one residential treatment provider in Anchorage.
3. There are no services or providers specializing in geriatric care.
4. The State of Alaska Division of Behavioral Health grants only target clients up to the age of 64 years.

Physical health status

As a person ages, their physical health changes; changes can include experiencing chronic pain and limitation in mobility. For Mat-Su adults aged 65-74 years, approximately 28% had a disability. For those 75 years and older, 54% had a disability. Physical health conditions can lead to depression, anxiety, and other behavioral health consequences.

Financial status

As one ages and retires from or reduces paid work, whether by choice or disability, income tends to decrease. Most older adults in Mat-Su on a fixed retirement income, depend heavily on the annual state Permanent Fund Dividend, and/or receive public assistance. Forty-three percent of older adults surveyed said they had enough money but little to cover anything extra, and 17% said they didn't have enough for some or all months. Data on annual household income for older adults in 2022 revealed that:

- 23% earn less than $25,000
- 22% - $25,000 to $49,999
- 21% $50,000-$74,999
- 35% >$75,000

Older adults in Mat-Su ranked their top financial security concerns as:

1. Costs of daily living, such as food, housing, heat, utilities, and transportation
2. Cost of health care and medication
3. High property taxes

1 Tribal service data was not obtained for this report and may look different.

The State of Alaska Division of Public Assistance provided the following benefits to Mat-Su older adults in FY2022:

- Temporary Assistance with a case relation of a grandchild (65 recipients, average benefit $610/month)
- Adult Public Assistance (826 recipients, average benefit $281/month)
- General Relief Assistance (14 recipients, average benefit $3,126)
- Heating Assistance Program (508 recipients, average annual benefit $1,646)
- Medicaid (2066 recipients - 1888 Long Term Care and 178 general Medicaid)
- Senior Benefits (1,873 recipients, average benefit $62/month)
- Supplemental Nutrition Assistance Program (979 recipients, average benefit $165/month)

Older adults have different abilities to apply for public benefits and may not know they could receive assistance. Those who were interviewed said that financial worries cause stress, embarrassment, and a feeling of not wanting to burden others, especially their children.

Independence

One of the greatest worries for Mat-Su older adults was staying independent in their homes. They feared being relocated because of needs related to aging. There were two groups this seems to commonly affect:

- Those who live "off the grid" with a lifestyle that includes daily hard physical labor.
- Alaska Native Elders who need to move to Mat-Su to access services unavailable in their village in another region.

When older adults were asked about the level of help they needed with household tasks, the most common tasks they said they could do by themselves were managing medications, finances, personal tasks, and shopping. Areas that they said were difficult or that they could not handle themselves were general home maintenance (64%) and household chores (30%).

Transportation

All providers and church staff felt there was a significant need for more affordable transportation options for Mat-Su older adults. They said that the existing options don't reach all older adults and don't adequately meet their needs to get to health care in Anchorage. Eighty-six percent of Mat-Su older adults said they had transportation anytime they needed it. This data was taken from the Alaska Commission on Aging (ACoA) online survey and may not represent all seniors, especially low-income seniors who may have higher transportation needs. Providers to older adults and church staff said that lack of transportation is linked to financial constraints, isolation, and health issues.

Housing

Since 2022, rent has risen by 7% on average across Alaska, and the cost of a two-bedroom apartment plus all utilities increased by 9% in Mat-Su. The current vacancy rate in Mat-Su is only 3.5%. Some older adults interviewed for this report had inadequate housing and reported living in motorhomes, a camper, their car, partially built houses without electricity or running water, and a dry cabin. The Alaska Homeless Management Information System (AKHMIS) recorded fifty Mat-Su older adults in the 2022 point-in-time data collection.[2] The main findings related to housing were:

- In the winter, many older adults lack assistance with plowing and shoveling.
- Older adults cannot make needed housing repairs due to their physical condition, lack of financial resources, or difficulty finding assistance.
- Older adults may be stuck in unsafe and inadequate housing conditions due to family situations such as a family member's drug use and mental health issues.

2 The point-in-time count collects demographic information on sheltered and unsheltered persons experiencing homelessness on a single night at the end of January.

Social Connection

Social isolation and loneliness are associated with sleep disturbance, fatigue, depression, and decreased levels of well-being in older adults. Stakeholders said that social isolation results from:

- Having family out of state
- Aging in an isolated place
- Not having transportation
- Having family and friends who have died
- Preferring to be isolated
- Being "snowed in"

Of the Mat-Su older adults, 1,417 males and 1,837 females lived alone. Sixty-four percent of the males were married, and 16% were widowers. Fifty-eight percent of the females were married, and 20% were widows. According to a Mat-Su household phone survey in 2022, 15% of Mat-Su older adults reported that they had 0-1 person they could count on, 43% had between 2-5 individuals, and 65% had six or more people they could count on.

Profile of Alaska Native Elders

Demographics: According to the 2021 American Community Survey, in Mat-Su, there were 292 males and 486 female Alaska Native or American Indian Elders 65+ years.[3] There were 61 grandparents aged 60 or older responsible for their grandchildren younger than 18 years of age.

Behavioral health status – past and present: Tribal service providers and survey results revealed that Elders struggling with behavioral health issues experienced loneliness, anxiety, depression, and grief. The main findings were:

1. Forty percent of surveyed Elders reported feeling nervous some of the time.
2. Forty-nine percent of surveyed Elders felt "downhearted/blue" some of the time, with about a quarter saying that nothing would cheer them at those times.
3. Seventy-six percent of Elders said they were a happy person all the time or most of the time, and 24% said some or none of the time.
4. Eighty-three percent of Elders reported their quality of life was excellent, very good, or good.
5. The most mentioned substances that were misused were alcohol and prescribed medications.
6. Tribal providers don't see Elders misusing substances often; however, living with a family member who has a substance use disorder can be difficult for the Elder.
7. Elders suffered trauma in their lives connected to being sent to boarding schools and other forced assimilation efforts – experiences that can have lifelong negative mental health consequences.

Access to care: Elders surveyed reported the top issues they faced in accessing medical care were:

1. The distance from services (17%)
2. Waiting too long for appointment availability (10%)
3. No transportation (8%)
4. Cost (8%)

Twenty-one percent of Elders said their health was excellent or very good; 49% said it was good; 29% said it was fair or poor. Most Elders had health insurance, and 93% said they had seen their doctor/provider in the last year. Thirty-three percent of respondents said they had been diagnosed with a disability.

Independence: Tribal providers said that sometimes Elders relocate to Mat-Su from a village in another region because they need services not provided in their original community. When they do this, sometimes Elders lose access to their family ties and cultural practices and food. Staff said that Elders will often try to cover up their needs to maintain their independence. They said most assisted living homes do not meet Elders' cultural needs because the facilities are run by non-Native people unaware of these cultural needs.

They stated that Elders often have a strong sense of responsibility to continue to care for their children and grandchildren, which, sometimes, could be at a cost to themselves. Staff noted that they have seen some situations they categorize as abusive or

3 The classification that was used with US Census data was that the respondent considered themselves Alaska Native and/or American Indian alone or in combination with another race.

exploitive when Elders are living with family members. Additionally, a Tribal staff member said that she sees many widowed women who are having to adjust to the life transition of losing a spouse. She mentioned the usefulness of a grief group in the community that helps Elders with this transition and provides socialization.

Transportation: Tribal providers stated that Elders in Mat-Su face similar problems with accessing transportation as non-Native Elders.

Social connection: The Elder survey revealed that most older adults live in a single-family residence (76%) and more than half with a family member (59%). Almost a quarter of Elders reported that they only left their homes 1-2 times per month, and slightly less than a quarter reported 3-4 times per month. All staff at the three main Tribal organizations emphasized the major role that social connection plays in supporting Elder mental health. Many of the cultural traditions asked about in the Elder survey involved social connection. The top cultural activities that Elders valued were:

1. Consuming traditional foods
2. Attending powwows
3. Smudging
4. Preparing traditional foods
5. Participating in talking circles

There is a rich network of services offered by the three local Tribal organizations that address several of the issues mentioned in this report, including providing social connection opportunities, home maintenance, and chore service for homeowners, and integrated primary care and home visits that include a behavioral health worker.

Recommendations

All individuals interviewed for this report (state agency staff, service providers, church staff, older adults) were asked the same question: "If you had a magic wand and could do three things to help older residents with behavioral health needs or mental well-being, what would you do?" The recommendations centered on three major themes: basic need recommendations, behavioral health services recommendations, and social connection recommendations.

Meeting basic needs recommendations:

1. Have more affordable and safe senior housing.
2. Provide affordable or free home modification, repair, and chore services.
3. Provide affordable or free transportation.
4. Provide more financial assistance.
5. Create more case management assistance for older adults.
6. Build a 24/7 low barrier shelter that provides "a one-stop shop" for all types of assistance.

Behavioral Health recommendations:

1. Have older adult-focused, accessible behavioral health providers.
2. Within the medical care system, adopt mental and physical health parity and truly integrate these types of health care.
3. Provide medical liaisons who can assist with mental and physical access to care and help with medications.

Social connection recommendations

Respondents made suggestions focused on creating social connections to help solve the problem of social isolation that many older adults face. Respondents felt that social connection is key to good mental health for older adults. Social connection magic wands focused on:

1. Ensuring all older adults "have a friend" by promoting peer-to-peer networks.
2. Promoting intergenerational activities between older adults and people of other age groups.
3. Increasing senior recreational activity opportunities with funding to senior centers and other organizations for activities and dedicated activity directors.
4. Providing more places in all communities for older adults and veterans to gather.
5. Developing new networks, including peer-to-peer networks and volunteer networks, where older adults can participate.

Conclusion

The older adult population in Mat-Su continues to grow and become more diverse. Older adults are especially vulnerable to economic downturns and unexpected personal financial events because most live on a fixed income. Adverse financial circumstances can affect their housing and transportation status. The physical health of older adults naturally declines with age, and their social circles often become smaller. Housing needs and ways of living change as older adults' physical and cognitive status change.

The picture of Mat-Su older adults that has emerged in this report is one of some older adults experiencing pre-existing behavioral health challenges, along with depression, anxiety, and grief due to their current life circumstances. The current statewide funding system does not support the development of geriatric behavioral health services or the parity and integration of physical and mental health care. Local behavioral health services reflect that omission. The lack of behavioral health services focused on older adults compounds the generational stigma associated with seeking help.

Mat-Su stakeholders have offered suggestions on how existing efforts can be amplified to further meet older adult needs and how to fill current gaps and areas of need. Tribal providers offer some exciting services and physical and mental health care integration that could be replicated in the non-Tribal service delivery system. As one church staff said, "It takes a village to care for a senior." It is especially important to build up a supportive community, as well as a wide array of older-adult-focused behavioral health and basic-need services to meet the needs of the fast growing older adult population in Mat-Su, projected to grow by 73% by 2050.

Background

This report was commissioned by the Alaska Mental Health Trust Authority and coordinated with the Mat-Su Council on Aging and the Mat-Su Health Foundation. Actionable Data Consulting was hired in March of 2023 to do a Mat-Su Older Adult Behavioral Health Needs Assessment. This report will focus only on the behavioral health (BH) needs of older adults and does not include the needs of older adults with dementia even if they have behavioral health challenges. For this report, behavioral health is defined as mental health and substance use disorders, life stressors and crises. In this report, adults 65 and older will be referred to as "older adults" or "65+." The term "Elders" or "Alaska Native Elders" will be used when referring specifically and only to Alaska Native/American Indian (AN/AI) persons 65 or older. The original usage will be retained when this report cites organizational or program names or titles of articles or direct quotes that use "seniors" or "elder" for older adults.

Methodology

This report uses secondary quantitative data (Table 1) and primary qualitative data (Table 2) to paint a picture of the lives of older adults and their behavioral health status. The quantitative data describes the demographics, health status, and social determinants of health for older Mat-Su adults. The data includes census, survey, service utilization, and vital statistics data.

TABLE 1. **QUANTITATIVE SECONDARY DATA SOURCES**

Source	Type of data for older Mat-Su residents
AK Department of Health, Division of Behavioral Health (DBH)	Behavioral health Medicaid claims that were paid
AK Department of Health, Division of Public Assistance	Public assistance benefit data
AK Department of Labor and Workforce Development	Demographic data
AK Commission on Aging (ACoA)	Attitudes and behavior survey data
AK Health Analytics and Vital Records (AHAVR)	Behavioral health emergency department and inpatient discharge data, death rate data
AK Hospital & Healthcare Association	Hospital utilization data
AK Protective Services (APS)	Allegations of elder abuse, neglect, or exploitation
AK Trauma Registry (ATR)	Fatal and nonfatal injury data
Behavioral Risk Factor Surveillance System (BRFSS)	Attitudes and behavior survey data
Matanuska Susitna Borough Emergency Medical Services (EMS)	EMS service utilization data
Mat-Su Health Foundation, Household Survey	Attitude and behavior survey data
Mat-Su Health Services	Patient utilization data
National Resource Center on Native American Aging Identifying Our Needs: A Survey of Elders VIII (Elder Survey)	Attitudes, behavior, and health status data
US Census, American Community Survey, (ACS, 2021, 2022)	Demographic, insurance, and housing data
Sunshine Community Health Center	Patient utilization data

The qualitative data used for this report came from individual and in-depth group interviews with stakeholders at churches and local organizations that provide support and services to Mat-Su older adults, as well as from older adults themselves. Seventy-six individuals were interviewed in 50 interviews. Of the 50

interviews, 7 were with staff from statewide agencies, 12 were with Mat-Su borough-wide organizations, 9 were with core (Wasilla and Palmer) area organizations, 7 from rural area organizations, 8 from area churches, and 14 were with older adults.[4] The sampling method for selecting respondents was purposive and snowball sampling, with stakeholders helping identify others who would have valuable insight to share on the report topic.

TABLE 2. **ORGANIZATIONS/AGENCIES OF THE STAKEHOLDER INTERVIEW PARTICIPANTS BY LOCATION**

Organization	# of respondents	Statewide	All Mat-Su	Core	Rural
AK Adult Protective Services	2	X			
AK Behavioral Health Ass ociation	1	X			
AK Commission on Aging	2	X			
AK Hospital and Healthcare Association	1	X			
AK Senior and Disability Services	1	X			
AK Warrior Partnership	1	X			
Chickaloon Village Traditional Council	1				X
Church on the Rock	1			X	
Connect Mat-Su	2		X		
Gerontologist Consultant	1		X		
Knik Tribe	3		X		
Long-term Care Ombudsman	2	X			
Mat-Su Aging and Disability Resource Center	4		X		
Mat-Su Behavioral Health Integration Team	5		X		
Mat-Su Borough EMS	1		X		
Mat-Su Council on Aging (3 interviews)	8		X		
Mat-Su Health Foundation	3		X		
Mat-Su Regional Medical Center	1		X		
Mat-Su Senior Services Inc.	1			X	
Mat-Su Regional Medical Center Senior Circle	1			X	
Northgate Alaska Church	1			X	
Palmer Church of God	1			X	
Russian Orthodox Church	1		X		
Santa Cops and Heroes	1		X		
Southcentral Foundation	4		X		
Sunshine Community Health Center	3				X
Talkeetna Baptist Church	1				X
Trinity Lutheran Church	1			X	
Upper Susitna Food Pantry	1				X
Upper Susitna Senior Center	1				X
Wasilla Area Senior Inc. (2 interviews)	2			X	
Wasilla Lake Church	2			X	
Willow Methodist Church	1				X
Older adults	14			X	X
Total	**76**	**7**	**12**	**9**	**7**

4 In this description an interview could be classified in more than one category.

The older adult phone interviewees lived in Wasilla, Palmer, Butte, Sutton, Willow, Trapper Creek, and the Knik-Goose Bay area. Local organizations (Santa Cops and Heroes, Willow Food Pantry, Wasilla Area Seniors, and the Palmer Church of God Food Pantry, Senior Circle) advertised the opportunity to older adults they encountered. All interviewees verbally provided informed consent. The older adult respondents received a $30 incentive (cash or gift card). The interviews were recorded and transcribed using TEMI online software (Temi Online Transcription Service, 2023). The interview transcripts were analyzed using the web application DeDoose, (Sociocultural Research Consultants, 2022), and a thematic analysis was conducted. Data analysis began with initial general coding of the texts to identify data themes and create the code labels that served as the guide to group quotes under emergent themes.

Limitations

There are significant limitations accompanying the types of data that were used for this report , including the following:

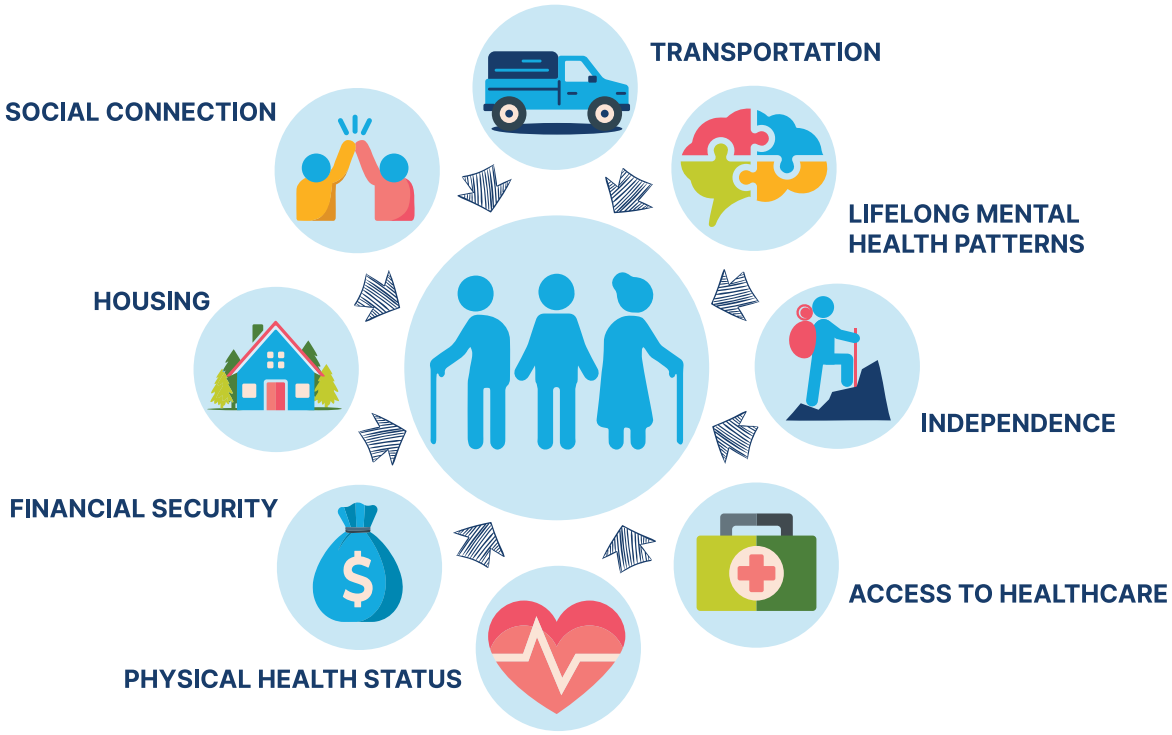
1. The survey data (ACS, BRFSS, Mat-Su Household Survey) was collected via phone interviews. If an individual lived "off the grid" or didn't have consistent access to a cell phone, they were not represented in the sampling frame. Additionally, some older adults may have been cautious about who they spoke with and may not have answered the phone if they didn't know who was calling. The Elder Survey collected phone responses and talked to Elders who visited the Valley Native Primary Care Center (VNPCC). This sampling method may lead to a higher representation of Elders more likely to seek health care. Finally, the ACoA online survey may preclude older adults who do not have internet access or who do not readily use social media. These factors may have skewed the data towards older adults who use the internet and social media to connect with others.
2. The selection of older adults to participate in the in-person interviews was not random and may have been skewed toward low-income older adults based on a snowball sampling technique that started with organizations that help older adults meet their basic needs. These results may not represent the full range of older adults living in the Mat-Su but may include more low-income older adults.
3. The choice of which organizations and churches with whom to seek staff interviews was targeted towards those who serve older adults; however, there may have been organizations and churches that do this work, and their staff were not asked to participate in an interview. Thus, all organizations and churches assisting Mat-Su older adults may not have been included in the interview pool.

Interestingly, the first two limitations may balance each other out if the reader uses a gestalt of all the data in developing their understanding of the needs of Mat-Su older adults.

Overview: Determinants of Older Adult Behavioral Health

Being a human at any age can be complex and challenging, depending on one's life circumstances. This is especially true for older adults who are moving through "old" age with health status that declines until death. Several factors can make things easier or harder for an individual. In this study, the providers, church staff, and older adults who were interviewed all mentioned at least one of the eight determinants shown in Figure 1 as affecting an older adult's mental health and well-being. These determinants of behavioral health for older adults are explored in this report.

FIGURE 1.
DETERMINANTS OF BEHAVIORAL HEALTH FOR OLDER ADULTS



The following are three composite case studies that examine each determinant in the lives of the fourteen older adults interviewed for this report. It is valuable to look at the lives of older adults as a whole and not just to focus on isolated parts of their lives, such as behavioral health diagnoses. For many older adults, their behavioral health status is undiagnosed, and they rely on support outside the medical and social support system, or they have no support. Additionally, for the current generation of older adults, providers report that stigma and other barriers often prevent these older adults from identifying with a behavioral health need and seeking care. The stories from the older adults are grouped into three levels of financial status. Financial status can have an overwhelming impact on a person's day-to-day life and, according to older adults themselves, can affect their mental health. The case studies are composite descriptions of multiple older adults interviewed for this report. They are put into three groups with these labels: no income, some income, or financially secure.

Older adult profile: no income

The three older adults with no income all lived in substandard housing in Trapper Creek, Willow, and Palmer. They had previously worked in one or more of the following jobs: building caretaker, heavy machine operator, pilot driver, veteran, and hairdresser. One was living in their car after a fire burned down their house (a 65-year-old), another had a motorhome in the woods on property they didn't own or rent (a 72-year-old), and the third was living in a cabin (a 60-year-old). All had no electricity or running water, and heat was obtained by burning heating fuel or coal or turning on the car. These people (one female and two males) lived by themselves. One had a running car, another a barely running truck, and the other had a nonrunning truck.

The physical status of this group included one person with Chronic Obstructive Pulmonary Disease (COPD), asthma, and arthritis; one with a combat injury that inhibited walking; and the third who had lost an eye and had a blunt trauma injury that needed surgery. One individual had no health insurance; another had Medicaid and Medicare; and the third qualified for Tribal health care. One reported that they never seek care other than when the situation requires the emergency room; one had sought health care but didn't feel they could return to the clinic because they owed money (even though they needed medication), and the third said they were getting great care at the local Tribal health center. The individual with no health insurance tried to apply for Medicaid/Medicare but failed in negotiating the "red tape."

They said they could find joy each day by playing with their dogs and reading, gardening, and playing with their cats. The three reported the following social connections: going to the food bank and visiting with people there; not really liking to see people and only having social contact when someone visits them; texting with a couple of friends and their sister.

Mental health issues included Post Traumatic Stress Disorder and depression for one person and anger issues for the other two. Day-to-day concerns included:

- How to get water every week without transportation
- Not freezing in the winter because they can't afford heating fuel (a minimum purchase of 100 gallons is required)
- How to get plowed and shoveled out in the winter
- Not getting kicked off the land they were squatting on
- Dealing with bears that come around their living area
- Getting gas for their truck to get to the foodbank
- Affording and acquiring medication
- Not having enough food to feed their dogs
- Trying to get rides to get the things they need

When asked what is crucial to the mental well-being of older adults, they responded: being with someone you love and being around people; not letting the day-to-day things get you down; not worrying about paying bills; and being secure enough not to worry about being kicked off the land you are on.

Older adult profile: some income

Eight individuals earned some money but still had some financial insecurities and lived in Sutton, Butte, Palmer, Knik-Goose Bay, Willow, and Wasilla. They had previously worked in one or more of the following jobs: being a truck driver/equipment operator, a hospital administrator, a grocery store clerk, a paralegal, a real estate agent, a veteran, and a small business owner.

Two individuals lived alone in partially built houses they were trying to singlehandedly finish (70 and 73-year-olds), and two lived in a house alone (a 79-year-old and a 71-year-old). One individual each lived in older adult housing with their spouse (a 63-year-old), in a motor home with their disabled son (an 81-year-old), in a camper van in an RV park with their spouse (a 66-year-old), and in a house living with a spouse (a 77-year-old). One individual was disabled and home-bound and relied on rides from others; one had a car but preferred not to drive, and the others had their own vehicles. They all stated they had some income and mentioned one or more of the following: receiving $1600/month, earning money from breeding dogs, a small retirement income, savings, and Supplemental Security Income due to a disability.

Their physical statuses included having had prostate cancer and glaucoma, being a disabled amputee with heart disease, experiencing back pain, and having hyperglycemia and heart disease. They

all had some form of health insurance (Medicare, Medicare/Medicaid, private insurance/Medicaid, Tribal beneficiary, or VA benefits). One individual had a "falling out" with their local health clinic and will not return there for health care.

When asked where they found joy each day, they responded: being outside in the backyard/writing/TV, gardening/painting/cooking, doing stuff at home/woodworking/wife, a cat who acts like a dog, waking up each day, playing bingo with friends, and two people said they don't have joy in their lives. The group had two different levels of social connection. Several reported many opportunities for social connection, such as volunteer commitments, grandchildren, children, spouses, and friends. In contrast, several mentioned only one social connection outlet: going to the Vet Center, a thrift store, and attending a weekly knitting group.

Mental health challenges included anger issues, grieving (husband, pet), and mild depression. Day-to-day concerns included:

- Having enough money for gas, electricity, food, and dog food
- Having a large vet bill because someone shot their dog
- Worry about not getting medication delivered because they are homebound
- Having money for gas and groceries
- Having money problems
- How to get transportation to volunteer commitments
- Shoveling and plowing in the winter

When asked what is crucial for an older adult's mental health, responses included having a safe place to be and doing what one enjoys without concerns about whether one could afford it. They also mentioned that loneliness, forgetfulness, and mental and physical health issues contribute to poor mental health.

Older adult profile: financially secure

Three older adults interviewed were financially secure. Past jobs included owning an assisted living home, being a college professor, and being a motorcoach/bus driver. They lived in a cabin next to their daughter and son-in-law (an 84-year-old), in a house next to their son and daughter-in-law (an 82-year-old), and with their spouse in their own house on 1.5 acres (an 80-year-old). All had running water and electricity. They all had working cars. These older adults had incomes of several forms, including shared retirement savings with a spouse, a pension, and social security/savings.

They found joy each day from gardening and being outside, looking forward to projects and volunteering, and grandchildren and viewing a soap opera with a spouse. Their social connection opportunities included being with children/grandchildren/other family, being at the Senior Center/at church, and volunteering.

They were insured by Medicare, private insurance/long-term care insurance, and by being a Tribal beneficiary. Their physical health struggles included recovering from a hip surgery and having "creaky bones." Mental health challenges included anxiety, grieving a spouse, being in recovery from substance use disorder, having a husband who was depressed, and stress from dealing with physical health limitations and problems.

Day-to-day concerns included:

- Putting stress on themselves to get things done – getting papers in order and making decisions about their will.
- Being worried about the eventual loss of independence and inability to get out and drive.
- Being worried about being a burden to their kids.
- Grieving the death of a spouse.

When asked what is crucial for an older adult's mental well-being, they responded: people reaching out and offering to help/hugs/social contact, sex and other physical contact with a spouse, not being alone/not losing one's independence.

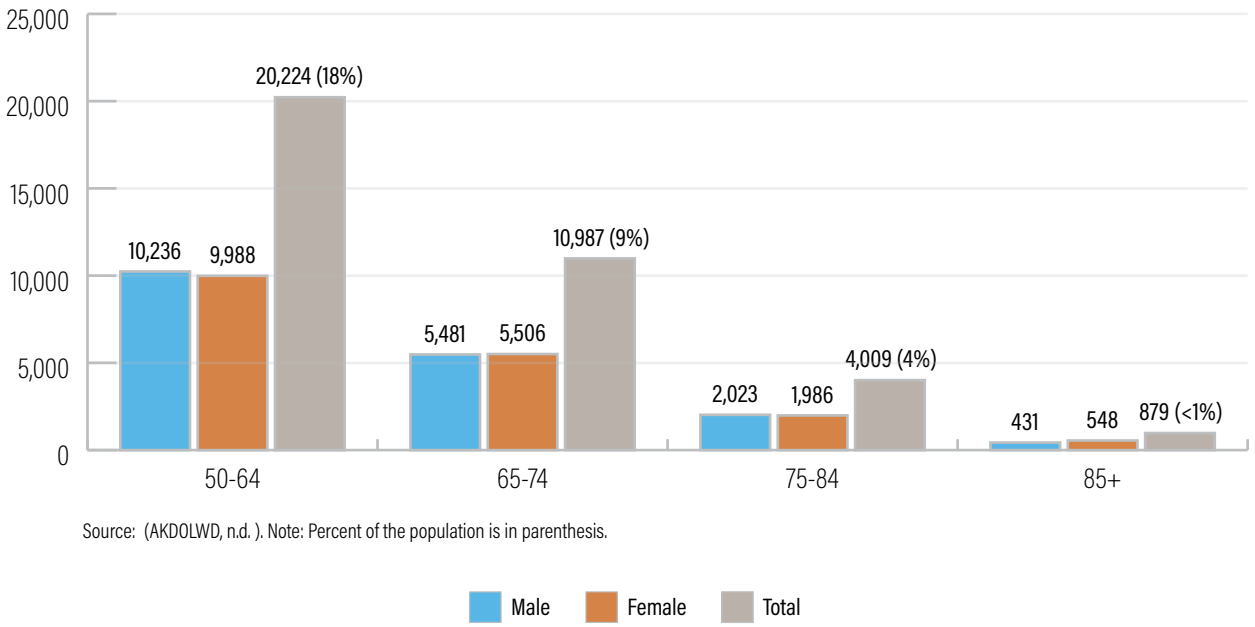
Demographics of Mat-Su Older Adults

KEY FINDINGS: **DEMOGRAPHICS**

1. In 2022, there were 15,975 older adults 65 and older (65+) in Mat-Su. This represents 14% of the population.
2. Adults 65+ will increase from 14,907 in 2021 to 25,806 in 2045, a change of 73%.
3. The Mat-Su areas with the largest 65+ populations were Knik-Fairview (14%, 2,300), Wasilla (9%, 1,477), North Lakes (8%, ,1322), Meadow Lakes (8% 1,259), and Tanaina (6%, 1000).
4. The Mat-Su population who were 65+ comprised 90% White individuals, 6% Alaska Native/American Indian people, 2% each of Black people, Asian, and Hispanic origin people, and <1% Native Hawaiian/ Pacific Islander population.
5. Veterans made up 27% of the Mat-Su older adult population, 6% were living in poverty with almost half of those in poverty reporting they have a disability (48%).

According to the National Center for Chronic Disease Prevention and Health Promotion, in 2019, one in every seven Americans was 65 or older; of those, twenty-five percent will live past age 90, and one out of 10 will live past age 95. The U.S. life expectancy is now 84.3 years for men and 86.6 for women. Women continue to live longer than men; eighty-five percent of adults 100 or older are women. Throughout the U.S., lifetimes of gender income inequality result in older women experiencing poverty rates almost double those of older men. Nearly 50% of women aged 75 or above live alone, reflecting the trend for older adults to live alone in one-income households as they age (NCCDPHP, 2023).

FIGURE 2.
MAT-SU POPULATION COUNT BY AGE AND GENDER, 2022



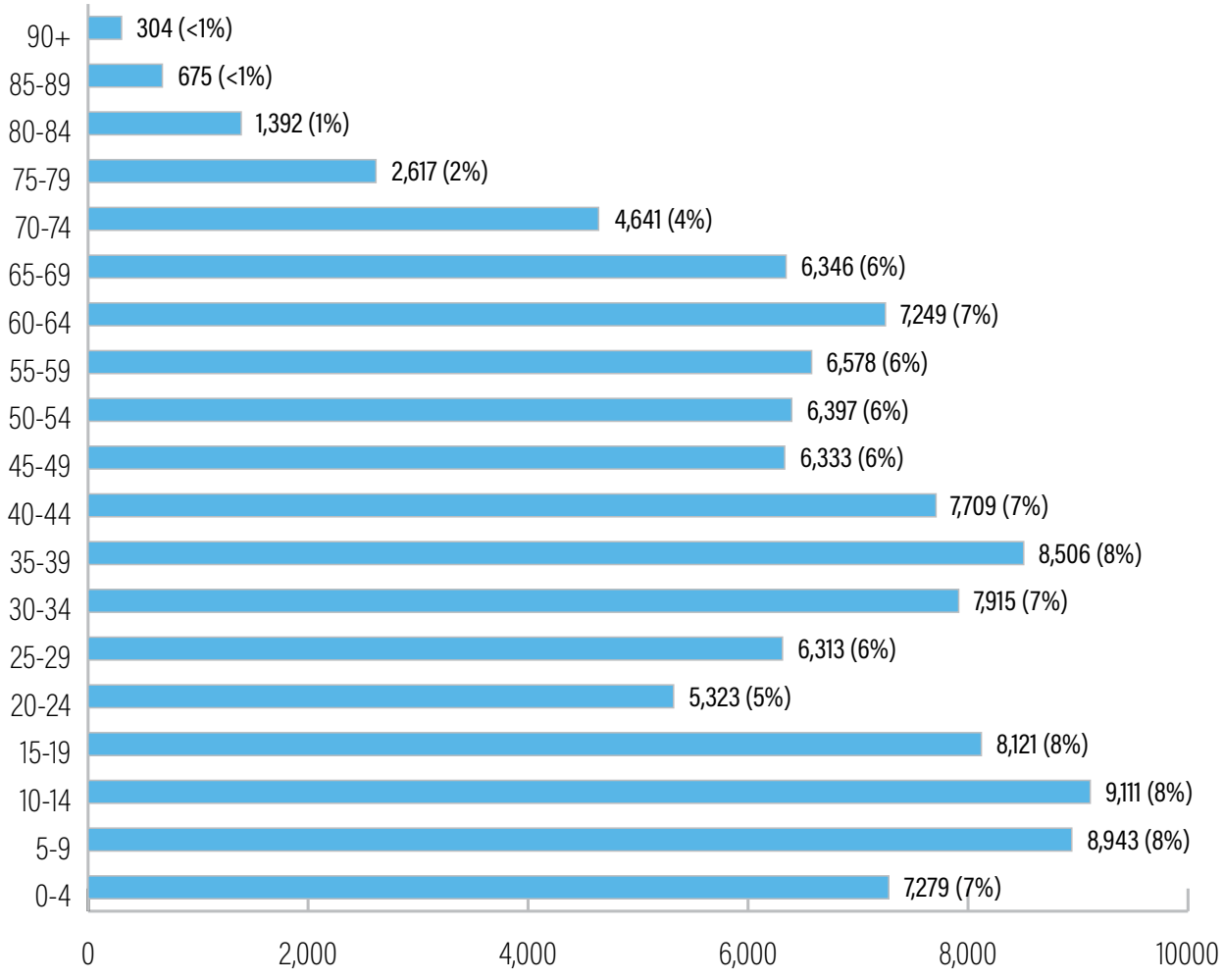
Source: (AKDOLWD, n.d.). Note: Percent of the population is in parenthesis.

In 2022, 18% of the Mat-Su population (20,224) were aged 50-64, and 14% (15,975) were 65 or older (Figure 2). Of those 65 years+, 69% are between 65-74 years, 25% are between the age of 75-84 years and 6% are aged 85+ years. Looking at the gender profiles of the different age groups, the percentage of males and females varied. For residents 50-64 years, there were 248 more males; for residents 65-74, 25 more females; for residents 75-84 years, 37 more males; and for residents 85+, 117 more females.

Older adult population change

Examining the five-year age group populations in Mat-Su (Figure 3), the 60-64 year cohort, with a population of 7,249, stands out as the largest of the five cohorts between 45 and 69. The average population of these five cohorts was 6,581. The three younger age cohorts, from 30 to 44, had populations ranging from 7,709 to 8,506 and were larger than any of the older five-year cohorts. Using the data in Figure 3 to project trends in the number of people aging into the 65+ cohorts, one might expect a growing number of residents will turn 65 in the next five years. After that, the number of residents turning 65 will decrease for about 15 years. Twenty years out, as the generation now 30-44 turn 65, the population over 65 grows again. All these numbers will be affected by migration/emigration and unusual factors affecting death rates (i.e., pandemics). See the section below, "Older adult Population Change," for Mat-Su population estimates for 2019-2045 from the State of Alaska Department of Labor and Workforce Development (AKDOLWD, n.d.).

FIGURE 3.
COUNT OF MAT-SU POPULATION BY AGE, 2022



Source: (AKDOLWD, n.d.) Note: Percent of the population is in parenthesis

For persons aged 50-64 years and 65+ years in Mat-Su, the 2015-2022 in-migration and out-migration of individuals in these age groups had a minimal impact on population size with an addition of 23 people in the younger age group and a reduction of 21 in the older age group (Table 3). Deaths had a much higher impact on the number of people in each age group, with 1,238 people aged 50-64 dying between 2015 and 2022 and 3,578 adults 65+ dying during the same period.

TABLE 3. **CAUSES FOR CHANGES IN POPULATION FOR MAT-SU AGE GROUPS 50-64 AND 65+, 2015-2022**

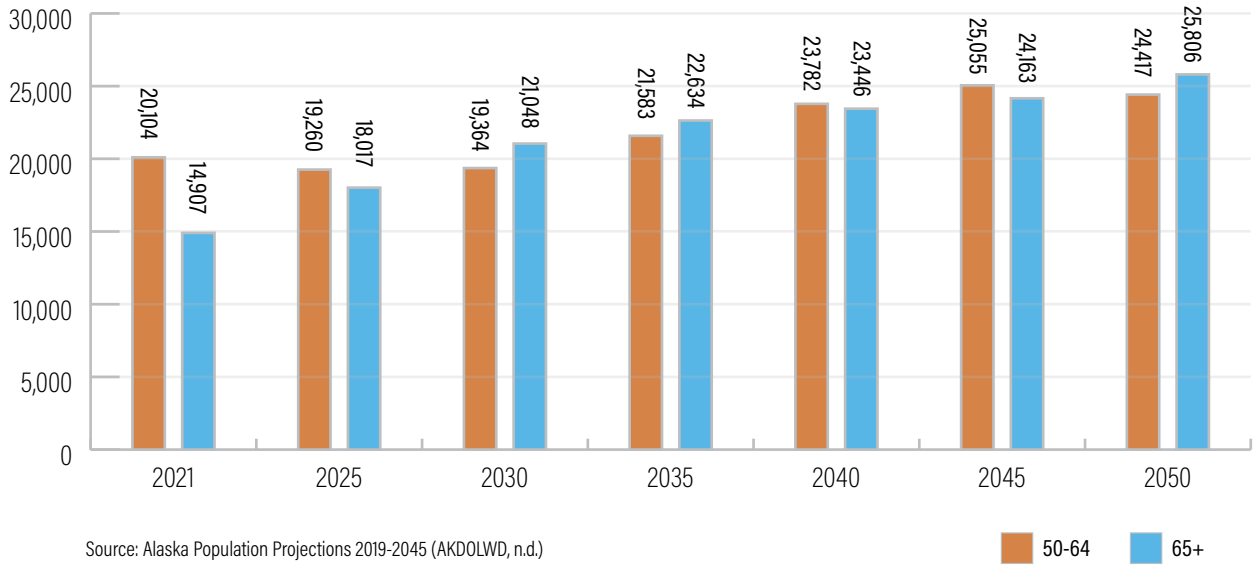
Age group	In-migration	Out-migration	Change due to migration	Deaths
50-64 years	1178	1155	23	1238
65+ years	566	587	-21	3578

Source: (AKDOLWD, n.d.)

In 2023, persons aged 78 and above are from the "Silent Generation". Those below age 78 are from the "Baby Boomer Generation." "Generation X" will start turning 65 in 2045. Research has shown that Baby Boomers value social engagement and healthy lifestyle behaviors and seek wellness and independence as they age. In the last decade, the Baby Boomer generation has been turning 65 years old. In 2010, in Alaska, 54,900 older adults were Baby Boomers. The Baby Boomer population grew to 94,000 in 2020 and 105,600 in 2022. This generation will not stop turning 65 until 2029 (Slotterback, 1996).

Figure 4 shows the total Mat-Su population of older adults aged 65+, is projected to increase from 14,907 in 2021 to 25,806 in 2050, a change of 73%. While older adults made up 14% of the population in 2021, this percentage increases to 17% of the population in 2050.

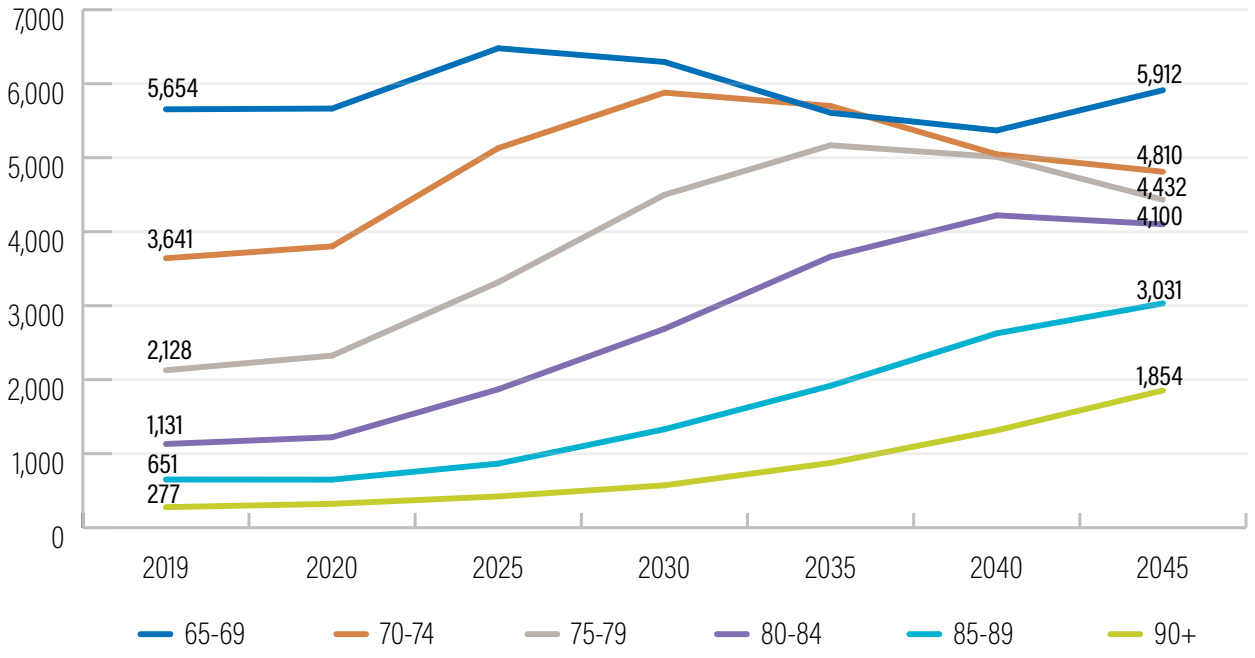
FIGURE 4.
MAT-SU POPULATION BY AGE GROUP ESTIMATES 2021-2050



Source: Alaska Population Projections 2019-2045 (AKDOLWD, n.d.)

Figure 5 shows the estimated growth by five-year age intervals for older adults of different ages. The difference between 2019 and 2045 for the different age groups is +258 for the 65-69 cohort, +1169 for 70-74, +2304 for 75-79, +2969 for 80-84, +2380 for 85-90, and +1577 for 90+.

FIGURE 5.
MAT-SU OLDER ADULT POPULATION ESTIMATES BY 5-YEAR INCREMENTS, 2019-2045



Source: Alaska Population Projections 2019-2045 (AKDOLWD, n.d.)

Grandparents caring for grandchildren

A growing trend is older adults assuming the role of caregiver for their grandchildren under 18 years of age (NCCDPHP, 2023). In the United States, a quarter of the estimated 2 million older adults have primary caregiver responsibilities for their grandchildren. In 2022, in Mat-Su, there were 706 grandparents 60+ years old responsible for caring for their grandchildren under the age of 18 years (ACS,2022). Two hundred and three of those grandparents also had a disability.

Place of residence

In 2022, the estimated population of the Mat-Su Borough was 111,752, with 15,975 adults aged 65 years or older. The cities and census-designated places with a population over 1000 with the highest older adult populations were Knik-Fairview (14%, 2300), Wasilla (9%, 1477), North Lakes (8%, 1322), Meadow Lakes (8% 1259) and Tanaina (6%, 1000) (Table 4).

TABLE 4. **POPULATION OF MAT-SU CITIES/CENSUS DESIGNATED PLACES WITH 1,000 OR MORE PEOPLE, JULY 2022**

Area name	Total population	Population 65+	Percentage of Population 65+
Knik-Fairview CDP	20,098	2300	14
Wasilla City	9,547	1477	9
North Lakes CDP	9,830	1322	8
Meadow Lakes CDP	9,675	1259	8
Tanaina CDP	8,957	1000	6
Palmer City	5,936	891	6
South Lakes CDP	5,258	879	6
Big Lake CDP	4,023	836	5
Gateway CDP	6,142	700	4
Fishhook CDP	5,761	636	4
Butte CDP	3,682	631	4
Willow CDP	2,386	612	4
Farm Loop CDP	2,795	388	2
Susitna North CDP	1,639	372	2
Lazy Mountain CDP	1,578	351	2
Houston City	2,046	340	2
Talkeetna CDP	1,060	233	2
Point MacKenzie CDP	2,092	173	1
Buffalo Soapstone CDP	1,081	166	1
Sutton-Alpine CDP	1,049	151	0.9
Total Borough Estimate	111,752	15975	14
Balance	7,117	1258	8

Source: (AKDOLWD, n.d.) Note: Balance indicates the total number of people living in places with populations <1000.

Race and ethnicity

In the United States, 10% of older adults from all racial and ethnic groups live in poverty. The economic outlook for older people of color, approximately 25% of the population age 65 and older, reflects the racial and ethnic inequities found for other age groups as they are more likely than older White adults to live in poverty (Frey, 2018).

Table 5 shows a cross-sectional view of the population in Mat-Su in July 2021 by age and race. One trend seen here is that the older the population of White people, the larger percentage they are of the total population. For the non-white population groups, as the group age increases, the fraction the group makes up of the total population (of the same age) decreases.

TABLE 5. **MAT-SU POPULATION BY AGE, RACE (ALONE OR IN COMBINATION) AND HISPANIC ORIGIN, JULY 2021**

	0-49 years	50-64 years	65 and + years
All individuals	82,262	20,864	15,323
White people	64,818	18,247	13,858
White %	79	87	90
AN/AI people	10,698	1,692	953
AN/AI %	13	8	6
Black people	2,400	329	287
Black %	3	2	2
Asian people	3,299	461	287
Asian %	4	2	2
NHIP People	1,047	135	57
NHIP %	1	1	<1
People of Hispanic Origin	5,051	691	369
Hispanic %	1	1	<1

Source: AKDOLWD, Research and Analysis Section Vintage 2021. All numbers are based on 2020 geography. Notes: These data were developed through a combination of estimates from the AKDOLWD and the U.S. Census.

In Mat-Su in 2021, the population between the ages of 50-64 was made up of 87% White individuals, 8% Alaska Native/American Indian individuals, 2% Black people, 2% Asian people, 1% Native Hawaiian/Pacific Islander people, and 3% people of Hispanic origin.

The population of older adults 65+ was composed of 90% White individuals, 6% Alaska Native/American Indian people, 2% Black people, 2% Asian people, <1% Native Hawaiian Pacific Islander population, and <1% people of Hispanic origin.

Veteran status

According to the ACS, in 2021, Mat-Su veterans make up 27% of adults 65+ (4,022). Most veterans were male (Table 6). About 26% of Mat-Su veterans of all ages had a disability (ACS, 2021). Approximately 6% of veterans 65+ live with income below the poverty level and 48% of these veterans report having a disability. The veterans turning 65 in the next 15 years are more likely to be female than the current older adult veteran population.

TABLE 6. **MAT-SU VETERANS BY AGE, GENDER, POVERTY, AND DISABILITY STATUS**

Age	Count	Percentage male (%)	Percentage female (%)	Percentage with income below the poverty level (%)	Percentage below poverty level with a disability (%)
55-64 years	2539	86	14	10	40%
65 and older	4022	96	4	6	48%

Source: (ACS, 2021)

Older Adult Behavioral Health Status

KEY FINDINGS: **BEHAVIORAL HEALTH STATUS OF MAT-SU OLDER ADULTS**

1. The most common issues seen by providers and others were depression or suicidal ideation, anxiety, stress, grief, and alcohol and pain medication misuse.
2. Both mental and substance use disorders in older adults were intertwined with:
   a. Fear of stigma and undiagnosed mental health issues
   b. Social isolation
   c. Resistance to seeking treatment
   d. Failing health, including feeling cognitive changes coming on
   e. Limited mobility
   f. Financial insecurity and homelessness
   g. Difficulty enduring long, dark, and snowy winters
   h. Misuse of prescribed medication – intentionally to self-soothe
   i. Misuse of prescribed medication – unintentionally due to misunderstanding or cognitive decline
   j. Self undermedication to prompt admission to the hospital for social connection
3. Ten percent of older adults reported in the last year using opioids; 9% drinking heavily; 7% binge drinking; 8% using marijuana.
4. In 2021, there were 985 behavioral health-related discharges for Mat-Su older adults from inpatient hospitals, 517 for drug-induced diagnoses, and 62 for alcohol-induced diagnoses. The discharge rates for Mat-Su were higher than all of Alaska for behavioral health related and drug-induced diagnoses, and lower for alcohol-induced diagnoses.
5. In 2021, there were 639 discharges for Mat-Su older adults for behavioral health related diagnoses from emergency departments, as well as 327 for drug-induced diagnoses and 64 for alcohol-induced diagnoses. The discharge rates for all three diagnoses from emergency departments was lower for Mat-Su as compared to all of Alaska.
6. One hundred twenty-four older adults were discharged from Mat-Su Regional Medical Center (MSRMC) services with a primary behavioral health diagnosis (2022).
7. In 2022, the local core area FQHC, Mat-Su Health Services, saw 90 older adults for psychiatric care, 84 for counseling, 90 for MAT, and 15 for case management (2022). The Upper Su area FQHC, Sunshine Community Health Center saw only 18 seniors for 108 behavioral health visits in 2022,
8. In 2018-2019, 163 older adults called EMS for altered mental status or psychiatric problems.
9. In 2021, there were 5 suicide deaths among older adults, and the older adult suicide death rate per 100,000 of the population in Mat-Su (29.6) was higher than in Alaska (21.4).

Historically, in the United States, the rates of mental health disorders for those 65+ are lower than those of younger adults. While one in four older adults experience mental health concerns such as depression, anxiety, or schizophrenia, these conditions rarely begin for the first time in old age. An exception to lifetime mental well-being continuity would be those older adults who develop symptoms of Alzheimer's disease and related dementias (ADRD). Some of the symptoms of ADRD are similar to those of depression, and older adults may experience unprecedented anxiety with the onset of ADRD (National Institute of Neurological Disorders and Stroke, 2022).

While aging influences the capacity for physical activity for older adults, their personality expression and mental well-being usually continue their life patterns as younger adults. However, they face new risk factors for depression and may develop their first episode after 65. Adults with extroverted ways of engaging with society in their youth are more likely to continue extrovertive social interaction styles as older adults; those adults whose social engagement tended towards introversion throughout their lives are more likely to continue those patterns as they age. Likewise, those who experience depressive episodes as older adults are more likely to have had a lifetime history of depressive symptomatology (Novotney, 2018).

Suicidal ideation stems from factors other than aging processes; however, older people experience age-related conditions with the potential to exacerbate depressive symptoms, contributing to suicidal ideation as they reduce a person's internal resources for handling stressors and recognizing suicidal ideation as caused by a mental illness. These conditions include poor physical health, chronic pain, cognitive deficits, limited access to physical activity due to fear of falls, dementia, and loss of social connections. Racial identity and ethnic origin also can influence the risks for suicidality, with White men ages 85 and older having the highest risks for suicide completion of any age group (Laflamme et al., 2022).

The interactions between multiple medications and the suicide risks from misuse of opioid and benzodiazepine prescriptions are particularly acute for older adults, whose bodies cannot absorb or break down medications as efficiently as younger adults (Schepis et al., 2019). Data collected from 2009 through 2011 from ten healthcare systems participating in the Mental Health Research Network indicated that about 64% of patients who attempted suicide had a primary care health visit within a month of their attempt (Ahmedani, 2015). The authors of this study concluded that considering sociocultural differences in the expression of suicidality and integrating suicide prevention measures into routine primary care would increase the accuracy of suicide risk assessment and potentially reduce the lethality of those risks.

According to the National Survey on Drug Use and Health (NSDUH), the percentage of adults 65 and older using drugs increased from 19.3 percent in 2012 to 31.2 percent in 2017 (Blanco, 2020). The consumption of alcohol, the most common substance misused by adults in the US, decreases after 30 years of age and continues to decline, with the most notable decrease after age 65 (Delker et al., 2016). In the US, over 10 percentage of adults 65 years or older are estimated to engage in sporadic binge drinking (five or more drinks per occasion for men, four or more drinks per occasion for women). Screening for binge drinking, in addition to screening for daily use, could identify those at risk for harmful outcomes such as falls (Han et al., 2019).

As the number of adults over the age of 65 continues to grow, the number of older adults with substance use disorders likewise continues to grow, as does the need for treatment programs either inclusive of them or designed for them. Most older adults with substance use disorders (SUD) also experienced SUD in their earlier years. Rarely do incidences of SUD start with aging (Compton et al., 2007). The prevalence of SUD rises for those identifying as White, male, divorced or widowed, with one or more disabilities, and with lower levels of formal education (Blanco, 2020). The increase in the need for SUD treatment services for older adults in the US is partially attributed to the higher lifetime substance use rates of the Baby Boomer generation compared to past generations (Novotney, 2018).

Most older adults who can obtain admission to treatment centers for SUD do so for alcohol use (NIDA. National Institute on Drug Abuse, 2020). While older adults who consume alcohol face greater risks than younger age cohorts for worsening physical and mental health conditions due to the aging body's decreased ability to metabolize alcohol, higher rates of diabetes and dementia, as well as the potential for alcohol to interact with other medications, they are less likely to be screened for alcohol use and to receive treatment for its overuse (Alliance for Aging Research, 2022).

Aging also decreases the chance of older adults receiving treatment for SUD for other substances, including illicit drugs (Blanco et al., 2015). Yet increases in polydrug use by older adults, involving marijuana, prescription opioids, and heroin, continue to rise. From 2015 through 2016, the NSDUH survey found that marijuana use amongst those 65 and older increased by 107% (Perlman 2019). As marijuana use amongst adults aged 65+ years increases, those who report using marijuana have been found to have higher rates of other drug use than non-marijuana users, including eight times the rate of cocaine use and two times the rates of prescription opioid misuse (Han & Palamar, 2018). Heroin use for those 55 and older doubled from 2012 to 2015, whether or not accompanied by marijuana use (Perlman 2019). For older adults, especially those with complex medical histories and multiple medications, broad screening for substance use, illicit and licit, could prevent or lessen adverse health outcomes, as older age cohorts face double the risks of dying from SUD than younger adults. As SUD symptoms can mimic those of diabetes, dementia, other chronic health conditions, negative reactions to life transitions, and depression, SUD screening tools could aid clinicians in identifying SUD and determining intersections with other conditions (Alliance for Aging Research, 2022).

Mental health status of Mat-Su older adults – interview data

When Mat-Su service providers, statewide agency, and church staff were asked about what they observed in their work related to older adults' behavioral health, the most common issues they reported were older adults struggling with depression or suicidal ideation, anxiety and stress, grief, and substance use problems. Table 7 provides examples of quotes of what providers said they see with their older clients or congregants.

TABLE 7. **EXEMPLAR QUOTES: COMMON MENTAL HEALTH CONDITIONS IN OLDER MAT-SU RESIDENTS**

Depression or suicidal ideation	We have several who have serious depression issues. They see counselors, and one of them has been on medicine but just can't tolerate the medicine. But they get life support from these [church] groups – just texting each other, making a phone call, whatever. It's just been "Wow!" In fact, I had to tell one the other day. I said, 'Now, don't you dare do anything to hurt yourself. If you are feeling like you're going to hurt yourself, you need to call immediately. You can call us. You need to call your therapist; you need to call somebody." But I could tell he was hanging on the edge. He has had a tough time getting things worked out because his counseling sessions were canceled. And I think if he had not had this group, he would've done something to hurt himself." – Church staff
Stress and anxiety	When I see stress, it is about health or family concerns – extended family living in another place – how are my kids doing? How to live on fixed retirement funding? That sort of thing. There may be a few who are struggling to meet their basic needs. There is some depression. – Church staff I've had elderly people come in with issues of being really stressed out and depressed and everything else due to the fact they didn't understand what they were gonna do about Medicare - the system is so complex, and they have problems and issues, and I've learned how to sit there and get them calmed down so they actually listen and understand so they'll learn what they're ready to get into. I don't know why I get a lot of people who start crying - they'll just start unloading and crying in the offices. I'll give them some moments to talk about it – what's going on with them, and then I'll ask them are you interested in seeking out services to get help with this? – Core area provider
Grief	Loss of loved ones – that is one very specific thing. They are not very much economically deprived so much, but there can be a little bit of that. - Church staff
Multiple challenges	Processing losses (loss of ability, loss of friends, etc.) that's not something that our culture or our society does a very good job of training or equipping or acculturating people to do. The folks that are coming into being seniors who are hard rockers and hard partiers and there are drug and alcohol and relational disruption and other things that our culture says "you don't talk about - those things." You don't deal with those things. You keep those things quiet. So, they have all of the consequences of those kinds of issues but are not willing to admit issues and not knowing where to go get help if you want it because of shame, guilt and the stigma attached. - Core area provider
Substance use issues	We know several who drink heavily, and sometimes we sense that they come into the food pantry that they may be high. It is hard to tell. Our sense is that there is huge drug usage in this area. - Rural provider
Mental health in general	I think 50% [of people who come into our mission ministry] might have some sort of mental health issue. I don't think they know that it exists. – Church provider about ministry work

Some providers also mentioned that they sometimes see people with schizophrenia, paranoia, and bipolar syndrome (Table 8).

TABLE 8. **EXEMPLAR QUOTES: OTHER MENTAL HEALTH CONDITIONS SEEN BY PROVIDERS**

Paranoia	Every time we get a wish list – there's a phone call involved. It's a moment where their isolation gets a little bit broken, and they feel heard and seen. But oftentimes, as they talk, they'll give little hints of how they see the world – sometimes that looks like distrust or really paranoia. [They say] "I don't know if I can have someone come to my house to deliver it because I just don't talk to people. It makes me too afraid or too anxious." – Mat-Su provider
Schizophrenia, bipolar, depression, and SUD	We can have someone who's over 60 who comes in, and there's a few in my head that we know of with anxiety, there is depression, schizophrenia, bipolar, substance abuse is a big one. – Core area provider

Providers paint a picture of the older people they serve as often being reluctant to seek behavioral health care because of the cost, stigma, and not wanting to admit their vulnerability. These factors may also be true of respondents who answered surveys from which data were taken for this report. The quantitative data most likely underreports the mental health struggles in Mat-Su.

The discussions of behavioral health struggles were always intertwined with other challenges that either caused or exacerbated these struggles. Older adults faced the following situations:

1. Fear of stigma and undiagnosed mental health issues
2. Social isolation
3. Failing health, including feeling cognitive changes coming on
4. Limited mobility
5. Financial insecurity and homelessness
6. Difficulty enduring long, dark, and snowy winters

Later in this report, we look in-depth at social connection, isolation, financial security, and independence issues to identify how widespread the challenges related to these issues are in Mat-Su.

Table 9 lists some quotes from providers that illustrate the connection between mental health and the issues they see.

TABLE 9. **EXEMPLAR QUOTES: FACTORS AFFECTING AN OLDER ADULT'S BEHAVIORAL HEALTH**

Stigma and undiagnosed behavioral health issues	One of the challenges that a lot of long-term facilities are having is because there has been such stigma around behavioral health [for the older generation]. [There are people] who definitely have serious mental illness, but were never diagnosed and need medication, but because they didn't receive a diagnosis in their 30s or 40s, they aren't allowed to give the medication for them because there's regulations about overmedicating residents and so they're really feeling stuck. Honestly, I believe that has a lot to do with generational stigma around behavioral health issues. – State agency staff
Isolation	So, it's the recipe (isolation + depression + suicidal ideation). Our whole goal is to get them out of isolation. Alaskan veterans want to be on their own. They want to survive on their own. They try to live in an area that's unhabitable by most people in the world. There are absolutely huge needs. So that is 99% of our elderly cases. They just need someone to talk to. – Veteran provider
Cold, hard winters and decreased mobility	I see some severe depression up here – and suicidal ideation. One of the old timers told me, 'I don't think I'm going to make it through this winter.' And I said why? I spent three hours talking to him on the phone (which I can do). He told me all the reasons why his family wasn't there anymore. It was harder for him to get around, he had to struggle more. He spends a lot of time in his cabin alone. He can't get out the way that he used to. There was just no purpose or point. I do hear that a lot. I hear all the markers that tell me I think a person is going to commit suicide. – Rural provider
Financial insecurity	So, there are people who have had a very stable life for a good while during their working time. And they've had some mental health challenges maybe along the way, but those challenges are only increasing as they go through the aging process. It becomes very difficult for them – they no longer have stability. Maybe they've retired or have been let go from their job. And now they are at a place where they need the funds. Maybe some of their cognitive challenges are happening where it becomes much more difficult for them to find good resources. Especially resources that are not available in a timely manner. Then it becomes all the more difficult for them to be able to get the resources that they really need for that stage in their life. – Church ministry staff
Mental illness	I have one [congregant] who comes in episodically who has schizoaffective disorder, and she's in treatment . I have another one who's schizophrenic and he's in treatment also – he comes more frequently but he seems in good shape. He has housing. They both have housing. They both look like they are well cared for. But I see a lot of red flags in my care ministry program that really distresses me to look at. They're the ones with the dark grayish black hands and obvious dirt on their face and clothes with evidently no existing hygiene facilities. Those kinds of things are really distressing for me because they are highly at-risk people. I'm thinking that as far as mental health wise that is a real red flag. – Church ministry staff

TABLE 9. **EXEMPLAR QUOTES: FACTORS AFFECTING AN OLDER ADULT'S BEHAVIORAL HEALTH**	
Homelessness	There is an old guy – 60 or 64 years. He lives out in the woods. We're helping him out – I'll drive him back to his place so he's not trying to tote that stuff (from the food pantry) in the wintertime. He lives in his tent that's super fortified. But the snow this past winter was too heavy and started collapsing in on him. Living that way is not ideal. And he's got something going on mentally, you know? I just try to be nice to him and sometimes he tries back. – Church ministry staff I think of someone – she's experiencing homelessness – really has no place to go. There's no place for her to lay her head. She lives in her vehicle, and you know, she's worked in the school district and she has worked in different places, and she has some great abilities and competencies, but she is getting a little older now and having a hard time finding resources. – Church ministry staff

Substance use disorder status of Mat-Su older adults – interview data

The clinical and church staff stated that older adults struggle the most with alcohol and pain medication misuse. Providers identified the following themes as being intertwined with substance use disorder:

1. Mental health problems like isolation, depression, and suicidal ideation
2. Stress due to financial insecurity and sometimes homelessness
3. Misuse of prescribed medication – intentionally to self-soothe
4. Misuse of prescribed medication – unintentionally due to misunderstanding or cognitive decline
5. Self undermedication to prompt admission to the hospital for social connection
6. Stigma and resistance to seeking treatment

Providers said that individuals are prescribed pain medication when there is a physical need, and subsequent misuse could be intentional or unintentional. They could continue a prescribed pain medicine regimen even in the absence of pain. They could be using pain medication to self-soothe, especially when they have other stressors, particularly homelessness, financial stress, or loneliness. They may end up addicted to a medication and not realize it for quite a while, then try to stop it on their own. They may have cognitive decline and not take their pain medication as prescribed. One state agency staff person said they felt that medical providers might be more likely to prescribe pain medication to older adults because they assume that pain in this population is expected. At the same time, they may be less likely to suspect misuse of substances in this population. Table 10 provides exemplary quotes for the major themes described by interviewees related to substance use.

TABLE 10. **EXEMPLAR QUOTES: SUBSTANCE MISUSE AND ABUSE IN OLDER RESIDENTS IN MAT-SU**	
Depression or suicidal ideation	"Most of the time, it's alcohol... If it's other drugs, they often don't make it to 65 or they are in a different situation. Right now, we have people on a call right now to someone who is an older individual who's drinking and suicidal. A lot of times, they are lonely. – EMS provider
Stress and sometimes homelessness	When people find themselves in very stressful situations, there's a higher likelihood that they will use substances at an unhealthy rate. – they're self-medicating. I'll use an example of someone who is living in their car, so when they don't have the resources available, of course, they become more likely to find something that will soothe. I can't say that the majority of seniors abuse substances. I don't think that is the case – but is there a connection there? There is absolutely a connection. – Church staff
Unintentional misuse	I think a lot that we've seen is prescribed pills and not using them correctly. I think we are seeing more of that. So, it's not that they're trying to get high off their pills. It's that they are getting high off their pills, and they're not aware that they're getting high because they are taking them in a way that they were told to take them....one lady she got super wasted when our staff member was going out to touch base with her. She was saying, "No, I just took my pills." She took two days of her pills at once. She took one and then came back and took another because she was unsure [if she had taken it.] – Mat-Su provider There are some folks who fall on hard times, and it's not because of this wrong choice that they've made or this addiction or substance. There are a couple of things with the aging population and addiction. It is cognitive decline – memory. They get hooked on some prescribed medications that they are on. It's really not a choice of their own. – Church provider
Resistance to treatment	I think they are a little bit more resistant to treatment. There were some issues with the pandemic with people that had been active in Alcoholics Anonymous (AA), but because they all went to an online format. I didn't have any seniors that were willing to do online AA meetings. I saw a lot of relapse in our senior population due to lack of sponsorship and social support that they would get from their meetings. – Core area provider
Under medicating	There is something as a medical professional I've seen – undermedication for admission to the hospital. For example, if someone will not take their medication and becomes ill, and then have to be admitted so that they can be around others and have some social time and attention. - Core provider
Alcohol use	I've seen quite a bit of drinking [on home visits]. When you go in to see them, I see multiple bottles, and it's only been a week and there is just one person living there. I teach my staff to kind of push for when we do our meal prep for them – push for healthier options or get the water bottles ready so if they need something, that is what they grab for. – Core provider
Prescription drug use	People end up getting first introduced to the drug through some kind of medical provider. Some kind of medical encounter. Who are the ones who are typically having the most aches and pains and some injuries? That's going to be seniors. The kid who wrecks his bike and breaks his leg and is given opioids to deal with it – you have those kinds of vector. But you also have the person who's got chronic osteoarthritis, and he or she is now being prescribed some that don't quite do it anymore, and so [the prescriber] adds something to that and then adds something to that and so on. – Mat-Su provider

Behavioral Health and Dementia

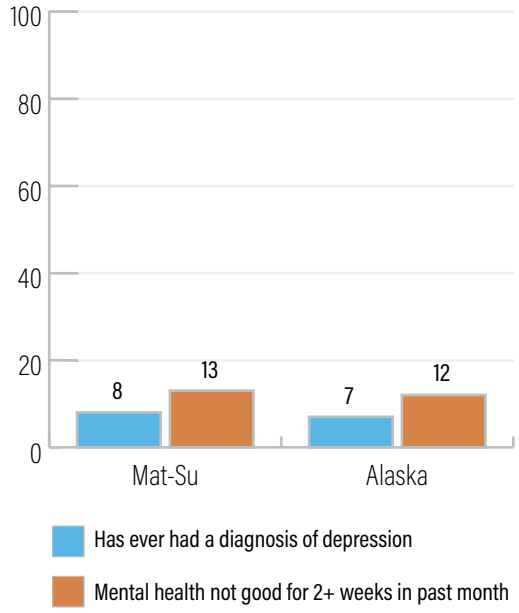
A 2016 evidence review conducted in England explored the relationship between dementia and mental health issues. The review found a dearth of data and findings on the challenge of living with co-morbidities with dementia and the experience of people with behavioral health conditions who develop dementia (Regan, 2016). A paramedic with the local emergency medical services and staff from the local hospital with an inpatient behavioral health unit said they often see older adults with both dementia and behavioral health conditions. The inpatient hospital staff stated that care decisions and treatment are more difficult for these individuals. For example, in an inpatient unit, an individual with dementia may not be able to be in a shared room, and there is a question about whether they can actively participate in a meaningful way in group therapy. The staff suggested that outpatient care may be more appropriate for that individual; however, adequate insurance coverage and a lack of available outpatient slots may be barriers.

SURVEY DATA

The Behavioral Risk Factor Surveillance System (BRFSS) survey is a population-based phone survey conducted throughout Alaska (BRFSS, 2023). From 2015 to 2021, 8% of older adults in Mat-Su reported that their mental health was not good for 2+ weeks in the last month, and 13% reported they had ever been diagnosed with depression (Figure 6). The percentage of older adults who had been diagnosed with depression or had poor mental health in the past month was just one percent higher for older adults in Mat-Su compared to Alaska.

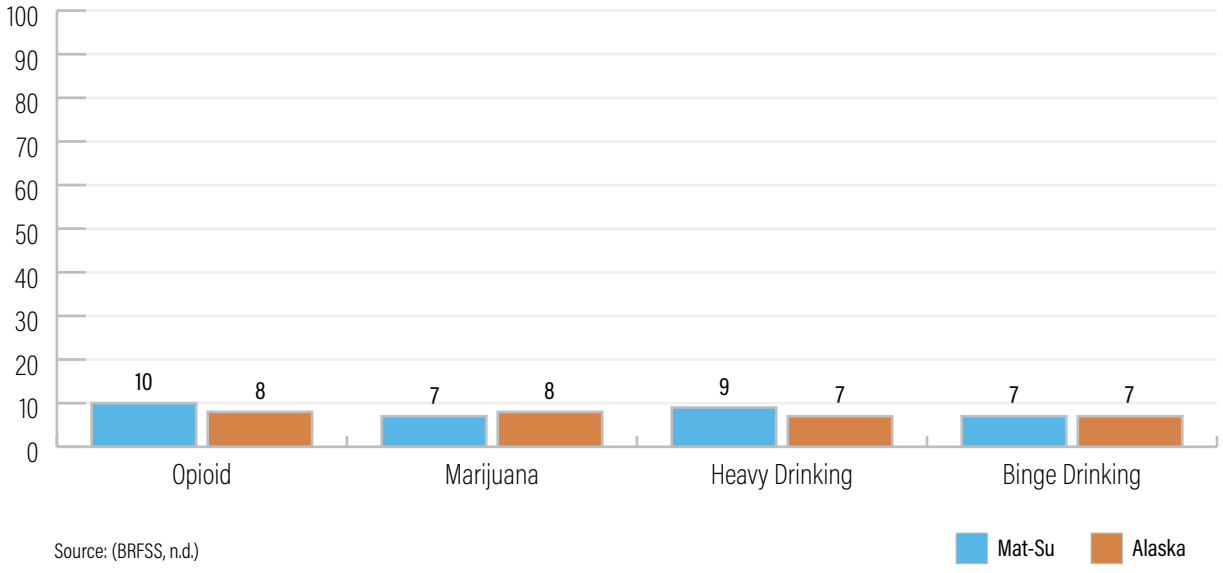
Reported opioid use, either as prescribed or misused, among Mat-Su older adults was 10% compared to 8% for Alaskans of the same age (Figure 7).

FIGURE 6.
DEPRESSION OR POOR MENTAL HEALTH FOR MAT-SU AND ALASKA OLDER ADULTS (%), 2015-2021



Source: (BRFSS, n.d.)

FIGURE 7.
SUBSTANCE USE BY MAT-SU AND ALASKA OLDER ADULTS (%), 2015-2021



Source: (BRFSS, n.d.)

Almost 7% of Mat-Su and 8% of Alaskan older adults reported using marijuana in the last 30 days. Nine percent of Mat-Su older adults reported heavy drinking in the past 30 days compared to 7% of all Alaskans aged 65+. Heavy drinking is defined as males having more than two drinks every day and females having more than one drink per day. The percentage of older adults in Mat-Su and Alaska reporting binge drinking was 7%. Binge drinking is defined as males having more than five or more drinks on one occasion and females having four or more drinks.

BEHAVIORAL HEALTH FACILITY DATA

The following facility data paints a picture of a small number of older adults using behavioral health outpatient services and a larger number being seen in hospital inpatient and emergency room settings.

Outpatient behavioral health facility data

Mat-Su Health Services (MSHS), a federally qualified health center with clinics in Wasilla, Palmer, and Big Lake, accepts Medicare and has a sliding fee scale. In 2022 at MSHS, 90 older adult patients saw psychiatric providers, 84 saw behavioral health providers for clinical care, 90 were Medication Assisted Treatment (MAT) patients, 20 were seen for case management, and five for assistance with daily living skills. These were not all separate patients; one patient could have accessed several services. Sunshine Community Health Clinic, a federally qualified health center serving the Upper Susitna region in Mat-Su, had 18 separate older adult behavioral health patients in 2022 who had 180 visits.

TABLE 11. **NUMBER OF VISITS AND UNIQUE PATIENTS AT MAT-SU FQHC (65+), 2022**

	Visits	Patients
MSHS - Medical visits	6,072	827
MSHS - Behavioral Health visits	2,238	Unique pts - DNA
Psychiatric	469	90
Clinical	643	84
MAT	490	90
Case management	289	15
Skills development only	347	5
SCHC- Behavioral Health visits	180	Unique pts 18

Source: MSHS and SCHC. Note: Data was not available (DNA) on the number of unique behavioral health patients for MSHS.

Facility data on Mat-Su older adults with Medicare and Medicaid having a paid behavioral health Medicaid claim

In Alaska, there are two types of Medicaid: regular Medicaid, which assists with paying for healthcare, and the Home and Community Based Care Medicaid Waiver, which provides case management services to persons at risk for nursing home or institutional placement.

If an older adult has regular Medicare and qualifies for Medicaid, they will automatically qualify for the Medicaid Savings Program, covering Medicare Part B premiums. Medicaid will also cover most out-of-pocket Medicare expenses like deductibles, coinsurance, and copays. Medicaid will also pay for nursing facility care (beyond lifetime days covered by Medicare,) prescription drugs (Extra Help Medicaid Program), and eyeglasses/hearing aids. The Medicare Advantage Program, which helps an older adult better coordinate Medicare and Medicaid benefits, is not offered in Alaska.

Providers that accept both Medicaid and Medicare will bill Medicare first, and Medicaid will make up the difference according to the State's plan regulations (Medicaid.gov). Dual eligibility is based on the Federal poverty level. According to the state of Alaska Division of Public Assistance, in FY22, only 178 Mat-Su older adults had regular Medicaid, and 1,888 had Long Term Care Medicaid. There may be Mat-Su residents who would qualify for Medicaid as older adults but do not

realize that this assistance exists, so they do not fill out the necessary paperwork.

Data from the Division of Behavioral Health on paid Medicaid claims for FY20 and FY21 revealed that only a very small number of dually insured adults 65-75 years in Mat-Su accessed behavioral health services using Medicaid each year – 67 total for both years.

The top three diagnoses of those with Medicaid behavioral health claims were major depressive disorder, reaction to severe stress, adjustment disorders, and bipolar disorder.

TABLE 12. **MAT-SU ADULTS 65+ WITH PAID BEHAVIORAL HEALTH MEDICAID CLAIMS DURING FY20, FY21**

Diagnosis	Count
Co-occurring disorder	6
Mental health only	62
Substance Use Disorder only	5
Other	3
Total	76

Source: State of Alaska, Division of Behavioral Health
Note: A client may span more than one age category within a year. If this is the case, the client may be counted twice. The treatment category is determined by looking at diagnosis codes with the fiscal year. The other diagnosis code indicates that a diagnosis for MH or SUD was not indicated.

TABLE 13. **TOP TEN DIAGNOSES FOR CLIENTS WHO HAD A PAID DBH MEDICAID CLAIM – FY20 AND FY21 MAT-SU OLDER ADULTS 64-75 YEARS**

Rank	Diagnosis	Count
1	Major depressive disorder, recurrent	26
2	Reaction to severe stress and adjustment disorders	17
3	Bipolar disorder	12
4	Other anxiety disorders	7
5	Major depressive disorder, single episode	7
6	Schizophrenia	6
7	Opioid-related disorders	<5
8	Schizoaffective disorders	<5
9	Unspecified mood disorders	<5
10	Other stimulant-related disorders	<5
10	Alcohol-related disorders	<5

Source: State of Alaska, Division of Behavioral Health.

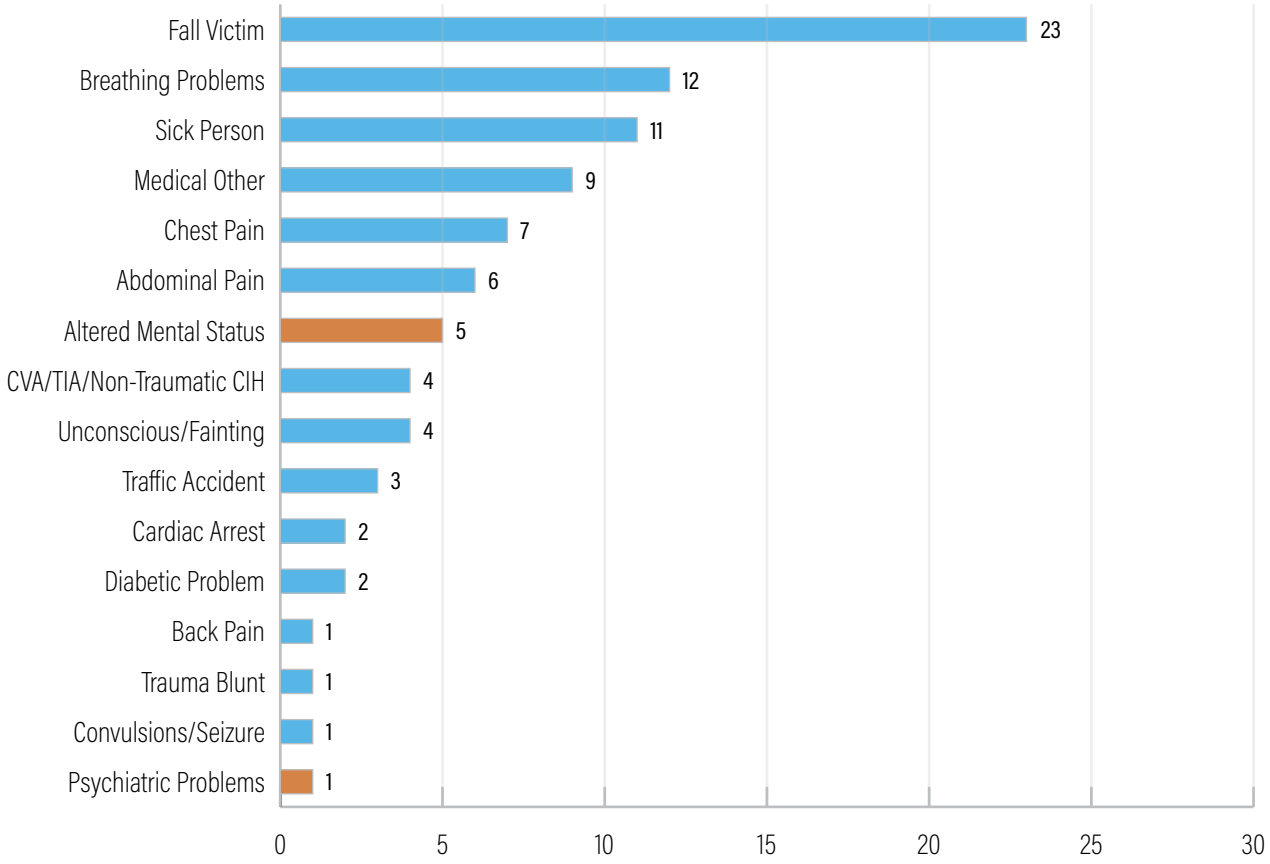
Facility data from Mat-Su Borough Emergency Services

Annually, there were approximately 2,722 Mat-Su EMS calls from older residents (60+ years), representing 29% of all 911 calls. The calls related to behavioral health were: altered mental status (5%, 136) and psychiatric problems (1%, 27). There may be behavioral health components among other call types. These figures may underestimate the number of clients with behavioral health struggles who call EMS because they have an underlying struggle but call for a physical health reason. A paramedic interviewed for this report stated that sometimes older adults call for EMS with a physical health problem when the underlying issue is loneliness (The Paramedic Foundation, et al., 2020).

Mat-Su older adults discharged at any emergency department (ED) or inpatient facility in Alaska

Hospital discharge data from the State of Alaska Health, Division of Public Health, Health Analytics, and Vital Records Section (AHAVRS) provides a view on the use of acute care for behavioral health among older adults. Mental health or substance use issues may be intertwined with physical health issues. To capture that combination, we looked at the diagnoses for hospital inpatient and emergency department discharges for Mat-Su older adults from any hospital in Alaska. We chose those where behavioral health was a primary or secondary diagnosis or combined with any other diagnosis except for dementia. The dementia diagnosis was intentionally left out due to the scope of this report.

FIGURE 8.
CALL TYPE FOR MAT-SU EMS OLDER RESIDENTS (60 YEARS AND OLDER), 2018-2019



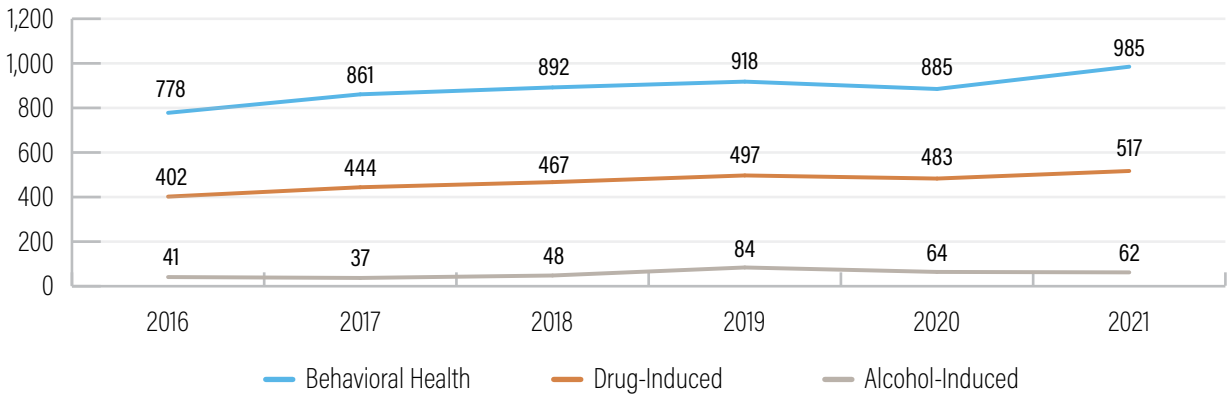
Source: (The Paramedic Foundation, et al., 2020). Note: Behavioral Health calls are highlighted in orange.

Appendix B includes a table outlining the code and assigned diagnoses used for the data in this section. In the figures below, behavioral health diagnoses included both mental health and SUD codes. Drug-induced diagnoses included substance use disorders (other than alcohol) as well as poisoning and physical conditions related to substance use disorder. Similarly, the alcohol-induced diagnoses included the standard alcohol use diagnosis codes along with alcohol-induced physical complications.

In 2021, there were 985 behavioral health-related discharges for Mat-Su older adults from inpatient hospitals, 517 for drug-induced diagnoses, and 62 for alcohol-induced diagnoses. Figure 9 shows the number of older adult discharges for hospital inpatient stays related to behavioral health diagnoses as a trend since 2016. Since then, there has been a steady slight increase in the number of discharges for these diagnoses, with a slight dip in 2020, perhaps due to the pandemic.

When comparing the rate for each type of hospital inpatient discharge in Mat-Su with Alaska, the behavioral health and drug-induced discharge rates in Mat-Su are higher than those in all of Alaska, but the alcohol-induced rate is lower (Figure 10).

FIGURE 9.
MAT-SU OLDER ADULT HOSPITAL INPATIENT DISCHARGES FOR PRIMARY OR SECONDARY BEHAVIORAL HEALTH DIAGNOSES, 2016-2021

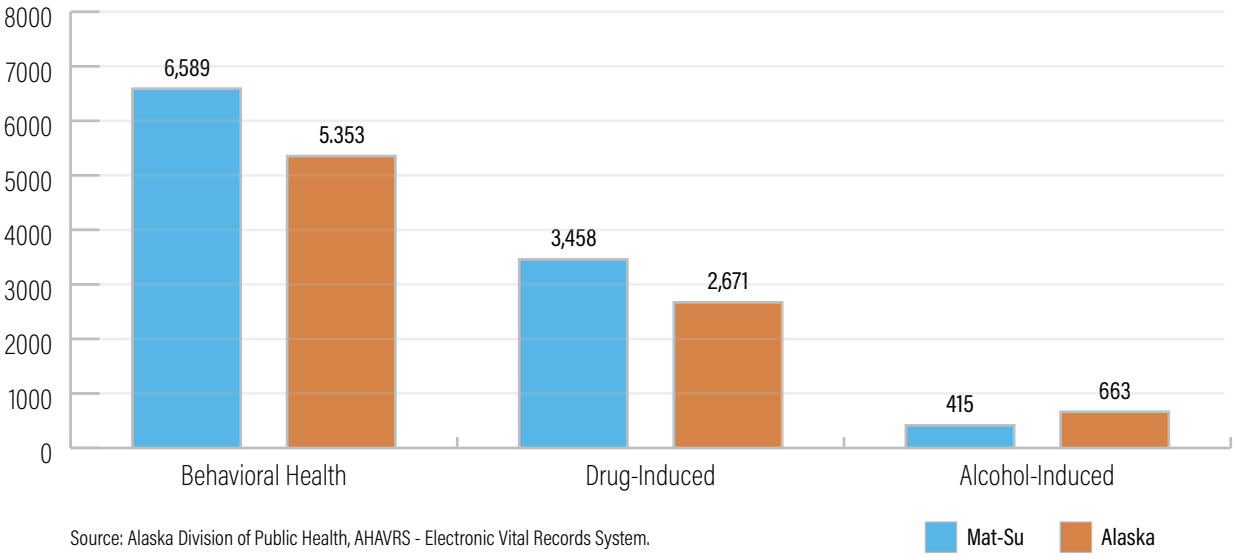


Source: Alaska Division of Public Health, AHAVRS - Electronic Vital Records System.

A slightly different pattern emerges when looking at the Emergency Department data for overall behavioral health and drug-induced discharges. In 2021, there were 639 discharges for Mat-Su older adults for behavioral health related diagnoses from emergency departments, as well as 327 for drug-induced diagnoses and 64 for alcohol-induced diagnoses.

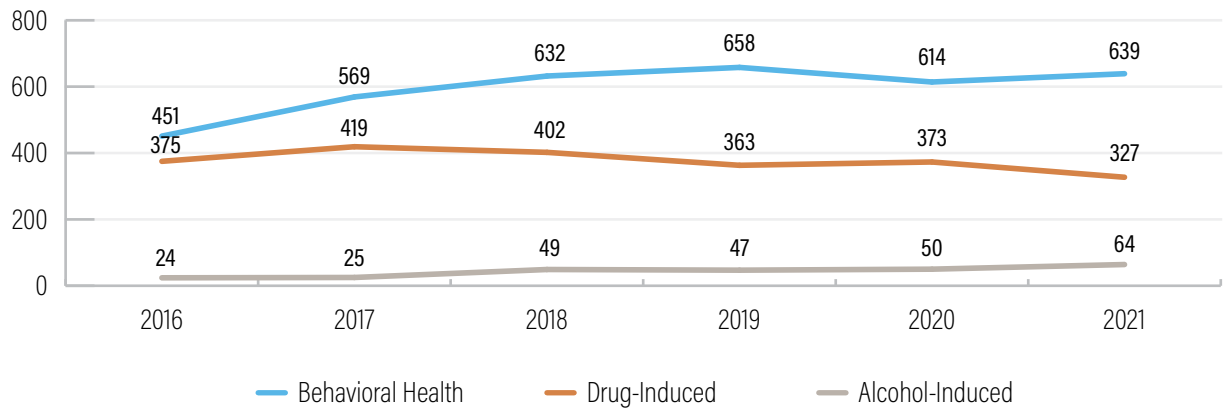
The total number of behavioral health diagnoses discharged from the ED increased from 2016 until 2019, dipped in 2020, and rose slightly in 2021. The number of drug-induced discharges showed small fluctuations from 2016 through 2021 and was lower in 2021 than in 2016. The alcohol-induced discharge rate increased significantly between 2016 and 2021.

FIGURE 10.
MAT-SU AND ALASKA OLDER ADULT NON-MILITARY FACILITY INPATIENT HOSPITAL DISCHARGE RATES PER 100,000 POPULATION BY DIAGNOSES, 2021



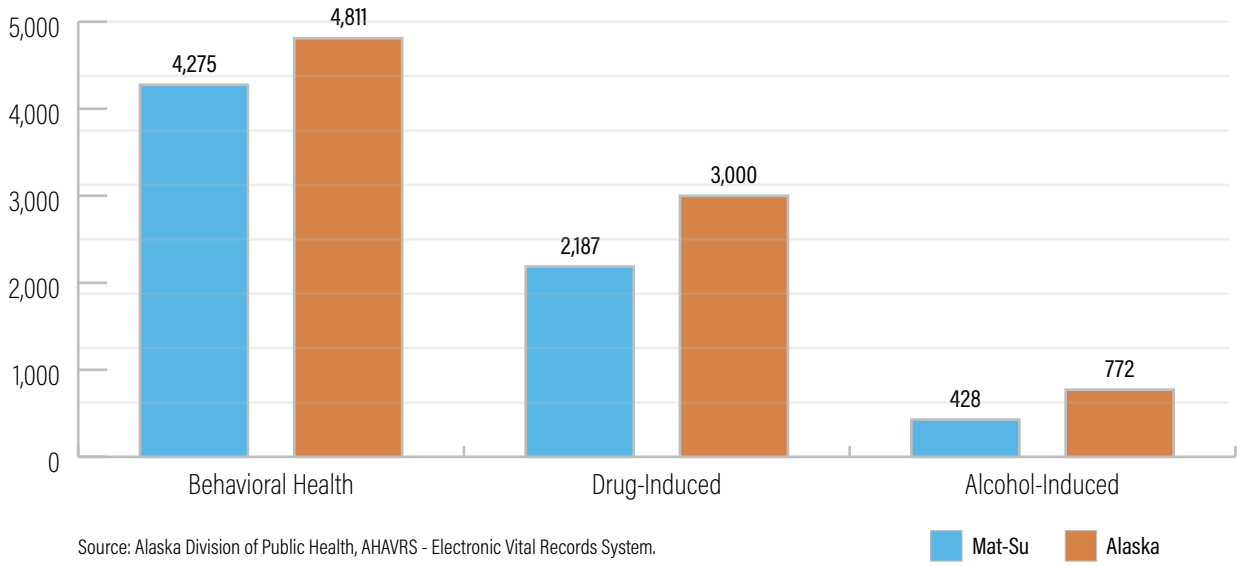
Source: Alaska Division of Public Health, AHAVRS - Electronic Vital Records System.

FIGURE 11.
MAT-SU OLDER ADULT EMERGENCY DEPARTMENT DISCHARGES FOR PRIMARY OR SECONDARY BEHAVIORAL HEALTH DIAGNOSIS, 2016-2021



Source: Alaska Division of Public Health, AHAVRS - Electronic Vital Records System.

FIGURE 12.
MAT-SU AND ALASKA OLDER ADULT NON-MILITARY FACILITY EMERGENCY DEPARTMENT DISCHARGE RATES PER 100,000 POPULATION BY DIAGNOSES, 2021



Source: Alaska Division of Public Health, AHAVRS - Electronic Vital Records System.

Facility data from Mat-Su Regional Medical Center (MSRMC):

Hospital Facility Discharge Data provided by the Alaska Health and Hospital Association (AHHA) for this report shows the hospital discharges within Mat-Su for patients with a primary behavioral health diagnosis. In 2022, there were a total of 124 patients who were seen at the Mat-Su Regional Medical Center (MSRMC) in four different types of services. Table 14 shows that most patients with a primary diagnosis were seen in the emergency department (75), followed by urgent care centers (27), the inpatient behavioral health (BH) unit (12), and finally, inpatient acute care beds (10).

TABLE 14. **OUTPATIENT DISCHARGES FOR MSRMC PATIENTS WITH A PRIMARY BH DIAGNOSIS. 65+. 2022**

Services	Count
Outpatient Emergency Services	75
Inpatient BH Unit	12
Urgent Care Centers	27
Inpatient acute care	10
Total	124

Source: Health Facilities Data Reporting, Alaska AHHA

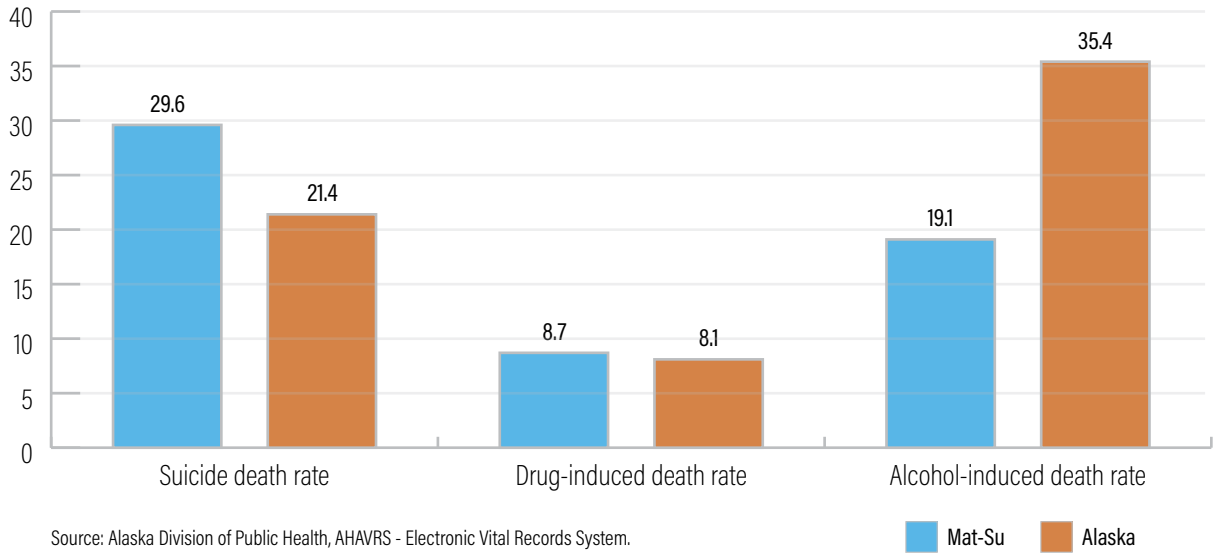
Most residents discharged from MSRMC with a primary BH diagnosis were females (60%), White (91%), and covered by Medicare (88%). Table 15 outlines the demographic description of the Mat-Su resident BH discharges.

TABLE 15. **CHARACTERISTICS OF MSRMC PATIENTS 65+ YEARS (%), 2022**

Characteristic	Percentage
Gender	
Male	40
Female	60
Payer	
Medicare	88
Commercial	5
Other	7
Race	
White	91
Alaska Native/American Indian	6
Other	3

Source: Health Facilities Data Reporting, Alaska AHHA

FIGURE 13.
MAT-SU AND ALASKA OLDER ADULT DEATH RATES PER 100,000 POPULATION BY UNDERLYING CAUSE, 2012-2021[5]



Source: Alaska Division of Public Health, AHAVRS - Electronic Vital Records System.

[5] Suicide (Intentional Self-Harm) underlying cause of death ICD-10 codes: U03, X60-X84, Y870.
Drug-induced underlying cause of death ICD-10 codes: D521, D590, D592, D611, D642, E064, E160, E231, E242, E273, E661, F110-F115, F117-F119, F120-F125, F127-F129, F130-F135, F137-F139, F140-F145, F147-F149, F150-F155, F157-F159, F160-F165, F167-F169, F170, F173-F175, F177-F179, F180-F185, F187-F189, F190-F195, F197-F199, G211, G240, G251, G254, G256, G444, G620, G720, I952, J702-J704, L105, L270-L271, M102, M320, M804, M814, M835, M871, R502, R781-R785, X40-X44, X60-X64, X85, Y10-Y14
Alcohol-induced underlying cause of death ICD-10 codes: E244, F10, G312, G621, G721, I426, K292, K70, K852, K860, R780, X45, X65, Y15.

Mortality Data

According to the AHAVR, among Mat-Su residents aged 65+, there were 34 suicide deaths over the 10 years between 2012 and 2021. The number of suicides among older adults has increased from three or fewer per year between 2012 and 2016 to 4-7 per year between 2018 and 2021. For older adults in Mat-Su between 2012 and 2021, suicide was the leading cause of behavioral health related death at 29.6 per 100,000 compared to 21.4 for all Alaska older adults. The reverse was true for the alcohol-induced death rate, where the rate for Alaska was 35.4 per 100,000 compared to 19.1 for Mat-Su. The drug-induced death rates were similar for Mat-Su (8.7) and Alaska (8.1).

Injury Data

Data from the Alaska Trauma Registry shows a slightly different view of these same three behavioral health challenges (ATR, n.d.). The registry is used to evaluate the quality of trauma care and inform injury prevention programs. To do this, they collect data on serious injuries from Alaska hospitals. Table 16 shows the number of non-fatal hospitalizations for injury for Mat-Su older adults for the ten years 2012-2021. The frequency of non-fatal hospitalizations occurred in the following order: alcohol-related (35), drug-related (15), and self-harm (2).

TABLE 16. **TRAUMA-RELATED HOSPITALIZATIONS AND DEATHS FOR MAT-SU OLDER ADULTS, 2012-2021**

Type of hospitalization	Count
Alcohol-Related Non-Fatal Hospitalizations	35
Drug-Related Non-Fatal Hospitalizations	15
Self-harm Related Non-Fatal Hospitalizations	2
Total	52

Source: (ATR, n.d.)

Elder abuse

When older adults experience abuse, the behavioral health effects occur in addition to the loss of control over their physical body and mental well-being that many older adults are already experiencing due to aging processes, reduced power within society, chronic illnesses, and increased dependence on others for completing tasks of daily living. If the abusers serve as caregivers, older adults need interventions and safety counseling similar to those designed for survivors of interpersonal violence in intimate relationships to remove themselves from the abusive situation in which their care needs are entwined. Damage to self-efficacy occurs frequently in survivors of abuse of any age. It is one of the deepest wounds of physical and emotional abuse as it impedes help-seeking attitudes and actions. Older adults who are targets of abuse may hesitate to seek or accept help. Well-intentioned advocacy on their behalf without their involvement risks further damage to their self-efficacy, particularly if the older adult's ethnic group faces discrimination and holds less power than that of the well-intended advocate whose efforts may be perceived as threatening the older adult's independence. Accepting help from human service professionals may be seen as laden with potential repercussions stemming from shame and fears based on prior experiences with dominant social groups (Fiolet et al., 2021). Data from 2021 on the prevalence of financial, emotional, and physical (including sexual) abuse of older adults by family members, collected for the National Elder Mistreatment Study (NEMS), reveals that within that year, the reported rates of abuse for American Indians and Alaska Natives people, (33%) were double those of respondents who identified as White (17.1%) (Crowder et al., 2022).

According to Alaska Protective Service (APS), in FY22 and FY23, 8% of all substantiated abuse, neglect, or exploitation allegations were in the Mat-Su Borough. Due to confidentiality issues, APS could not share more specific information on how many Mat-Su older adults experience elder abuse.

The 2023 ACoA survey asked older adult respondents about their experiences with elder abuse. Since this survey was completed online, the results do not represent all older adults in Mat-Su. The results should be interpreted as a window into what some older adults are experiencing.

- 12% of Mat-Su older adults surveyed reported knowing someone (including possibly themselves) who experienced elder abuse or exploitation.
- The most common type of abuse the respondent reported knowing about was financial exploitation, followed by emotional abuse and neglect.

- 13% of those who reported that they knew someone who experienced elder abuse reported it to APS, 4% to the Long Term Care Ombudsman, 9% to law enforcement, and 60% did not report it. Fourteen percent did not know to whom to report the abuse.
- Of those who reported the abuse, 26% of respondents said that the person received help, and 50% reported that no help was received.

Access to Care

KEY FINDINGS: **ACCESS TO CARE**

1. Eighty-seven percent of Mat-Su older adults had a personal health care provider.
2. The top reported barriers by older adults accessing primary care in Mat-Su were:
   a. The provider didn't accept Medicare (67%), Medicaid (23%) or VA/Tricare (29%).
   b. The older adult couldn't pay necessary costs (34%).
   c. The doctor was not taking new older adult patients (22%).
   d. The service was not available in the area (35%).
3. Ninety-nine percent of males and 98% of females 65-74 years had insurance coverage, and 100% of males and females 75+ had coverage.
4. There was a ratio of 614 to 1 of older adults to behavioral health providers who accepted Medicare. There were five clinical psychologists, six psychiatric clinicians, and 15 clinical social workers in Mat-Su who accepted Medicare.
5. There are just two outpatient SUD treatment programs and one residential treatment program in the area that accepted Medicare.
6. There were NO geriatric-focused behavioral health services in Mat-Su, and the State of Alaska Division of Behavioral Health provides behavioral health grants to community providers with the target population only going up to 64 years of age.
7. Ninety-seven percent of older adults responding said they had a computer and only 5% did not have a internet subscription.
8. Forty-five percent of Mat-Su older adults said they had a telemedicine appointment in the last month.

Older adults face age-related physical changes to their bodies that can be accompanied by worsening of lifetime mental health conditions and possibly an unprecedented onset of depression. Yet, they are less likely than younger age groups to seek and be offered treatment for depression and other behavioral health conditions. Older adults from racial and ethnic groups other than White are even less likely to receive behavioral health care (Teo et al., 2022). Older adults seeking behavioral health care or SUD treatment could benefit from supportive non-clinical persons to assist in the tasks involved with seeking help. As Cantor's model of social support hierarchies and compensation would indicate, reaching out to trusted

and supportive persons who are not behavioral health professionals is often the first step for many older adults to seek help for behavioral health needs (Cantor et al., 2000). This first step may or may not lead to obtaining professional help, depending upon whether those informal supports sufficiently ease the discomfort, as well as the attitudes and beliefs of the older adult and the informal, supportive persons towards mental illness and mental health care. Those choosing not to seek professional help may perceive professional behavioral health care as a loss of independence and control, or they may experience shame for their mental health needs or fear of negative consequences, especially if they have had negative interactions with health care providers in the past (Fiolet et al., 2021). Logistical barriers such as high costs and inaccessible locations of behavioral health care can prevent older adults who actively seek behavioral health care from accessing it.

Many older adults are facing behavioral health challenges to their well-being report symptom appraisal as an internal process that precedes seeking help. They may have experienced a crisis or a worsening of pre-existing symptoms that created the internal initiative to reach out for aid as they assess their needs to be more dire than in the past (Fiolet et al., 2021). For older adults from racial and ethnic groups of color, their symptom appraisal considers how they feel health care providers will perceive them, the potential systemic barriers they may face, and what alternative means of support are available (Rüdell et al., 2008). Language accessibility of services for speakers of languages other than English and immigration status also determine whether older adults can obtain behavioral health care and are considered along with symptom appraisal to determine if help-seeking actions will obtain the needed care. Older adults also view the social environment in which behavioral health and SUD treatments occur. When interventions involve group interactions, due to isolation and shame, older adults have been found to engage more with programs designed for their age cohort than with mixed age groups. Efforts to expand behavioral health care and SUD treatment for older adults could lessen systemic barriers to services for most clients by considering the experiences of those on the margins of behavioral health care systems, older adults and particularly older adults of non-dominant social groups, such as Alaskans Natives and other non-White populations (Kuerbis et al., 2013; Wyszewianski et al., 2002).

Access to care has historically been defined as focusing on:

1. Affordability of services to the client
2. Accessibility in terms of transportation to in-person appointments and, most recently, virtual visits
3. Availability of resources and services
4. Accommodation of services to the needs of the client (hours of operation, timeliness of care, etc.)
5. Acceptability of the services to the client

This section will focus on the affordability and accessibility of services. An environmental scan of existing services could, in the future, explore the other three dimensions of access to health care. The survey data related to access to health care for Mat-Su does not exclusively focus on behavioral health care. This section will consider access to primary care as a marker for access to behavioral health care. Primary care access is also relevant because, in an ideal system, this may be an entry point for older adults to be referred for behavioral health care or access integrated care.

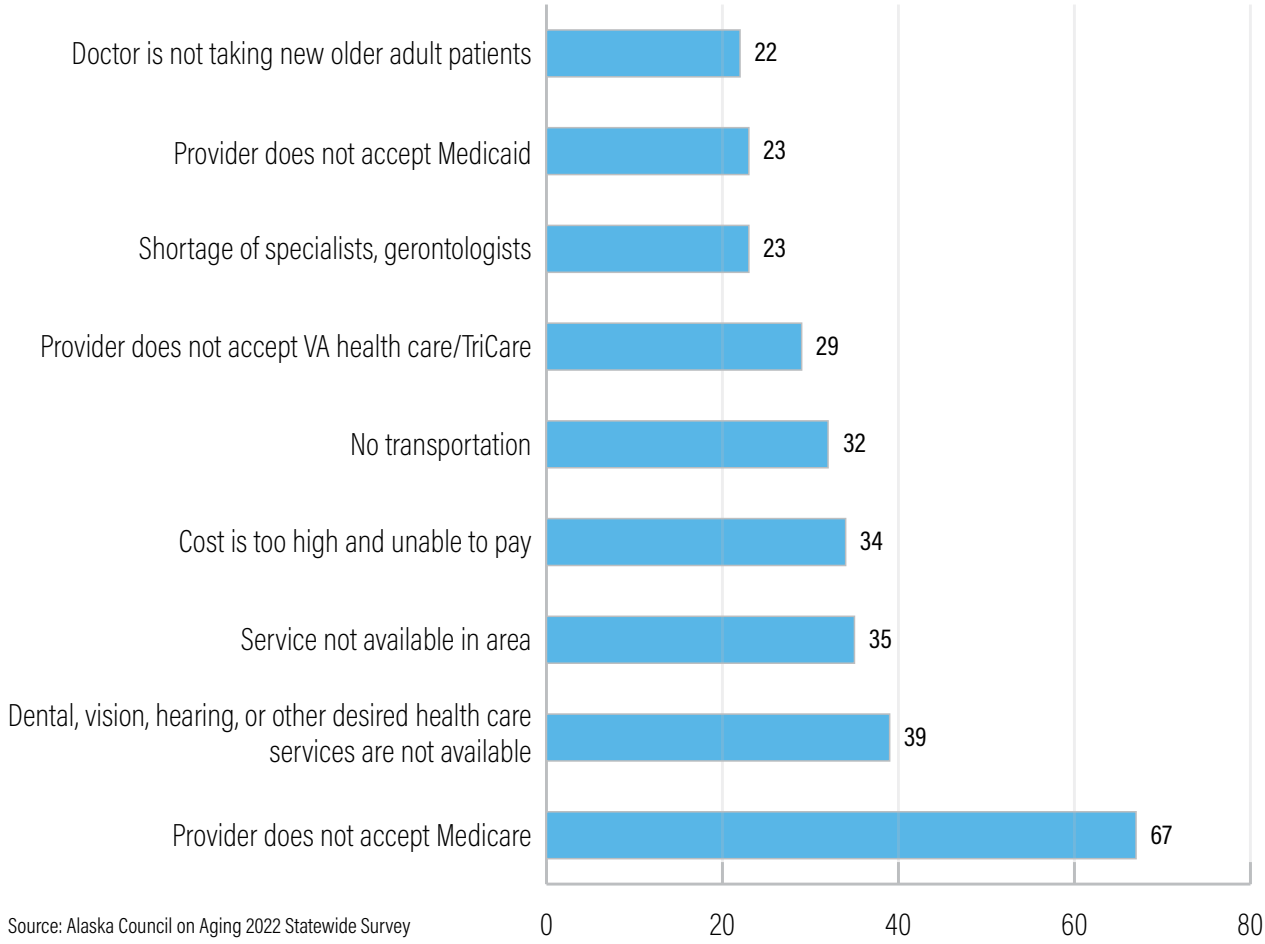
Having a personal health care provider

A visit to a primary care provider could be the doorway to a referral for behavioral health for an older adult. According to the BRFSS, between 2015 and 2021, 87% of Mat-Su residents 65 years and older reported having a personal health care provider – similar to the percentage for all of Alaska (86%).

Barriers to accessing care

The ACoA survey asked Mat-Su older adults about the barriers they face when seeking primary care. The most common responses related to insurance, with older adults saying that the provider didn't accept Medicare (67%), Medicaid (23%), VA/Tricare (29%), or that the older adult couldn't pay necessary costs (34%). Other responses referred to the prevalence of provider type or services: doctors not taking new older adult patients (22%), a shortage of specialists and gerontologists (23%), or the service not being available in the area (35%).

FIGURE 14.
TOP BARRIERS THAT OLDER ADULTS IN MAT-SU FACE WHEN TRYING TO ACCESS PRIMARY/BASIC HEALTH CARE (%), 2022



Source: Alaska Council on Aging 2022 Statewide Survey

Insurance coverage

According to the ACS, in 2022, older adults in Mat-Su had high insurance coverage rates. Ninety-nine percent of males 65-74 years had insurance coverage, and 100% of males over 75 had coverage. Similarly, 98.2% of women over 64 had coverage, and 100% of females over 75 were covered.

Most Mat-Su older residents aged 64-74 had Medicare (94%). This percentage grew to 99% for those over 75. Most of those covered had two or more types of health insurance coverage, with many having employer-based and Medicare coverage. Other combinations are listed in Table 18.

Although insurance coverage was high, a key factor to older adults seeking and receiving care was whether their insurance would cover behavioral health care.

TABLE 17. HEALTH INSURANCE COVERAGE STATUS BY SEX BY AGE, 2022				
	No insurance coverage		Insurance coverage	
	Count	Percentage	Count	Percentage
Males 65-74	17	.003	5168	99.7
Males 75 +	0	0	2160	100
Females 65-74	97	1.8	5238	98.2
Females 75+	0	0	2539	100
Total	114		15,105	

Source: (ACS 2022)

TABLE 18. TYPES OF HEALTH INSURANCE COVERAGE BY AGE, 2022		
	Count	Percentage
Medicare Coverage		
64-74 years	10,328	94%
75 years and older	4,938	99%
With one type of health insurance coverage	3,921	26%
Employer-based health insurance only	436	
With Medicare coverage only	3485	
With two or more types of health insurance coverage	11,184	74%
Employer-based and Medicare coverage	4137	
Direct purchase and Medicare coverage	1855	
Medicare and Medicaid/means-tested public coverage	1292	
Other public-only combinations	636	
Other coverage combinations	3264	

Source: (ACS 2022)

TABLE 19. TYPES OF SERVICES COVERED BY MEDICARE	
Service	Type of Coverage
Psychiatric evaluation	Medicare Part B
Individual and group psychotherapy	Medicare Part B
Family Counseling	Medicare Part B
Partial hospitalization	Will be covered by Medicare Part B in 2024
Intensive Outpatient	Will be covered by Medicare Part B in 2024
Psychiatric hospital care	Medicare Part A (190 days in lifetime)
Inpatient mental health	Medicare Part A ($1600 deductible per benefit period, daily copays of $400 for days 61-900; $800 per day for lifetime reserve of days)
Prescription Drugs	Medicare Part D (Out-of-pocket costs for prescription drugs to treat BH may vary among Part D plans, including standalone plans, and, though they are required to cover all or substantially all drugs in six protected classes, including antidepressants and antipsychotics, insurers may use cost management tools.)

Source: Medicare.gov

Medicare Part B covers one depression screening per year, individual and group psychotherapy with doctors and licensed professionals depending on a state's rules, family counseling related to treatment, psychiatric evaluation, and medication management. Regarding SUD treatment, Part B covers one alcohol misuse screening annually and up to four subsequent counseling sessions. Part B also covers outpatient services related to substance use disorders, including services related to opioid use disorder treatment, such as medication, counseling, drug testing, and individual and group therapy. New changes made by the Biden Administration expanded the types of providers covered by Medicare. Table 19 summarizes the behavioral health services that Medicare will cover. Medicare Part A will cover 190 days of inpatient psychiatric care (in a lifetime) and inpatient mental health treatment with a $1600 deductible and daily copays of $400 for days 61-100 and $800 per day for the remaining lifetime reserve of days. Depending on the plan, Medicare Part D will cover outpatient prescription drugs and may include copays and other fees (Centers for Medicare & Medicare Services, 2023a).

Low-income older adults and older adults with disabilities are eligible for Medicaid coverage. If an older adult has Medicaid, it will help pay Medicare premiums and out-of-pocket expenses. Medicaid will also pay for nursing facility care, prescription drugs, eyeglasses, and hearing aids. Services that accept both Medicaid and Medicare will bill Medicare first, and Medicaid will make up the difference according to the State's plan regulations (Centers for Medicare & Medicare Services, 2023b). Dual eligibility is based on the Federal poverty level. Data from the Division of Behavioral Health on paid Medicaid claims for FY20 and FY21 showed that only 68 Mat-Su older adults had a paid Medicaid claim for behavioral health services.

Providers who accept Medicare

Since Medicare predominantly covers older adults, a key access issue is finding a behavioral health provider who accepts this form of payment. Accessing the Medicare.gov website and searching for nearby doctors and clinicians accepting Medicare yielded the following information: As of September 1, 2023, there were 614 older adults for every behavioral health clinician accepting Medicare. For the general population in Mat-Su, there was one mental health professional per every 340 people. Behavioral health providers accepting Medicare included five clinical psychologists at three clinics, six psychiatric clinicians at three sites, 15 clinical social workers at four clinics, and two clinics offering outpatient SUD services. One residential SUD treatment program in Anchorage accepts Medicare, and the local hospital, MSRMC, accepts Medicare and has acute inpatient BH beds.

TABLE 20. **AVAILABLE BEHAVIORAL HEALTH SERVICES THAT ACCEPT MEDICARE FOR OLDER MAT-SU ADULTS**

Geriatric behavioral health specialists	Clinical psychologists	Psychiatry clinician	Clinical social workers
0	5 at 3 clinics	6 at 3 sites	15 at 4 clinics
Medicated Assisted Treatment Programs	**Residential SUD treatment program**	**Outpatient SUD treatment programs**	**Acute inpatient behavioral health beds**
3	1	2	1
Ratio mental health providers to the older adult population			
1 to 614			

Source: Medicare.gov accessed September 1, 2023.
Note: These are acute behavioral health beds for all ages.

Availability of geriatric focused BH care

There are no geriatric-focused behavioral health services in Mat-Su. A local State of Alaska Division of Behavioral Health grantee pointed out that the Division's grants for behavioral health services state that the target age for the population to be served only goes up to 64 years. He also stated that they don't turn away older clients, but no Federally Qualified Health Center outreach activities are focused on older adults.

Getting to the care

Providers state that lack of transportation is common among Mat-Su older adults (see Transportation section). Since the pandemic, telemedicine has become a more common way to access care. In the ACS 2022 survey, 97% of older adults who responded to the census reported having a computer, 92% said they had a broadband internet subscription, and 8% were not connected to the internet because they didn't have a subscription (5%) or a computer (3%). According to the BFRSS, 45% of Mat-Su older adults said they had a telemedicine appointment in the last month. The appointments were for physical health care 67%), followed by specialty care (43%), and only 10% were for behavioral health care.

Physical Health Status

As older people age, their physical health changes, generally declining until death. Physical health changes can include experiencing chronic pain and limitation in mobility due to health status. These changes can lead to depression, anxiety, and other behavioral health consequences. In Mat-Su, 50% of older adults reported their health was excellent to very good, 30% said it was good, and 20% reported that it was fair (BRFSS, n.d.).

Disability Status

According to the 2021 ACS survey, the older the age group in Mat-Su, the higher the percentage of individuals who were disabled. For adults aged 65-74 years, approximately 28% had a disability. For those 75 years and older, 54% had a disability.

TABLE 21. **DISABILITY STATUS BY AGE IN ALASKA, 2021**

Age	Alaska count	Alaska percentage	Mat-Su count	Mat-Su percentage
Under 5 years	199	0.4%	0	0%
5-17 years	8,263	6%	659	3%
18-34 years	13,908	9%	1,992	9%
35-64 years	38,114	14%	6,191	15%
65-74 years	18,060	27%	2,824	28%
75 years and older	13,846	46%	2,323	54%

Source: (ACS 2021)

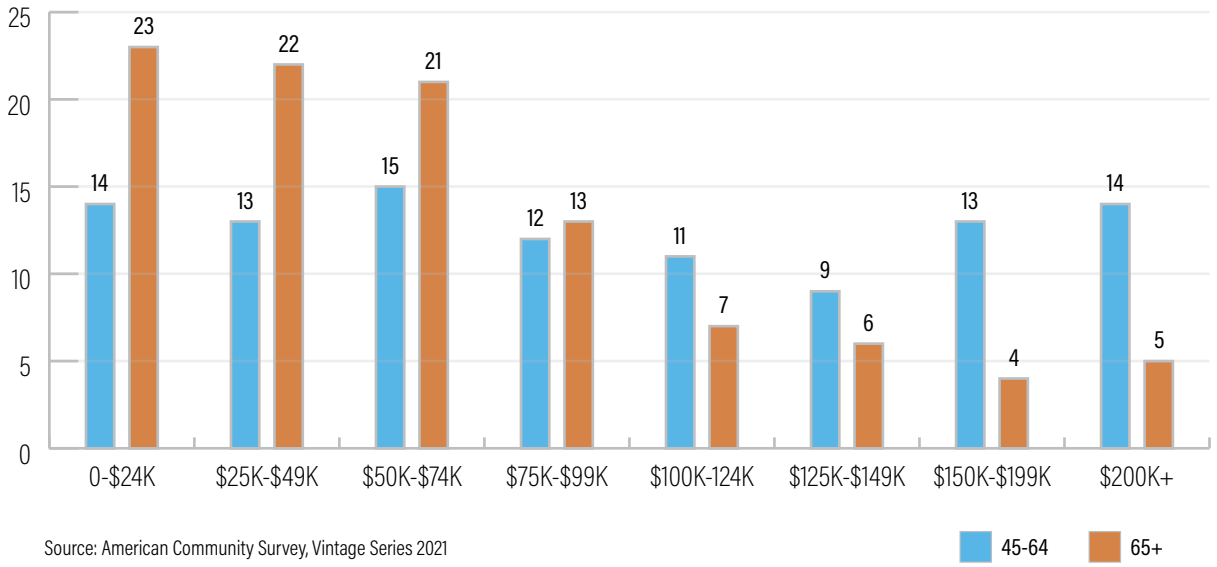
Financial Status

KEY FINDINGS: **FINANCIAL STATUS**

1. As one ages and reduces or stops working, one's income generally decreases. Almost one quarter (23%) of older adults 65+ had incomes between $0 and $24999. Almost half (45%) earned less than $50,000 and 22% earned more than $100,000.
2. Thirty-eight percent of older adults said they have more than enough money to meet their expenses, 43% said they had enough but little to cover anything extra, and 17% said they didn't have enough for some or all months.
3. Forty-three percent of older adults did not feel secure handling unanticipated expenses.
4. Mat-Su older adults' top financial security concerns were ranked as (1) costs of daily living such as food, housing, heat, utilities, and transportation, (2) cost of health care and medication, and (3) high property taxes.
5. The AK Division of Public Assistance provided the following benefits to Mat-Su older adults in 2022:
   a. Temporary Assistance with case relation of a grandchild (65 recipients, average benefit $610/month)
   b. Adult Public Assistance (826, annual average benefit $281)
   c. General Relief Assistance (14, annual average benefit $3,126)
   d. Heating Assistance Program (508, annual average benefit $1,646)
   e. Medicaid (1888 Long Term Care and 178 general Medicaid)
   f. Senior Benefits (1873, annual average benefit $62)
   g. Supplemental Nutrition Assistance Program (979, annual average benefit $165)
6. Older adults said financial worries cause stress, anxiety, embarrassment, and a feeling of not wanting to burden others.
7. Some providers said that some older adults live the entire year off their Permanent Fund Dividend which was $1312 in 2023.

If an older adult's financial status is insufficient to meet expenses or cover the cost of health care (including behavioral health care), the resulting stress, worry, anxiety, or depression can negatively affect mental health. As one ages and retires from or reduces paid work, whether by choice or disability, income tends to decrease. This trend is seen in Figure 15, which shows that Mat-Su residents aged 45-64 have higher incomes overall than those aged 65+. Approximately half of householders in Mat-Su (54%) 45-64 years had incomes less than $100,000 compared to over three quarters of adult householders 65 years and older (79%). Almost a quarter of older adults had incomes below $24,999 (23%) compared to only 14% of individuals 45-64 years.

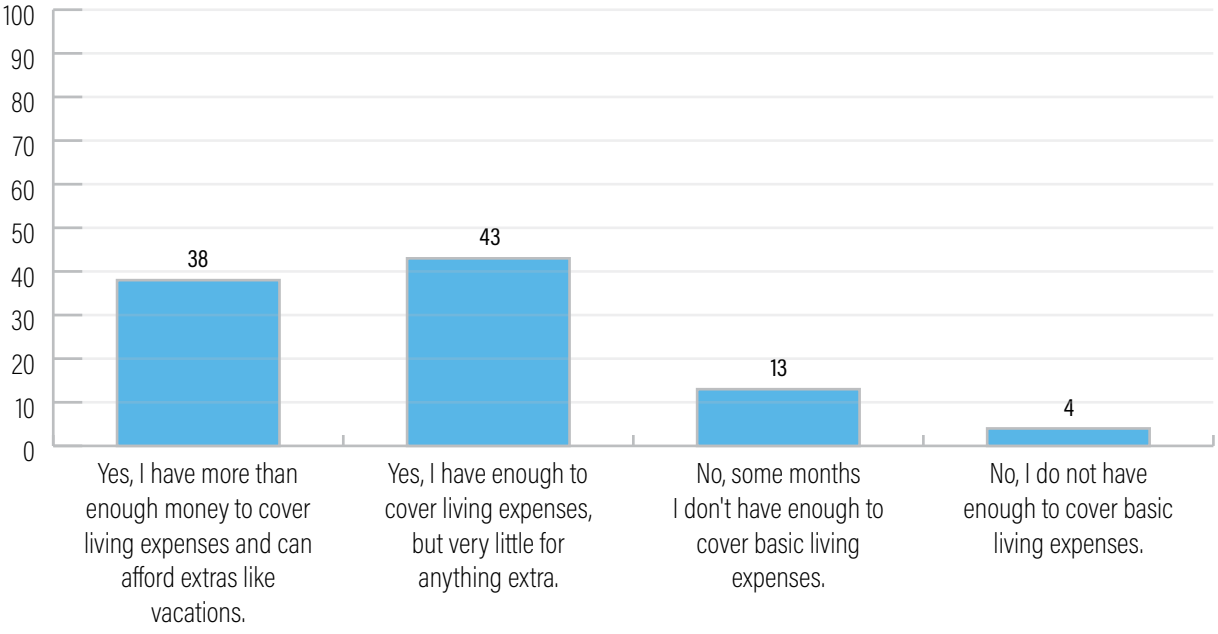
FIGURE 15.
HOUSEHOLD INCOME OF MAT-SU OLDER ADULTS BY AGE, 45-64, 65+ YEARS (%), 2022



Source: American Community Survey, Vintage Series 2021

The online survey conducted by the ACoA asked older adults if their monthly income was enough to meet their monthly expenses. Thirty-eight percent said they have more than enough to meet their expenses, 43% said they have enough but little to cover anything extra, and 17% said they didn't have enough for some or all months (Figure 16). Older adults were also asked how secure they felt in handling unanticipated expenses, and 43% said they did not feel secure.

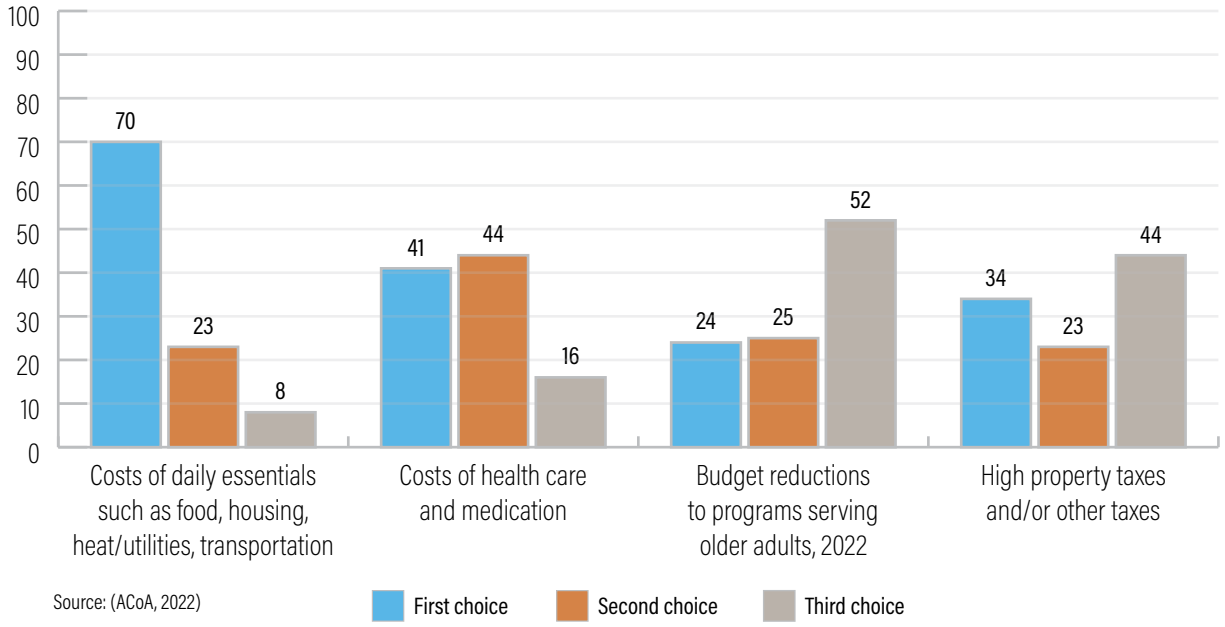
FIGURE 16.
IS YOUR MONTHLY INCOME ENOUGH TO MEET ALL YOUR EXPENSES? (%), 2022



Source: (ACoA, 2022)

When asked to identify the top financial security concerns they face, Mat-Su older adults reported that the cost of daily essentials ranked number one, followed by the cost of health care and medication, then high property taxes and other taxes, and finally, budget reductions to programs serving older adults (Figure 17).

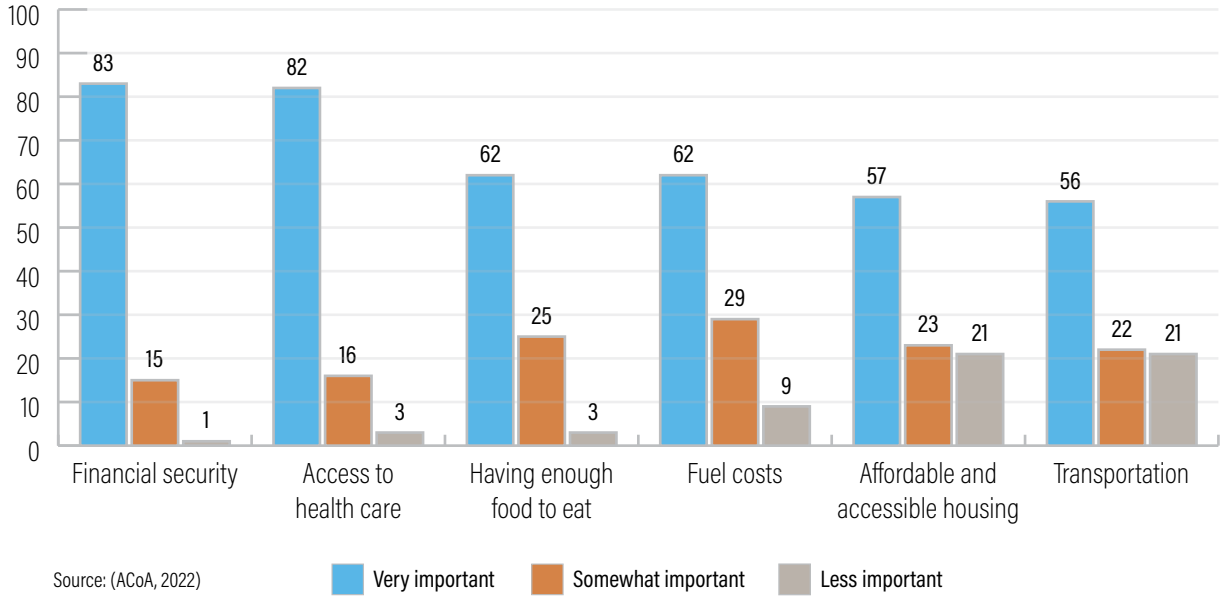
FIGURE 17.
RANKING OF TOP THREE FINANCIAL SECURITY CONCERNS (%), 2022



Source: (ACoA, 2022)

For older people with a fixed income age, meeting basic needs becomes a concern that can cause anxiety. The ACoA survey asked Mat-Su residents to rank the importance of several basic needs categories. The two concerns that ranked highest in importance to the group were financial security and access to health care, followed by having enough food and fuel costs.

FIGURE 18.
RATING THE IMPORTANCE OF THESE CONCERNS (%), 2022



Source: (ACoA, 2022)

The AK Division of Public Assistance provides support for older adults that in 2022 included:

1. Adult Public Assistance (826, average monthly benefit $281)
2. General Relief Assistance (14, average benefit $3,126)
3. Heating Assistance Program (508, average annual benefit, $1,646)
4. Medicaid (1888 Long Term Care and 178 general Medicaid)
5. Senior Benefits (1873, average monthly benefit $62)
6. Supplemental Nutrition Assistance Program (979, average monthly benefit $165)

Several churches with staff who participated in interviews stated that they have ministries that help low-income older adults. The focuses of these ministries include:

- A food pantry
- A mission that provides showers, laundry, a job center, a clothes closet, toys, household items, and food distribution
- Assistance with heating and firewood
- Giving away gas cards
- A Christmas wish list program for isolated older adults

When older adults were asked how financial worries affect a person's sense of well-being, the primary themes mentioned were stress, worry, embarrassment, and a feeling of not wanting to burden others. A picture emerged of older adults who don't have a lot of options due to limited income. Some providers stated that some older adults live on the State of Alaska Permanent Fund Dividend they receive once a year. The 2023 dividend was $1312. Some representative comments about financial worries and their effect on well-being are shown in Table 22.

TABLE 22. **EXEMPLAR QUOTES. HOW DO YOU THINK FINANCIAL WORRIES AFFECT AN OLDER PERSON'S SENSE OF WELL-BEING?**

I think if there are financial problems, that has to make life stressful, and if there is a married couple, it could cause stress between two married people. – 73-year-old female
If you are on a fixed income, you tend to worry about it a lot. – 79-year-old male
I don't have a tremendous amount; I still qualify for the food bank and all that. I have a close-knit group of friends, and their rent [in older adult housing] went up $225 – like boom! A couple of people had to move. The woman was sitting crying and said that, "By the time I pay my electric bill and my rent, I have $30 for the month." Many people are too proud to seek our help [at the food bank]. One gentleman was really honest [about this], and I packed up a package for him to take to his wife in the car. She wouldn't come in. She was embarrassed because they'd never had to seek help. – 81-year-old food bank volunteer
I think it's extremely important to think that you can take care of yourself till the end of your life. So that could be a real worry. I decided a long time ago that since I was not married and my husband had died and I was alone – we had both had cancer and we were destitute at that point. I decided the only thing I really wanted was to not be a burden on my family when I was older. I started planning on that, but I'm sure that people who haven't planned it are having a hard time with that. – 80-year-old female
My husband used to deliver Meals on Wheels here in the Palmer area, and there's elderly people in these hotels trying to survive on social security–barely because they don't have enough money. All these hotels have turned into crack hotels around them, and now they are stuck. – 65-year-old female
I don't have much money–I worry about getting heating oil. I ran out of it in November of last year, and I've been trying to get heat and oil since then. That stuff's so high. You have to buy a hundred gallons for them to bring it out here. I lost my truck in November. The snow plow put snow up against it into the engine and tore it up. The city won't pay for it. – 73-year-old male

Independence

KEY FINDINGS: **INDEPENDENCE**

1. The major themes mentioned by providers around independence included:
   a. Independence is very important to older adults.
   b. In Mat-Su, a number of older adults live "off the grid" and have a lifestyle that includes hauling water and wood at a remote cabin. Many of these older adults can't imagine living any other way. Moving someone accustomed to being independent in this way gives rise to unexpected issues.
   c. Sometimes, neighbors and other community members help some older adults to maintain their independence.
   d. It can be difficult for Alaska Native Elders to become accustomed to new surroundings not attuned to their culture.
2. Mat-Su older adults said their greatest worry related to independence was staying independent in their home, declining health, being on a limited income, or being unable to afford necessities.
3. When older adults were asked about the level of help they need with household tasks, the most common tasks they said they could do by themselves were managing medications, finances, personal tasks, and shopping. Areas in which they said they had difficulty or could not do themselves were general home maintenance (64%), and household chores (30%).

The Matanuska Susitna borough's 25,259 square miles offers unlimited opportunity for individuals to build a unique life based on subsistence and rugged independence (AKDNROHA, 2023). Some people have moved to Mat-Su because they want to live away from urban cities and towns, live off the land, and have their privacy. Often coupled with this independence and lifestyle is extra manual work, such as hauling firewood and water. Additionally, no matter where one lives, plowing and shoveling a roof is often something that must be done in the winter, in addition to the usual general maintenance chores. Stakeholders talked about neighbors rallying around some older adults to help with these tasks, and others have mentioned that this is a major problem for some isolated older adults.

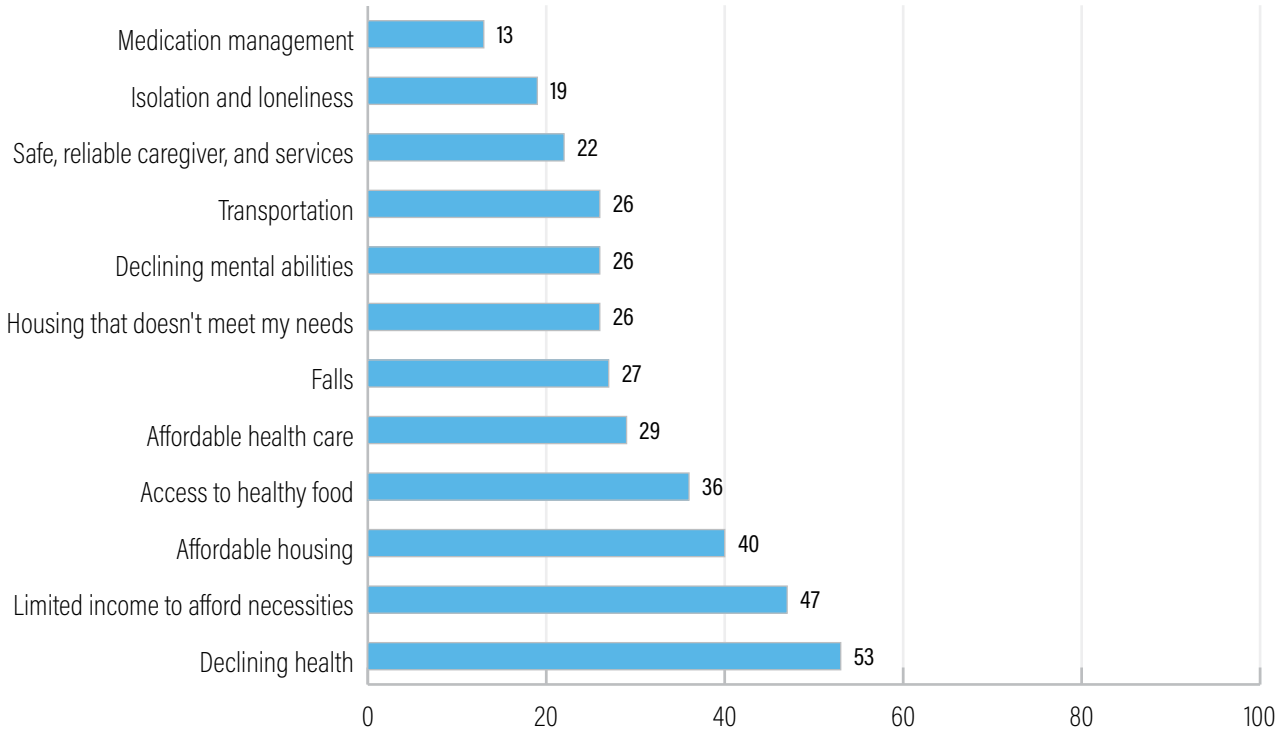
Such independence looks different for Westerners versus Indigenous people. Some non-indigenous people living in Alaska came as homesteaders, colonists, or rugged individualists seeking an independent life. Indigenous people have lived in rural and remote villages both outside and within Mat-Su before colonist contact. They have a life that revolves around family and living an independent, subsistence-based lifestyle. The major themes that came up from all providers around independence include:

a. Independence is very important to older adults.
b. In Mat-Su, some older adults live "off the grid" and have a lifestyle that includes hauling water and wood at a remote cabin. Many of these older adults can't imagine living any other way. Moving someone accustomed to being independent in this way gives rise to unexpected issues.
c. Sometimes, neighbors and other community members help some older adults to maintain their independence.
d. It can be difficult for Alaska Native Elders to become accustomed to new surroundings not attuned to their culture if they move to Mat-Su from villages in other regions.

TABLE 23. **EXEMPLAR QUOTES ON OLDER ADULT INDEPENDENCE**	
Importance of independence	It reminds me of my three-year-old who wants to do things even though she can't. She wants to do 'em anyway because that is part of being independent. I think as one gets older, you want to continue to be independent; you want to be able to do your own things. You want to be able to live alone or live at home, right? Because home is where you feel comfortable. It's a place for you. – Church staff And I know that's a little morbid, but I have that same feeling. I'd prefer to just die in my cabin than to be shifted to Anchorage or even here in the Valley- away from the community that I've established out there. – Provider
Western rugged lifestyle progression	They are people who came when the resources were low, and they built their world out of nothing. And so, when you are 20 or 30, and you are going to go to Alaska to mush dogs. You get your 20 acres somewhere, and you carve out a lifestyle, and now you are 70 or 80. You are still cutting firewood. And then I hear as a provider the challenges that they face, like the inability after losing a partner to cut enough firewood to last for the season, but that's their only way to stay warm. – MCoA member
Neighbors helping	I have dozens of stories – you know – neighbors coming together around someone who was a homesteader, was there for years, lost their spouse, continued to live that lifestyle, got to the point where, you know, they needed some help. So, the local neighborhood or whoever came in and helped and had well-meaning conversations with them around the need to live somewhere else. And they are saying "No, I'm fine with dying here. I'm either going to die here at some point, or you are going to take me out of here and I'll die more quickly." – MCoA member This winter in the Valley was pretty rough. We were checking on our neighbors. Our road doesn't get services, so it was up to us on this road to make sure we figured it out. We plowed out that older lady over there who couldn't even get out of her driveway for days, but she wouldn't tell anyone. She's independent as hell. – Provider
Other issues arise	So, who are we to tell them that this cabin or paper shack or whatever is no longer appropriate because it may not be, but you are unleashing a whole another array of issues when you solve that issue. – Provider
Older adults living off the grid	There are a number of elderly people out in Glacier View. I'm stunned that people who are 90 years old are still living in the log cabin they built 50 years ago. – MCoA member
An organization that is helping	A staff member at a Veteran's organization stated, "[I know a man -] He lives in an aero stream trailer from the seventies, and when it was negative 40 degrees out there and he would not move. He's unable to cut down firewood, and if you're living in that situation, you gotta cut down the firewood, you know. So, he about froze to death this winter. So, he was isolated. So, we got him ahead of the game, and we got somebody to go out there on a weekly basis and give him a load of firewood and spend time with him and drink coffee."

The ACoA survey asked Mat-Su older adults what their great worry or fear is when they think about staying independent in their homes. The most common fear was declining health, followed by limited income to afford necessities, then affordable housing. Other fears mentioned as their number one fear by more than one quarter of older adults were access to healthy food, affordable health care, falls, housing that doesn't meet their needs, declining mental abilities, and transportation.

FIGURE 19.
AS YOU AGE, WHAT IS YOUR GREATEST WORRY/FEAR AS YOU THINK ABOUT STAYING INDEPENDENT IN YOUR HOME? (%), 2022



Source: (ACoA, 2022)

When older adults were asked about the level of assistance they needed with household tasks, the most common tasks they said they could do by themselves were managing medications, finances, personal tasks, and shopping. Areas in which they said they had difficulty or could not do themselves were general home maintenance (64%) and household chores (30%).

TABLE 24. **IN GENERAL, HOW MUCH HELP DO YOU NEED WITH THE FOLLOWING TASKS? (%), 2022**

	I can do it myself	I can do this, but with difficulty	I cannot do it myself
Managing finances	89	8	1
Getting to appointments or other places	85	10	3
Personal tasks	85	12	1
Shopping	84	12	2
Preparing meals	86	10	2
Household chores	69	25	5
General home maintenance	28	31	33
Managing medications	90	4	1

Source: (ACoA, 2022)

When older adults were asked if they could get the assistance they needed to complete the tasks mentioned in Table 23, 42% said they could always or most of the time get assistance, while 29% said they could get help some of the time or none of the time.

Transportation

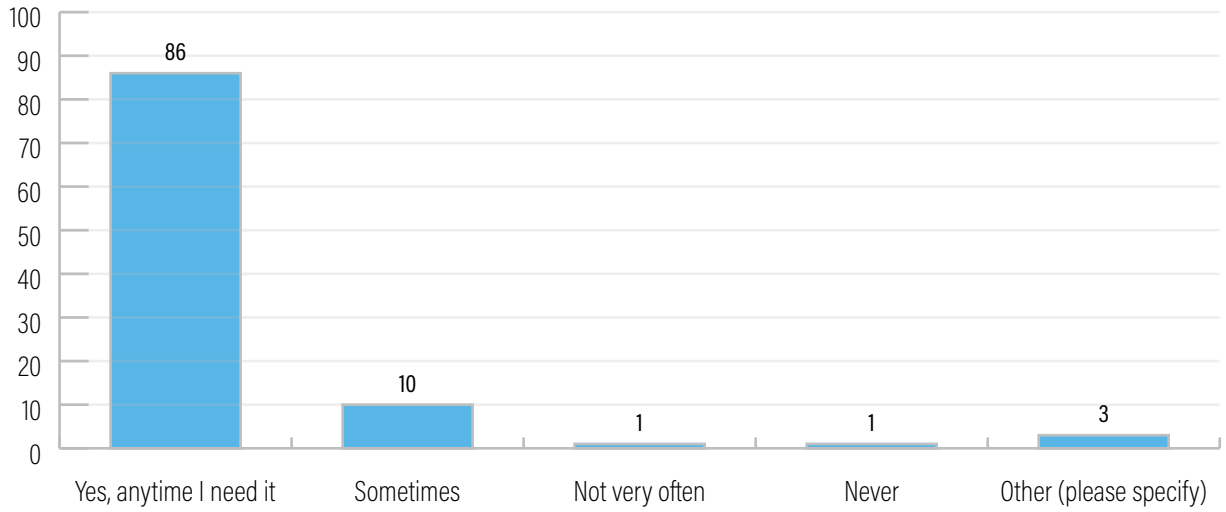
KEY FINDINGS: **TRANSPORTATION**

1. All providers and church staff felt there was a need for more affordable transportation options for Mat-Su older adults – the existing options didn't reach all older adults and didn't adequately meet their needs to access health care in Anchorage.
2. Eighty-six percent of older adults filling out an internet survey said they had transportation anytime they needed it.
3. Fifty-six percent of older adults said they lived less than 10 miles from the food, medical, and social activities they visit, 24% said less than 20 miles, and 19% said more than 20 miles.
4. Lack of transportation was linked to financial constraints, isolation, health issues that prevent driving, and the need to move from a rural area to a more centrally located community.

Access to transportation in Mat-Su was one of the first improvement opportunities mentioned by all providers of older adult health care. The providers acknowledged that several Mat-Su organizations offer transportation. Still, they felt that it doesn't always reach all older adults and doesn't help when older adults need to go to Anchorage for medical appointments. Some of the older adults interviewed did not have transportation and said they had to rely on people visiting them, food being delivered by the food bank or Meals on Wheels, or "begging" rides from people. The public and private transportation options in Mat-Su were not considered sufficient for everyone. Additionally, for many older adults, the cost of gas also limited their ability to drive.

The Mat-Su Household Survey asked older adult respondents: "In the last 12 months, did anyone in your household experience inadequate transportation?" Six percent of respondents in households with an older adult responded "yes." If this percentage is extrapolated to the total number of older adults in Mat-Su, 959 older adults experienced inadequate transportation the previous year. According to the ACoA survey, 92% of Mat-Su older adults reported that the cost of transportation had risen in the past year. Most older adults who filled out the online ACoA survey reported having reliable transportation whenever needed (86%). In comparison, 12% reported that they sometimes, not very often, or never had access to transportation. Both surveys may not reach all seniors, especially low-income seniors with higher transportation needs.

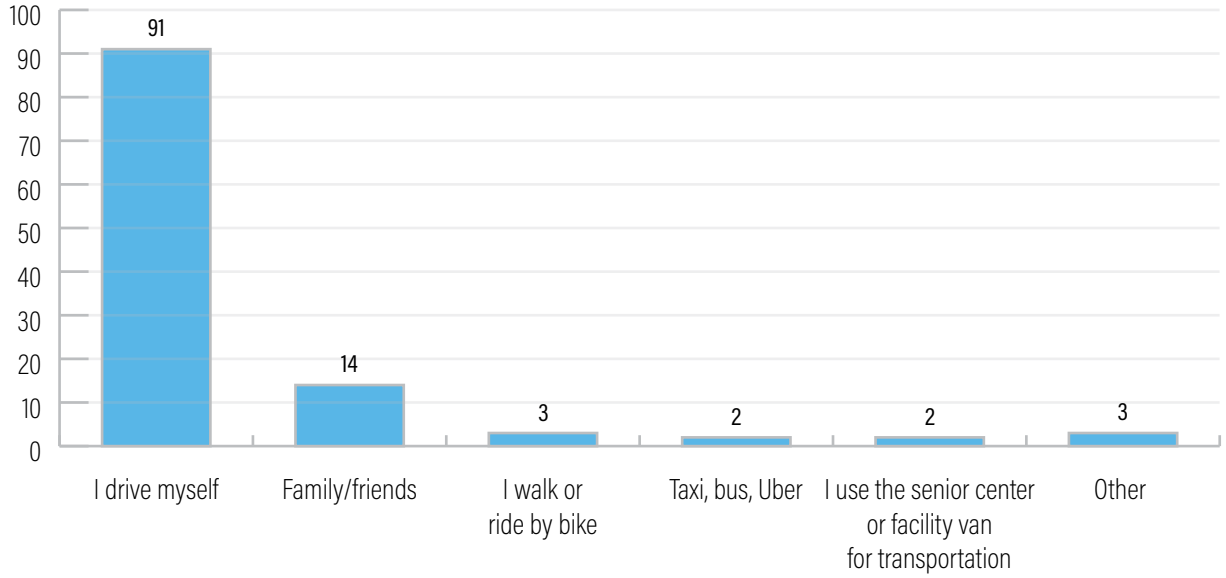
FIGURE 20.
MAT-SU OLDER ADULTS: DO YOU HAVE ACCESS TO RELIABLE TRANSPORTATION? (%), 2022



Source: (ACoA, 2022)

Most older adults (91%) who reported having transportation said they drove themselves, and 14% stated that family and friends drive them. Among the transportation methods mentioned by 3% or fewer respondents were walking or riding their bike, taking a taxi, bus, or Uber, or using a senior center van. Mat-Su is a large borough, and transportation can be a challenge for older adults who do not drive and don't live close to the core areas with shopping and medical facilities.

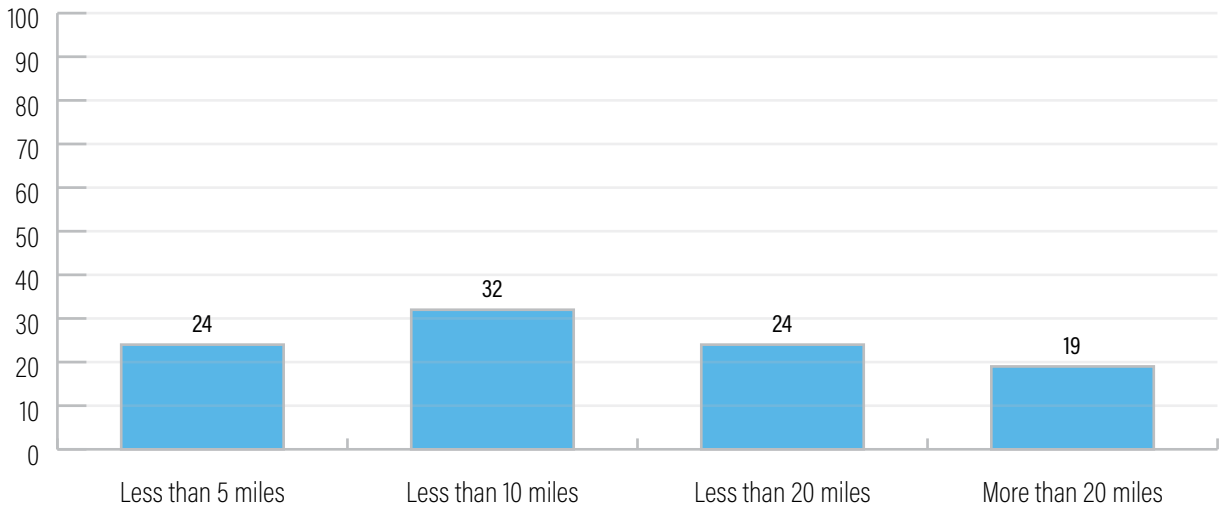
FIGURE 21.
MAT-SU OLDER ADULTS: WHAT TRANSPORTATION DO YOU USE REGULARLY? (%), 2022



Source: (ACoA, 2022)

The ACoA survey asked older adults how far away they were from food, medical care, and social activities. Fifty-six percent of older adults said less than 10 miles, 24% said less than 20 miles and 19% said more than 20 miles. One provider stated that it doesn't matter how many miles you live away from things if you don't have a car and it is too far to walk – you are stuck without transportation.

FIGURE 22.
MAT-SU OLDER ADULTS: APPROXIMATELY WHAT DISTANCE ARE YOU REQUIRED TO TRAVEL TO SHOP FOR FOOD, ATTEND MEDICAL APPOINTMENTS OR SOCIAL ACTIVITIES? (%), 2022



Source: (ACoA, 2022)

Older adult providers, church staff, and older adults gave various examples of transportation struggles, including physical conditions that preclude driving, financial constraints that prevent them from fixing a car or buying gas, and not owning a car. They all felt that the Mat-Su did not have a public transportation system and that sometimes older adults needed to move from rural areas into the core area to be closer to services. In several cases, isolation was linked to a lack of transportation.

TABLE 25. **EXEMPLAR QUOTES ON OLDER ADULT INDEPENDENCE**	
Physical conditions preventing an older adult from driving	Well, I'll give you an example. I was just at the Upper-Su Senior Center and had lunch next to a wonderful lady. But she recently had a stroke. She can no longer drive. She and her daughter live in a rather remote location. She goes nowhere unless her daughter drives her there, but her daughter works full-time. So, she is dependent on her family, and transportation is a challenge. And then, of course, within that home, she and her daughter do not have the technology to interface with anyone. There are some challenges for her to live more independently in that location where she is more reliant on others. – Provider
No good transportation system in rural areas	So, transportation is a challenge in our more rural areas for our seniors because we really don't have a system that starts somewhere, picks people up, takes some somewhere here, and then makes the circle back. I mean, our senior centers do provide some transportation. But if one has an appointment in Anchorage, you know, how would they achieve that? – Tribal provider
Some older adults need to move from rural areas to the core area of Mat-Su	It [a transportation system] doesn't exist. This has been a problem for a long time. I mean, there's been a lot of reports done on it. But what we really don't have is a really comprehensive plan. What happens is that most rural residents, as soon as they have real needs, they have to move into town. That is going to be a reality for certain people. Sometimes, you can't live on the homestead anymore. After you've had a stroke or a broken hip. So, that's aging. - Provider
Isolation and lack of transportation	Isolation is really like transportation. Isolation is the number one issue. There's no public transportation in the valley. – Church staff Transportation on Sunday would be lovely. In other words, we care for them, you know, through the whole week, but there are many who I think would connect with churches if they simply had better transportation on Sundays to get them places. – Church staff
Lack of transportation due to lack of money	I don't have much money. The snowplow ran over my truck – put snow up against it, into the engine, and tore it up. They won't pay for it. – Older adult What I really need is a vehicle. I need something to drive. Cause I hate trying to call people and beg for a ride. A taxi costs $85 to come out here where I live and take people, and it just takes me one way. I don't do that- I can't do that. – Older adult

Housing Status

KEY FINDINGS: **HOUSING STATUS**

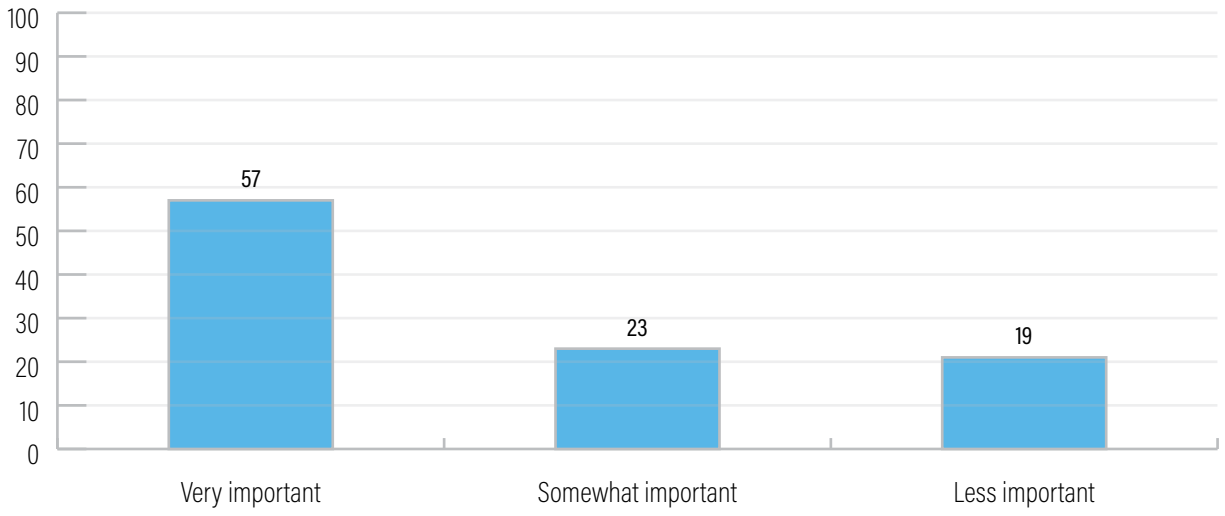
1. Since 2022, rent has risen on average by 7% across AK, and the cost of a two-bedroom apartment plus all utilities increased by 9% in Mat-Su. The vacancy rate in Mat-Su is low, at only 3.5%.
2. The Mat-Su Household survey found that at least 479 older adults lived in inadequate housing.
3. The AK Homeless Information Management System (AKHMIS) recorded fifty older adults in the 2022 point-in-time data collection.
4. Providers and church staff said there is a need for more affordable older adult housing and an immediate low barrier shelter that serves as a "one-stop shop" for needed services.
5. Some older adults interviewed for this report had inadequate housing, i.e., motorhomes, a camper, their car, partially built houses without electricity or running water, and a dry cabin.
6. Older adult housing can be unsafe and inadequate for several reasons:
   a. In the winter, older adults struggle to get their homes and driveways plowed to come and go from their houses.
   b. Older adults cannot make needed housing repairs due to their physical condition, lack of financial resources, or difficulty finding assistance.
   c. Older adults may be stuck in unsafe and inadequate housing conditions due to family situations such as family member's drug use and mental health issues.
7. Home repairs and maintenance were a big challenge for older adults. Forty-one percent of adults stated that their house needed modifications to be safe and comfortable with the most common modification being weatherization (60%), followed by accessibility modifications (48%) and electric/plumbing repairs (39%).
8. It was estimated that 75 adults lack indoor plumbing, and 619 heat their house solely with wood. As people age, hauling water and wood can be difficult.

The Mat-Su Household Survey asked respondents if someone in their household experienced inadequate housing in the last year. Three percent of respondents said yes. This percentage translates to 479 individuals if applied to the 2022 population of residents 65+. Of the 14 older adults who were interviewed for this report, half of them were living in inadequate housing:

- 2 in partially built houses without running water or electricity
- 2 in motor homes without running water or electricity
- 1 in a camper with a propane heater
- 1 in their car
- 1 in a dry cabin

The ACoA survey asked respondents to rate the importance of affordable and accessible housing based on how it affects them (Figure 23). Fifty-seven percent of respondents said that it was very important. Fifty-eight percent of respondents said their housing costs had risen in the last year.

FIGURE 23.
PLEASE RATE THE IMPORTANCE OF AFFORDABLE AND ACCESSIBLE HOUSING ON HOW MUCH IT AFFECTS YOU (%), 2022



Source: (ACoA, 2022)

Mat-Su housing availability

Since 2022, rent has risen, on average, by 7% across Alaska. The cost of a two-bedroom apartment plus all utilities in Mat-Su increased by 9%, with the median rent being $1,189. The vacancy rate in Mat-Su is one of the lowest in the State at 3.5%, down from an average rate of 4.7% in 2010 (AKDOLWD, n.d.).

The official data collection system for Mat-Su collects data on homelessness on a single night in January. In 2022, this system revealed there were 50 individuals in this system who were 65 years or older. There were slightly more males (56%) than females. The majority were White (86%), 8% were Alaska Native/American Indian, and 4% each were Black, Native Hawaiian/Pacific Islander, or Hispanic. Sixty-four percent had a self-reported disabling condition, 10% were veterans, and 12% had experienced domestic violence. There may have been other homeless older adults who were not counted on that night.

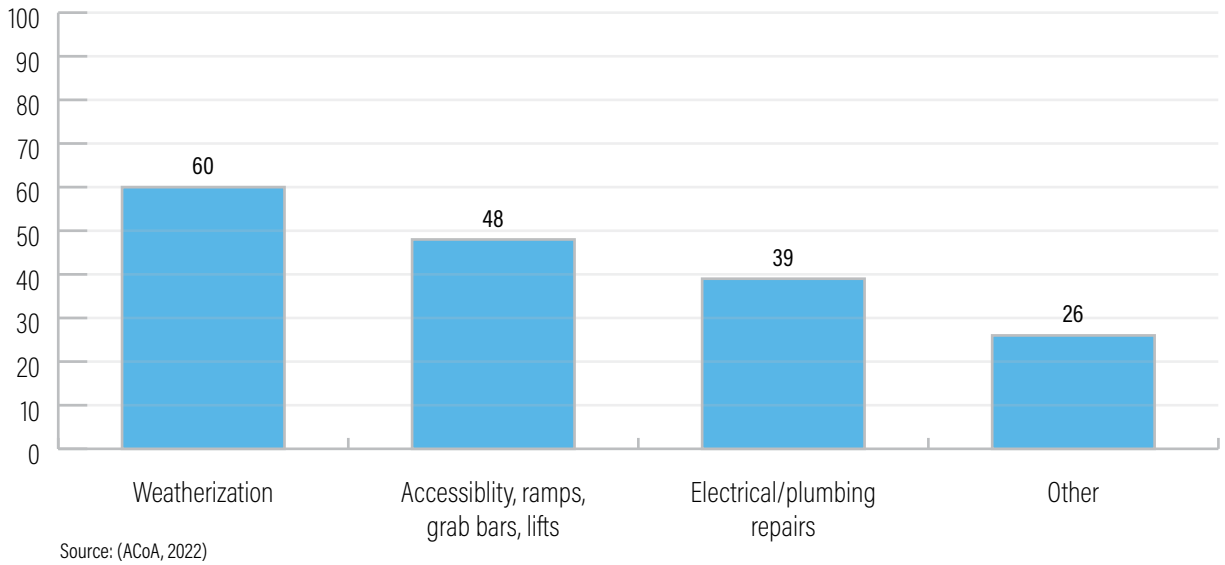
The ACoA survey asked Mat-Su residents what their greatest worry was when they thought about staying independent in their homes. Forty percent said having affordable housing was their greatest worry, and 26% said it was having housing that doesn't meet their needs (see Figure 19).

As people age, they often need modifications to their living environment to maintain their safety. These modifications are in addition to routine maintenance and occasional major repairs. Finding contractors and covering the costs of these repairs may be a challenge to those on a fixed income. Forty-one percent of older adults stated that their house needed modifications to be safe and comfortable, with the most common modification being weatherization (60%), followed by accessibility modifications (48%) and electric/plumbing repairs (39%).

TABLE 26. HOMELESSNESS PROFILE OF MAT-SU OLDER ADULTS 65 YEARS AND OLDER (%), 2022	
Number of unique Mat-Su clients in the AKHMIS	1,412
65 years and older	50
Male	56%
Females	44%
White	86%
Alaska Native/American Indian	8%
Black	4%
Native Hawaiian/Pacific Islander	4%
Hispanic	4%
Chronic homelessness	2%
Self-reported disabling condition	64%
Experienced domestic violence	12%
Veterans	10%
Homeless prevention programming	39%
Transitional housing	2%
Rapid rehousing	8%
Permanent housing	2%

Source: This is data from the point-in-time count that collects demographic information on sheltered and unsheltered persons experiencing homelessness. This count is conducted on a single night at the end of January. The count includes those in an emergency shelter, transitional housing, and unsheltered. https://www.alaskahousing-homeless.org/data

FIGURE 24.
IMPROVEMENTS ARE NEEDED: PLEASE INDICATE WHAT IMPROVEMENTS YOU WOULD LIKE TO HAVE (%), 2022



Source: (ACoA, 2022)

A group of Mat-Su residents live in housing that is primitive or "off the grid" and requires extra work to conduct activities of daily living. Such a living situation may present a problem as individuals age, and their ability to do physically challenging daily activities (such as securing and carrying wood for heating and getting water when there is no indoor plumbing) lessens. In Mat-Su, it is estimated that at least 305 older adults lack indoor plumbing, and 784 heat their houses solely with wood (AKDOLWD, n.d).

Most services providers for older adults mentioned that having safe, affordable, and stable housing is something that not all older Mat-Su residents have. They also mentioned that there is not enough housing for older adults nor options for immediate shelter for homeless older adults. While of the service providers who were interviewed do not provide actual housing or referrals for housing, they often hear about older adults in housing situations that do not appear safe. As discussed in the section on independence, many older adults choose (or feel they have no choice) to remain in inadequate housing to maintain familiar surroundings, independence, or family linkages.

The main themes that emerged related to housing were:

1. Senior center housing affords valuable relationships to residents.
2. Homelessness among older adults is increasing.
3. Sometimes, children move their aging parents to Alaska, thinking there are abundant older adult housing options when there are not.
4. Older adult housing can be unsafe and inadequate for several reasons:
   a. In the winter, older adults struggle to get their homes and driveways plowed to come and go from their houses.
   b. Older adults cannot make needed housing repairs due to their physical condition, lack of financial resources, or difficulty finding assistance.
   c. Older adults may be stuck in unsafe and inadequate housing conditions due to family situations such as family member's drug use and mental health issues.
5. There is a lack of rural older adult housing.

TABLE 27. **EXEMPLAR QUOTES ON HOUSING**

Senior center housing	Because we operate affordable housing, we have a whole lot of seniors that we have a reoccurring and deep relationships with. If you're renting from us, we're going to interact with you at least once a month and oftentimes more than that. So, by design, we offer to develop relationships with those in our housing. – Senior center staff
Older adults in less adequate housing	"Fred" was living with his son or daughter, and they moved him out of the house into the garage because he had a real drinking problem. Fred would come to the senior center, and he seemed fine to us. He'd come in for a few hours, have lunch, go home, and that's when he would start drinking, and he would just drink himself into an obnoxious, bothersome kind of drunk. His kid said we don't want you in the house anymore, but we can't let you live in a ditch, so go live in the garage. – Senior center staff
Homelessness	I want to give you an example of a homeless senior who comes into the center. He doesn't tell us where he sleeps (back to the independent part). He doesn't tell us where he goes. We do know that he doesn't have a place to sleep. We do know that he circles around probably a couple mile radius. Cause he walks everywhere. One morning, he came in and he was leaning on the door, and I don't know if he spent the night here outside. This individual who doesn't qualify for housing because he doesn't make enough money even though he gets like social security...He said, "I have no place to go. And I feel like nobody cares. I have no support." And it was very heartbreaking to listen to him because we can't give him a house. We don't have that kind of housing here. We don't have homeless shelters. – Senior center staff

TABLE 27. **EXEMPLAR QUOTES ON HOUSING**	
Moving parents to AK	I think there's a lot of families that move their aging parents to AK thinking that they're just gonna find them senior housing, they're just gonna get them into health care services, and access is just not there for any of these things. – Older adult provider
Snow plowing	Wintertime was pretty bad because I had no one to do my roof. All the snow came off my roof at once, so it was pretty waist-deep and I couldn't remove it all. So, it was very hard because I have no one to come or even trying to find someone to hire – they are ridiculous with the amount they want. I let it melt – right up until May. I did manage to get someone who dragged along a couple of friends, and they were $20 buck an hour, and they cleared me a path to get in and out. That was after I crawled over it and worked around it for about a month or two. – 73-year-old senior male
Home repairs	In winter, it's very difficult for them (repair people) to travel. A lot of folks don't want to spend the hour and a half drive one-way just to come to see folks. Trying to get people up here to do any kind of work, especially for seniors, is difficult. If they have housing repairs, it might take them five or six months. So, that can be depressing for folks, especially if they have rain leakage. – Older adult provider
Rural housing needs	The huge thing is this crisis I was describing of coming to AK when you're young, and it was OK. And now, when they are 60 or 70 – how do they get transplanted into a place that both meets the needs that they felt in coming to AK? I said to one of the people, "You can't stay out here in this way many more years." And she says, "Yes, but I can't live in Anchorage either because of the crowdedness." So how do we bring more adequate housing out into your rural areas, so they don't lose the whole fabric of the community and they are in a safer, warmer space? We have very limited senior housing, and some of them are only living on the dividend. – Church staff
Unsafe housing due to family issues	I get a lot of calls about, um, family neglect. Because families are hurting so badly. They can't also take care of a senior – Church staff

Social Connection

KEY FINDINGS: **SOCIAL CONNECTION**

1. Social isolation and loneliness are associated with sleep disturbance, fatigue, depression, and decreased levels of well-being in older adults.
2. In Mat-Su, there are 15,090 older adult households, three quarters of whom were family households – 29% with a spouse. There were 1,417 men living alone and 1,837 women living alone.
3. In 2022, 64% of male and 58% of female older adults were married. Sixteen percent of male and 20% of female older adults were widowed.
4. In 2022, 15% of Mat-Su older adults reported that they had 0-1 people they could count on, 43% had between 2-5 individuals, and 65% had six or more people they could count on.
5. Fifty-three percent of those 65 and older were embedded in communities where favors were done often or very often.
6. Most Mat-Su residents aged 65+ said they seek advice on handling financial, emotional, or work-related issues from family or friends (79%). Fifteen percent of persons 65+ said they sought advice from "nobody."
7. Providers and church staff felt that social isolation among older adults resulted from having family out of state, aging in an isolated place, not having transportation, having family and friends who have died, preferring to be isolated, or being "snowed in."

This report defines social connection as "having close and positive relationships with others." Social connection may be evidenced by an individual feeling cared for by others, caring for others, and feeling a sense of belonging to a group. Social isolation and loneliness are associated with sleep disturbance, fatigue, depression, and decreased levels of well-being in older adults (Suragern et al., 2021). A recent report from the U.S. Surgeon General reported that loneliness and social isolation increase an individual's risk for:

- Premature death
- Heart disease
- Stroke
- Anxiety
- Depression
- Dementia
- Being susceptible to viruses and respiratory illness

The report also states that in the United States, people are becoming increasingly socially isolated, and their social networks are getting smaller. The report found that older adults are one of the groups most susceptible to social disconnection. People with poor physical or mental health, disabilities, financial insecurity, or those living alone were likelier to be lonely and isolated (U.S. Surgeon General, 2023).

In Mat-Su, there are 15,090 older adults in households, three quarters of whom were in family households – 29% with a spouse. There were 1,417 men living alone and 1,837 women living alone (Table 28).

TABLE 28. **RELATIONSHIP BY HOUSEHOLD TYPE FOR THE POPULATION 65 YEARS AND OLDER, 2022**

Insurance status	Count	Percent
In households	15,090	
In family households	11,410	76%
Spouse	4,438	39%
Parent	846	7%
Parent-in-law	157	1%
Other relatives	490	4%
Nonrelatives	121	1%
In nonfamily households	3,680	24%
Male living alone	1,417	39%
Male not living alone	256	7%
Females living alone	1,837	50%
Female not living alone	38	1%

Source: (ACS 2022)

In 2022, 64% of male and 58% of female older adults were married. Sixteen percent of male and 20% of female older adults were widowed (Table 29).

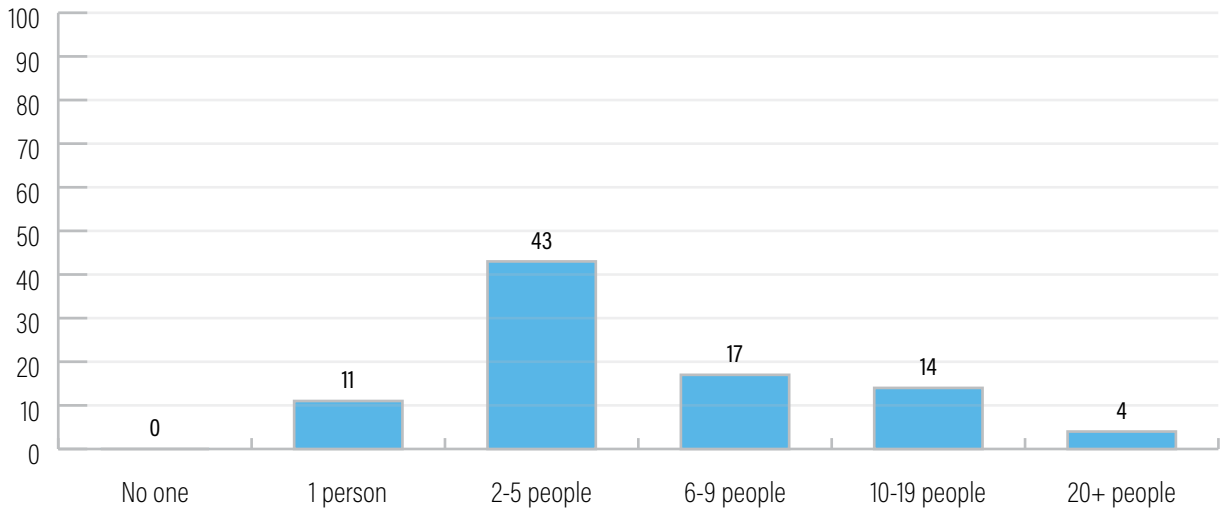
TABLE 29. **MARITAL STATUS BY SEX FOR MAT-SU OLDER ADULTS 65 YEARS AND OLDER (%), 2022**

	Total	**15,458**
	Males	**Females**
	7,562	**7,896**
Married	64%	58%
Widowed	16%	20%
Divorced	**16%**	**21%**
Separated	1%	.2%
Never married	4%	1%

Source. (ACS, 2022)

The Mat-Su Health Foundation Household Survey, conducted in 2022, asked residents how many people they could count on for help. Fifteen percent of adults 65 and older reported that they had 0-1 people they could count on, 43% had between 2 and 5 individuals, and 65% had six or more people they could count on (Figure 25).

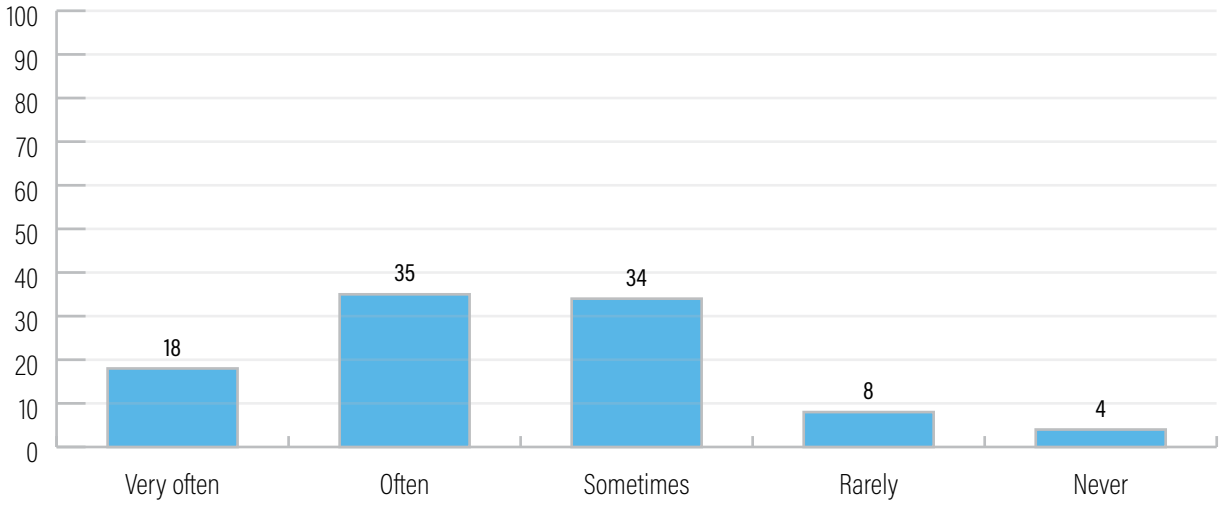
FIGURE 25.
NUMBER OF PEOPLE MAT-SU OLDER ADULTS STATE THEY COULD COUNT ON TO HELP WITH PRACTICAL PROBLEMS (%), 2022



Source: Mat-Su Household Survey, 2022

A sense of community connection can offset social isolation. Older Mat-Su residents were asked how often they or people in their community did favors for each other. Fifty-three percent of those 65 and older were embedded in communities where favors were done often or very often.

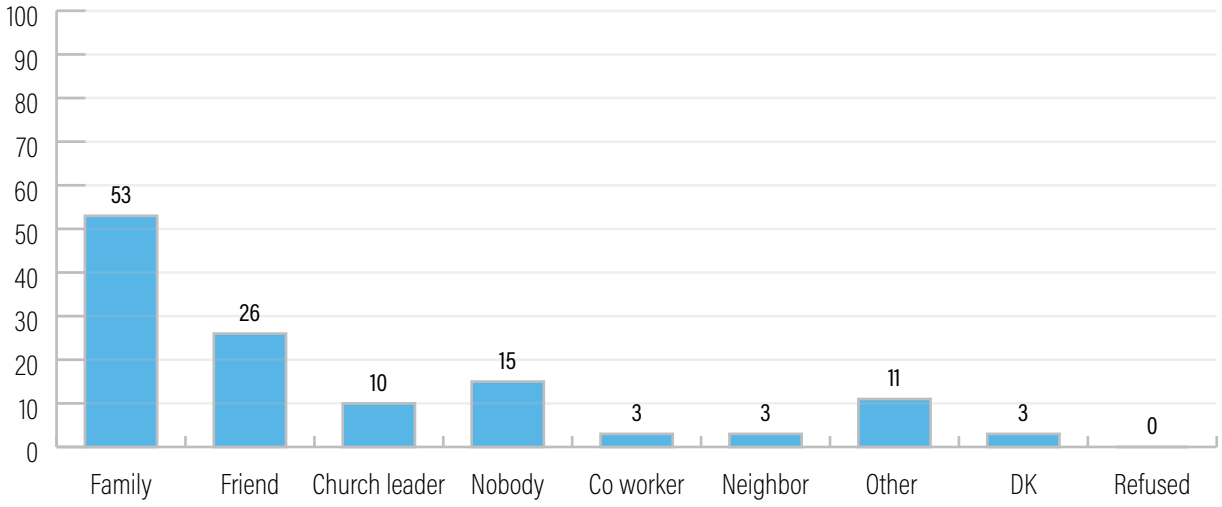
FIGURE 26.
DO YOU AND PEOPLE IN YOUR COMMUNITY DO FAVORS FOR EACH OTHER VERY OFTEN, OFTEN, SOMETIMES, RARELY, OR NEVER? (%), 2022



Source: Mat-Su Household Survey, 2022

Another key aspect of social connection is the ability to seek and give advice to others. Most Mat-Su residents aged 65+ said they seek advice on handling financial, emotional, or work-related issues from family or friends (79%). Fifteen percent of persons 65+ said they sought advice from "nobody."

FIGURE 27.
IF YOU NEED ADVICE ON HOW TO HANDLE A PROBLEM, SUCH AS A FINANCIAL, EMOTIONAL, OR WORK-RELATED ISSUE, WHO WOULD YOU ASK FOR HELP? (%), 2022



Source: Mat-Su Household Survey

Providers and church staff felt that social connection was crucial to mental wellness and quality of life. They noted that social isolation in Mat-Su often results from:

- Having family outside the state
- Having been a young, "independent" person who is now aging in an isolated place
- Not having transportation
- Having spouses/partners and family/friends who have died
- Preferring to be isolated
- Being "snowed in"

The effects of social isolation on Mat-Su older adults, as described by those who work with them, are:

- Anxiety and depression
- Difficulty surviving without help with daily living tasks, transportation, and home maintenance
- Degrading mental and physical health
- Worsening dementia
- Suicidal ideation

TABLE 30. **EXEMPLAR QUOTES DESCRIBING OLDER ADULT SOCIAL CONNECTION STATUS**

"We really do believe that human beings are social creatures, and if you cut off the social connection, then we degrade. And that degradation is both physical and mental. And so we try to keep people engaged with other people as much as we can." – Provider
"[There is a woman] who came to Alaska with the Alaskan Dream – at 96 years, weighing about 80 pounds, she has no one except her neighbor. Her sister passed away, and I think she wasn't married. She lived most of her life here, and now she is alone." – Provider
"We fairly frequently get calls for people who really don't need an ambulance and for whatever reason they're lonely, or they have needs that are not related to 911." – EMS provider
I'm alone in this house with three dogs. I have my kids; they're right here, but they go to work all day long. I'm here by myself unless someone decides to stop and visit me. I don't have that many friends because I never made that many friends. I have three great-grandchildren who visit once in a while, and I try to go to their school activities. – 82-year-old female
[Being socially connected] gives you a sounding board, and you can get some bounce back and find out if you're on the right track for things. It helps to run things by your buddies to see if it's in line with expectations. It is nice to have the support from a few friends here or there, but like I say, I have very few, and every time I think I got one, that's it. I get my expectations up and then they are dashed. – 73-year-old male
[Where do you get social connection?] I would go down to Goodwill. That is a pretty neat store when they opened that and gave you a good discount - 50% off practically. I bring a puppy and would be there and try to sell it, and other people come in, so it gets me a lot of attention. – 73-year-old male
I live in Willow, and I am very active in the community and I love community service. I find that's a great way to meet with residents of Willow and beyond. I'm just blessed by the Lord to still be active. I volunteered at the Recycle Center yesterday. And I go to Church on the Rock – 84-year-old female
I'm home-bound, basically. This man takes me to church every Sunday and takes me shopping. And I socialize with everybody there. I've got people that I can call and then events during the year that the senior center supports. – 79-year-old male
My social connection is through my volunteering. I've made friends through volunteering because I came to Alaska and knew no one except my son. – 81-year-old female

TABLE 30. **EXEMPLAR QUOTES DESCRIBING OLDER ADULT SOCIAL CONNECTION STATUS**
I know on Friday nights, I often go up to the yarn shop over there next to Lowe's. Between four and seven, there is a Knitters Group. If she opens up her store, you can go in and grab a chair and sit and knit with a bunch of people. I enjoy that. As far as going to the senior center and all that – I don't do that – I'm not really a "joiner." I like being out with people, whether it's in the grocery store. I know no strangers – I talk to everybody. – 71-year-old female
I have a few friends and my sister, who I text.... I don't mess with other people. I try to avoid that at all costs. – 60-year-old male
I am in a 12-step program and have been clean and sober for 37 years. And my husband got in Al-Anon when we got married or even before. We have a church family, and we go to the senior center daily when we're in town. – 80-year-old female
Me and my wife talk a lot, but we don't like to go places where we socialize with a lot of different people because of COVID-19. We go to our granddaughters' stuff, and we'd love to go see our son, but he lives on the peninsula. That's gonna be a one-day trip here real soon. We gotta do a little bit of work on this car that we got. We go to church in Big Lake there. – 66-year-old male
[Where do you get social connection?] I am getting it here right now (at Food Pantry) because nobody I have as friends are living close. – 65-year-old female
Thank goodness for the Vet Center. They're the only ones that have done anything for me. They do my copies, they chit chat with me, you know, sit there, have coffee. They listen to my venting, you know. That's always, if I didn't have that, I would be really lost cause there's nobody around to help me talk to me, no family, friends. Everybody keeps [saying] we'll go see family and friends. Hey, if I had some, I'd do it, you know. But people keep saying it, and they don't realize how things are. – 69-year-old male

Profile of Mat-Su Alaska Native Elders

Alaska Native and American Indian Elders

The data for this section comes from the survey conducted by the National Resource Center on Native American Aging, Identifying Our Needs: A Survey of Elders VIII (Elder survey). The Knik Tribe collected data via phone and in person with Elders visiting the Valley Native Primary Care Clinic. They surveyed 90 Elders. Data for this section also came from the American Community Survey (ACS, 2021).[6] Finally, in-depth interviews were conducted with staff from the Knik Tribe, Southcentral Foundation, and the Chickaloon Traditional Council. For simplicity, the word "Elder" will be used to indicate an Alaska Native/American Indian individual 65 years or older.

Demographics

According to the ACS in Mat-Su in 2021, there were 292 male and 486 female Elders 65+ years.[7] Sixty-one grandparents aged 60 or older were responsible for their grandchildren under 18.

Elder behavioral health status

Tribal service providers and survey results revealed that Elders struggling with behavioral health issues experienced loneliness, anxiety, depression, and grief, sometimes combined with cognitive decline. The Elder survey revealed that 40% of respondents felt nervous some of the time, and 49% felt "downhearted/blue" some of the time, with about a quarter saying that nothing would cheer them at those times. Regarding substance use, the most mentioned substances were alcohol or prescribed medications; however, all staff stressed that they don't see Elders misusing substances often. Only 20% of Elders reported having a drink of alcohol in the last month, and 9% reported binge drinking 1-2 days per month. Tribal providers did mention that they sometimes see Elders affected by the substance misuse or addiction of family members with whom they live. Tribal staff also mentioned that many Elders have suffered trauma in their lives connected to being sent to boarding schools and other forced assimilation efforts. These traumas can have lifelong negative mental health consequences.

According to the Elder Survey, 84% reported that their quality of life was excellent, very good, or good. Seventeen percent stated it was fair or poor. When asked, "In the past month, how much of the time were you a happy person?" 76% said all of the time/most of the time, and 24% said some or none of the time.

Access to care

Elders surveyed reported that the top access-to-care issues they faced were the distance from services (17%), too long a wait for appointment availability (10%), no transportation (8%), and cost (8%). Only 16 males and 26 females did not have health insurance in 2021. Ninety-eight percent of Elders had public insurance, and 46% also had some form of private insurance (ACS, 2021).

Physical health status

Twenty-one percent of Alaska Native Elder survey respondents said their health was excellent/very good, 49% said it was good, and 29% said it was fair/poor. Ninety-three percent of Elders said they had seen their doctor/provider in the last year. Thirty-three percent of respondents said they had been diagnosed with a disability.

Financial status

According to the Elder survey, over half of Alaska Native Elders (52%) had an annual income of less than $25,000; 25% earned between $25,000-$49,000, and 25% earned more than $50,000. The Elder survey also revealed that 11% often or sometimes "felt that the food I bought just didn't last and I didn't have money to get more."

Independence

Sometimes, Elders relocate to Mat-Su from a village outside the borough because they need services not provided in their original community. Tribal providers mentioned that they sometimes lose

6 US Census data, including the American Community Survey can be found at this link, https://data.census.gov/

7 The classification that was used to retrieve data from the US Census was that the respondent considered themselves Alaska Native and/or American Indian alone or in combination with another race.

access to their family ties, cultural practices and food when they do this. Staff said that Elders will often try to cover up their needs to maintain their independence. They said that most assisted living homes do not meet their cultural needs because they are run by non-native people.

They stated that Elders often have a strong sense of responsibility to continue caring for their children and grandchildren, which could sometimes be at a cost to themselves. Staff noted that they have seen some situations they categorize as abusive/exploitive when Elders are living with family members. Additionally, a Tribal staff member said that she sees a lot of widowed women who are having to adjust to this life transition. She mentioned the usefulness of a grief group in the community that can help Elders with this transition and provide socialization.

Transportation

Tribal providers stated that Elders in Mat-Su face similar problems with accessing transportation as non-Alaska Native older adults.

Housing status

The Elder survey revealed that most Elders live in a single-family residence (76%) and more than half with a family member (59%) or someone else (11%). Non-Tribal providers in Mat-Su mentioned that Elders can face the same challenges in maintaining and doing household chores as non-Alaska Native older adults. The Elder survey asked about physical health problems creating issues with household chores and found that 24% of Elders said they had difficulties with doing heavy housework, 13% with preparing their meals, 12% with doing light housework, and 9% with getting outside.

Social connection

All staff at the three main Tribal organizations emphasized the central role that social connection plays in supporting Elder mental health. Many of the cultural traditions asked about in the Elder survey involved social connection. The top traditions followed by Elders were consuming traditional foods, attending Powwows, smudging, preparing traditional food, and participating in talking circles.

The Elder survey revealed that almost a quarter of Elders reported that they only left their homes 1-2 times per month, and slightly less than a quarter reported leaving their homes 3-4 times per month. According to the ACS, in 2010,[8] 201 Elders lived in family households (64 with a spouse, 23 with a parent, 22 with other relatives, and seven with non-relatives). One hundred and six elders lived alone (39 males and 67 females).

The staff stressed the importance of social connection in promoting mental health and stated that not all Elders they interact with attend the events they hold. They noted that lack of transportation may be a factor. Tribal organizations makes personal connections with their Elders via the phone and when they come to events, and the Bentah Nuutah Valley Native Primary Care Center has home visits where they reach out to Elders.

Tribal Elder services and gatherings

The Tribal providers mentioned activities specifically aimed at Elders or that include them along with the rest of the Tribal population. Some of these activities target needs identified for all Mat-Su older adults. At the Knik Tribe, they have a monthly Elder meal and an Elder-peer hotline. Further, the Knik Tribe has a support program that assists Elders who own their homes with safety issues such as replacing a window, fixing a door, putting in handicap railings, snow removal and plowing, and wood cutting.

The Chickaloon Traditional Council offers multiple services: Elder lunch in Sutton once a week, food delivery in the Sutton area for Elders, transportation to doctor appointments and shopping, help to pay bills, home visits to help with chores, a wellness group meeting 2x per month, and Elders available to help at the local Tribal school.

The Southcentral Foundation has a monthly Elders group at the Valley Native Primary Care Center. Additionally, they use the NUKA system of care, which employs a relationship-based, customer-owned approach. Elders and other beneficiaries are served by integrated teams (including behavioral health staff) when they seek primary care. They also have a referral-based team dedicated to visiting customer-owners in their homes or assisted living facilities

8 2010 was the most current year where these data were available for household type for Elders in Mat-Su.

in the Mat-Su. Home visits are conducted using an integrated approach where the team works in support of the customer's relationship with their primary care provider. Their mission is to prevent hospital readmissions and support customer-owners in obtaining all needed and available resources from the state, Tribe, or local sources. They also partner with behavioral health counselors in the home or by phone to meet customer-owners' needs.

TABLE 31. **EXEMPLAR QUOTES: ALASKA NATIVE ELDERS**

Family life	I think with our population, families like to be together, and I think that you see more multigenerational [homes]. – Tribal provider
Mismatch of culture in assisted living homes	[In assisted living homes], they are watching TV that they can't understand, or they [staff] are doing things that don't make any sense, or the food is not right. – Tribal provider
Adjusting to life when family members die	A lot of them are widowed, partners passed away after long years of marriage, and they just don't know what to do with their daily living because they don't have that other person. They don't have anybody. – Tribal provider
Giving up lifestyle as you age	So, giving up your lifestyle to get your needs met is a big adjustment for folks, regardless of where you live. Changes in your lifestyle are huge, as well as your lack of ability to take care of yourself anymore is also huge." – Tribal provider
Living in unsafe conditions with family	"Some of the Elders would like to stay home and so you try to support that as well as you can instead of getting them into assistive living, maybe a personal care assistant or however that might look for them. There are a number of Elders, though, that will put themselves through "hell" (this is probably a strong word) but at times – to support their family members. [They may be] in unsafe situations because they know the family members need their money to survive or something like that. – Tribal provider
Veteran living with family	Alaska Natives tend to not be as isolated because they live in homes that are three or four generations. So, they'll live in a small home, and it'll be their kids and then their grandkids in that home, as well. They are the Elders of the village, and they're the ones everybody kind of looks up to. So, they're not as worse off as a white male veteran that at some point in his life, said, "I want to move to Alaska for that amazing adventure and isolate and be away from everybody in the world." – Veteran provider
Lack of transportation and financial insecurity	[What else affects Elder mental health and well-being?] Not being able to go and get supplies, pay their bills. Like we have an Elder right now who lives out past Willow, and his daughter had taken his vehicle for a while. And he didn't have running water, and we were bringing him water, and he has a lack of income. And he got his car back, and then it caught fire, and now he has no transportation. So, transportation [is a need] for sure. – Tribal provider

Recommendations (Magic Wand) and Promising Practices

All interviewees (state agency staff, service providers, church staff, older adults) were asked the same question: If you had a magic wand and could do three things to help older residents with behavioral health needs or mental well-being, what would you do? They gave recommendations centered on three major themes: basic needs, behavioral health services, and social connection. In the next section, there will be information about model programs successfully implemented elsewhere that may address a recommendation.

Basic need assistance recommendations:

1. Have more affordable and safe older adult housing.
2. Provide affordable or free home modification, repair, and chore services.[9]
3. Provide affordable or free transportation.
4. Provide more financial assistance.
5. Create more case management assistance for older adults.[10]
6. Build a low barrier shelter for "one-stop shop" supportive services.

Housing and repair and chore services

Tribal, church, and rural providers suggested more older adult housing where people could have the support they need and be closer to other older adults. All non-Tribal providers noted the need for home adaptation and repair programs for older adults (Tribal providers provide this service). One rural provider said there were willing volunteers to do the labor; however, funding is needed to buy the supplies. Many interviewees mentioned the need for plowing out older adults in the winter.

Affordable transportation

Many respondents made affordable transportation their first choice for their magic wand. Suggestions included affordable or free transportation for going to medical and behavioral health appointments (including in Anchorage), to the store, to social connection events, and to access needed support and resources. They mentioned having a taxi-like service that people could book ahead of time.

Case management

Support providers describe older adults who had difficulty due to cognitive decline or who were exhausted when looking for the right person with whom to talk. Many suggested the need for more case management to help with this or a "one-stop shop" where older residents could get support for all their needs at once. One provider said this would assist all older adults and prevent people from "falling through the cracks." One senior center director described a situation where they were the "defacto" care coordinator for a gentleman who walked through their doors at 4:00 on a workday. The man thought he had broken his hand and had no support, and there were apparent behavioral health issues. The center staff talked with him, getting him medical care at the local urgent care, found him veteran's services and a spot to sleep that night, and drove him to Anchorage to that facility. These actions were not services the center provided or in the job description of any staff member. However, they felt they needed to help this older adult with case management so he would be safe and cared for. No service in the Ma-Su would have provided all those services for him. Older adults also suggested it would be helpful to have an advocacy agency they could call to ask questions about fraud and other situations they fear or predicaments they find themselves in.

Financial Assistance

Financial assistance was suggested by several older adults who were on a limited income and did not appear eligible or didn't know about financial assistance opportunities. Often, when older adults are hit with an unexpected expense or something they use wears out, they have no money to address the problem. Examples included rebuilding after a house fire, repairing a truck badly damaged by a snowplow, and a pet injury that requires veterinary care.

9 See Appendix C, Elder Home Repair and Maintenance Program, Central Massachusetts Housing Alliance as an example of this type of program.

10 See Appendix C, Collaborative Care Management (CoCM) for Seniors as an example of this type of program.

Food assistance

Food assistance was suggested by an older adult who also suggested that it would be helpful if older adults could sign up to get meals based on their diet and medical needs, such as a vegetarian diet or meals for those with kidney problems.

A faith-based provider who serves many low-income and unhoused people in the core area described the need for a low barrier shelter with a "one stop shop" of services and support for older residents -where people could come, rest, stay overnight, and express their needs, all of which could be met in one place with less "red tape" and less need for transportation instead of being "kicked around like a soccer ball" from one provider to another in the community.

Planning for old age

Both providers and older adults recommended that advice on planning for old age be made available to people while they are younger to ensure they have a safe place to live and the resources they need to live a fulfilling and satisfying life as an older adult.

TABLE 32. **EXEMPLAR QUOTES ON BASIC NEED RECOMMENDATIONS**

Transportation	A lot of them don't drive anymore, and we don't have a public transit system and, so getting them to appointments is really hard – that is a huge barrier. – Behavioral health provider
Housing	Subsidizing some housing, making it affordable to live – that would at least eliminate some of the exterior stressors that are making whatever existing health problems worse. – Connect Mat-Su
Chore assistance	There is an extensive waiting list for chore services, and they are not getting their needs met. So if someone is not able to clean their home, eventually they are going to be depressed, and it's going to lead to more issues. Basic needs are not being met for a lot of seniors, and they just don't have family members or access to the community to reach out to people....there are a lot of people who are willing to do a chore – like you get churches and whoever that are willing to help. – Older adult provider
Home modification and repair	When we're talking modifications, people think it's big. There's some basic modifications that make a world of difference for seniors, like neon tape on the stairs so they can see the edges. If they don't have electricity, just those motion sensor lights on a series of batteries so that they can see the depth – that is huge. – Rural provider
Case management	To address needs quickly when that can happen rather than saying, "Why don't you call this person and just see if they can help you?" And so for working with somebody who is having possibly cognitive decline or working with someone who has already called about 60 other people without luck....and someone saying, "Why don't you call the 62nd person today?" and they become very exhausted. Instead, if I can reply, "I have a place I can get the rest, transportation, and the onsite resources" – a place of respite care. – Church provider My experience with 211 – I need some help with a bill or something, and they'll give you a phone number, and then when you call them, they'll give you another number and after about eight tries you get a number that even doesn't work. This winter, it was extremely hard. I couldn't get out the front door, get to the woodshed to get wood. And I tried to call and get some fuel oil, and nobody wanted to help us get it. "We don't care." – that is the way it felt. – Senior 72-year-old
One-stop shop supportive shelter	You just wish there was a way to get everyone the help they need - easy access. Like the woman who called me in crisis, who later burned down her home down [and died]. I [wish] there was an easy way we could have connected her to care. – Church staff

Behavioral health recommendations

Behavioral health suggestions included:

1. Have older adult-focused behavioral health programs, as well as accessible providers.[11]
2. Within the medical care system, adopt mental and physical health parity and truly integrate these types of health care.
3. Provide medical liaisons to assist with mental and physical access to care and help to manage medications.

More accessible behavioral health providers

Some providers said that even if someone was identified with behavioral health issues and referred to services in the community, many barriers hinder the successful completion of that referral. Providers recommended having older adult-focused behavioral health clinicians do home visits or be located at a senior center to make services more accessible to older adults. Additionally, an older adult suggested having a liaison for mental health care to help remove the stigma and make people feel more comfortable. One older adult recommended having "discounted" mental health care so older adults could get care without a large out-of-pocket expense.

Medical Liaison

The use of medical liaisons was suggested to help older adults negotiate the mental and physical healthcare system, especially helping older adults design a system to take their medication appropriately.

Mental/physical health parity and integration

Both these recommendations were mentioned by local and state older adult advocates. Implementing these recommendations would require system and policy changes to address the inequities between the physical and mental health care systems with regard to the amount of paperwork required of providers and the pay they receive. Both factors can affect people's satisfaction and attraction to behavioral health career paths. A state agency staff person said that if the mental health system more closely approximated the physical health system, the number of mental health providers would increase, and care would be delivered quicker because of lower paperwork requirements. One state agency staff member stated that until there is parity, you won't have an industry that looks at the whole person. The integration suggestion included the assumption that older adults access physical health more frequently and easily compared to mental health services, and if both types of care could be integrated in one place, then access would be increased.

11 See Appendix C -Older Adult Services Program for Assertive Community Treatment (OAS PACT); Program to Encourage Active Rewarding Lives (PEARLS); and Healthy IDEAS, Identifying Depression and Empowering Activities for Seniors; Senior Hope, Compassionate Chemical Dependency Care for Seniors and their Families as examples of these types of programs.

TABLE 33. **EXEMPLAR QUOTES ON BEHAVIORAL HEALTH RECOMMENDATIONS**	
Medical liaison	These people have a laundry list [of medications]and they don't take them or sometimes take them all at once. They could use a medical liaison who could explain medication and help set up appointments. – Paramedic
More Medicare providers	[We need more providers] who take Medicare. Even if you have nice insurance, the moment you turn 65, your options become very limited – State agency staff
Mental/physical health parity	In order to have a robust continuum of care that we need for behavioral health services, we have to have parity between behavioral health and physical health in terms of reimbursement and lack of stigma. I was absolutely floored when I learned that there were residential treatment providers that had to hold fundraisers because the reimbursement rates that they were getting were insufficient to keep their doors open. There are no cardiologists that hold fundraisers. – Statewide agency staff
Integrated care	If you had a robust system that allowed for people to be treated for the whole person in one kind of all-encompassing, no-wrong-door entry point, I think that would be huge for the elder populations, and access would be higher because one of the only access points is the physical medical appointments. – Statewide agency staff

Social connection recommendations

Respondents made suggestions focused on creating social connections to help solve the problem of social isolation. As mentioned in this report – respondents felt that social connection is key to good mental health for older adults. Social connection magic wands were focused on:

1. Ensure all older adults "have a friend" by promoting peer-to-peer networks.
2. Promote intergenerational activities between older adults and people of other age groups.
3. Increase older adult recreational activity opportunities with funding to senior centers and organizations for activities and dedicated activity directors.
4. Provide more places in all communities for older adults, including veterans, to gather.
5. Develop new networks, including peer-to-peer networks and volunteer networks, where older adults can participate.

Promote relationships for older adults

Many providers and older adults expressed the need for older adults to have a friend, someone who will check in on them, especially in the winter. Another recommendation described the need for a culture change promoting the importance of natural social connections for older adults with family, friends, neighbors, and others.

Create intergenerational activities

One suggestion described a program that encouraged older women to connect with young women with depression, for example, in a community space where older women sit on park benches and welcome the younger women to sit next to them and talk. Other suggestions were to have older adults read stories to children in daycare centers or have youths go into older adults' homes to do chores and help them with technology. A church staff member suggested having a youth campus with youth/older adult mentoring opportunities.

Provide funding for older adult activity directors

A senior center director suggested the need for a funded older adult activity director who could organize activities, events, and field trips for older adults. While some staff may already do this, having a dedicated position for this role would increase their ability to promote these activities and get better attendance.

Create an older adult volunteer network

A few older adults interviewed for this report volunteer regularly, and another older adult requested information on volunteer opportunities. A borough-wide provider

suggested implementing a network specifically targeted at recruiting older adult volunteers.

Create more gathering places for older adult activities and events

Although there are existing senior centers, there was still a request from providers and older adults for a designated space for older adults to "hang out" and to hold events such as dances, game nights, veterans' gatherings, and other events.

Some of the magic wand items mentioned above are interconnected. For example, you need transportation for social connection opportunities and physical health services. A veterans' support staff is trying to create a multi-purpose program that checks in with older adults once a week, brings them firewood, plows their driveway, and sits and has a cup of coffee with the veteran.

TABLE 34. **EXEMPLAR QUOTES ON SOCIAL CONNECTION RECOMMENDATIONS**

Social Connection	Create a community that seniors can be a part of and eliminate loneliness. I was talking to someone a while back – and she was 87 years old, still quite spry, but was quite lonely. She lost her husband, lost her family, folks had moved away from her community. She didn't know her neighbors. She still drove and was competent. I suggested she get linked to the senior center. She said, "Well, senior centers are for old people." The question is – how do we have a community that is not segregated by age so that folks can develop cross-generational connections? – Provider
Check-ins	The veterans would come, sign up, and they would get a weekly donation of firewood, their driveway shoveled, and somebody to sit down with them and have coffee and make sure that they are taken care of – you know – the roof wasn't caving in – that sort of thing. – Veteran provider In case someone falls, there is no one checking on them. Because I got a phone call from Juneau saying my grandfather has fallen and he can't get up. So, he was stuck there for over three days; he couldn't stand up. So, a place for seniors to live [so] that they can be cared for. – Church staff
A friend	We need more contact for seniors with someone because they will call [EMS] for that reason. We have a veteran and he calls on Veteran's Day, and I felt very clearly that the reason he is calling is because he is lonely. So, it's hard to say, but probably human contact is going to be the most important thing for these people. – EMS worker If I had a magic wand, everybody would have a friend. Ideally, that friend would be another human being, but if they can't tolerate another human being, then they would have an animal, but they would be another living thing. – Provider
Peer-to-peer network	If they just had someone to talk with who listens to them, it makes a big difference. I've often thought a peer-to-peer network that actually worked with seniors in our area [that would listen and have contacts, call to chat, ask questions.] People who would just listen at any time of day when you're feeling down. – Rural provider
Intergenerational connection	I have this dream in my head of Youth 360 or Youth Thrive volunteers going into the homes of seniors to do chores or help around the yard or help them learn technology or like all of those things. There's so much power and learning in that space, and I think those two groups could learn from each other and that it would be beneficial for connection on both levels. – Church staff

TABLE 34. **EXEMPLAR QUOTES ON SOCIAL CONNECTION RECOMMENDATIONS**	
Culture change	If I had a magic wand, I would figure out a way to make it so that our value system about our seniors changed so that these people who contributed, raised children, contributed to communities, built fantastic things - didn't become the discarded generation. We would value our elders/seniors and regard them as the people that need to be treated with respect and dignity until they passed away. – Provider
A gathering place	The other thing I want is near our elder Housing – it's a big piece of property. We have fish camp every year. So, I want a building that is multi-use, and other people could rent it. We could go in there and have classes or trainings with our youth and the elders because the elder housing is right there. And then also have the option of an outdoor area to process fish and a trail that had the traditional plants for medicine marked that they could walk and/or maintain. – Tribal provider

Model Programs

A comprehensive literature review yielded model programs that contribute to the mental well-being of older adults. They fit into the broad area of recommendations. The model programs are summarized below and complete descriptions can be found in Appendix C.

Elder Home Repair and Maintenance Program, Central Massachusetts Housing Alliance

Within its mission to prevent homelessness, the Central Massachusetts Housing Alliance addresses the unique needs of low-income aging homeowners unable to maintain their homes independently with limited financial resources. Referrals for older adult home repair and maintenance services come from health and human service agencies. Clients may also self-refer. The Central Massachusetts Housing Alliance covers the labor costs for repairs necessary for a home to be safe for habitation. Clients pay for the materials for the repairs. Older adult homeowners can also access home maintenance services such as snow shoveling and removal, gutter cleaning, grass mowing, and other routine maintenance needs. The provision of these additional services is determined on a case-by-case basis, considering the urgency of the need and preserving other networks of support.

Collaborative Care Management (CoCM) for Seniors

Collaborative Care Management for Seniors aims to make behavioral health care more accessible to populations facing health inequities by centering treatment options in one location. Pharmacologic and psychotherapeutic interventions for common mental health disorders such as depression and anxiety are integrated into primary care settings with a team-based model of care similar to those for chronic illness management. Patients interact primarily with their Behavioral Health Care Managers who provide Behavioral Activation and Problem-Solving psychotherapies, conduct follow-up check-ins available at home, administer the assessments, present cases in systematic case reviews, and communicate with the primary care providers who provide prescriptions for pharmacological treatments when needed. Psychiatric Consultants, usually psychiatrists or psychiatric mental health nurse practitioners, perform systematic case reviews.

Healthy IDEAS, Identifying Depression and Empowering Activities for Seniors

Health and human service agencies interested in Healthy IDEAS first complete a self-readiness tool that helps them to determine if the program is a good fit. Healthy IDEAS is a program for professionals who interact with older adults as case managers, care coordinators, or similar roles and have regular contact with a given client for at least three months. Following the initiation of a contract, professionals are trained to identify symptoms of depression in their clients and provide specific interventions to increase daily activity levels and social engagement behaviors. Agency staff complete a curriculum in which they learn to administer validated measures of depressive symptoms, provide psychoeducation about depression and treatment options, refer clients to mental health care, engage clients in Behavioral Activation, and follow up with clients over time.

Behavioral Activation, a short-term intervention focused on increasing activity levels and social interactions, can be implemented by multiple groups of professionals to assist older adults with depression in maintaining their engagement with relationships and life moments that they enjoy. Local behavioral health professionals serve as coaches to case managers and other agency staff, providing information and guidance to clients.

Intergenerational Programs to Promote Social Connections for Older Adults

Intergenerational programs combine the designs of child- and age-friendly public spaces and programs to facilitate opportunities for spontaneous intergenerational interactions between older adults and diverse age groups. Rather than segregating environments and activities by age, the needs and preferences of older adults, such as walking on paved paths instead of swinging or engaging in water play, are met within proximity of those areas preferred by younger adults, children, and youth. For example, playgrounds built near outdoor fitness areas accessible to older adults, with trees, seating, and shade, support spontaneous multigenerational social engagement. In intergenerational spaces, diverse age groups can safely navigate all areas and connect with each other. Structured intergenerational programming also brings together the accumulated knowledge of child- and age-based best practices to create opportunities for older adults to share their knowledge through volunteering or teaching and learn from younger generations about topics such as technology. Examples of structured initiatives include the "Time After Time" program in the UK that integrates storytelling, classroom activities, and a choir of diverse ages, as well as school-based co-learning programs such as "Bridges Growing Together" in the Massachusetts town of Sudbury, in which older adults learn about the generational realities of fourth graders who complete interview assignments with older adults who also participate in weekly group discussions with the children.

Mental Health First Aid (MHFA) for Older Adults

MHFA courses center on implementing an action plan to provide informed support to individuals experiencing symptoms of depression and other mood disorders, anxiety disorders, trauma, psychosis, and substance use disorders. The action plan also addresses responses to crises stemming from these conditions. Upon completion, participants can implement the MHFA action plan. The action plan will Assess suicide risk or harm, Listen nonjudgmentally, Give reassurance and information, Encourage appropriate professional help, and Encourage self-help and other support strategies (ALGEE). The MHFA for Older Adults curriculum also includes information on supporting older adults with stressors of aging, such as bereavement and physical health concerns. Local professionals are trained to teach the MHFA for Older Adults courses. The local trainers grant certificates of course participation upon completion of the training curriculum.

Older Adult Services Program for Assertive Community Treatment (OAS PACT)

OAS PACT staff provide services designed specifically for older adults, including ongoing case management, client advocacy, assistance in medication management and substance use interventions, and recovery support. For home-bound older adults, behavioral health clinicians within the OAS PACT Senior Health Outreach and Prevention Program (SHOPP) conduct field-based client assessments, crisis interventions, resource and referral counseling linking them to other community services, and provide psychoeducation for caregivers and families. SHOPP staff assist home-bound older adults in addressing logistical challenges they may face when seeking services designed for the general population (i.e., transportation). In parallel with SHOPP, the OAS PACT Substance Abuse Resource Team (START) provides in-home treatments designed for older adults with both mental illness and substance use disorders, including brief and long-term interventions, care coordination, and linkage to inpatient treatment programs.

Program to Encourage Active Rewarding Lives (PEARLS)

PEARLS addresses depression in older adults as a community issue to be handled by paraprofessionals as well as behavioral health professional community members. Agencies integrating PEARLS into their programs first train interested staff to serve as coaches. Staff are not required to have a mental health background. Upon completion of the coaching courses, staff obtain materials and questionnaires from a PEARLS implementation kit. The University

of Washington Health Promotion Research Center provides free technical assistance and monthly support calls. Staff members match older adult clients they feel would benefit from the program with a PEARLS coach. The coach meets with clients for 6-8 sessions over 4-5 months, conducting the present-focused approaches of Problem-Solving treatments and Behavioral Activation. Clients participate in the sessions in the venue of their choice. The agency hires licensed behavioral health professionals to serve as the clinical supervisors for the coaches. Evaluation data consists of aggregate reports of the accumulated baseline and final PEARLS questionnaires, the session questionnaires, and the Patient Healthcare Questionnaires (PHQ-9) administered in each session to track symptom levels. The PEARLS curriculum is available in multiple languages and was designed to be culturally adaptable.

Senior Hope, Compassionate Chemical Dependency Care for Seniors and their Families

Senior Hope provides individual and group substance use disorder treatments designed for older adults within the trauma-informed Restorative Integral Support (RIS) model, a whole-person approach in which the client addresses substance use disorders within the context of lifetime events, especially Adverse Childhood Experiences (ACEs). In addition to hosting a range of specialized group sessions, including Alcoholics Anonymous, Senior Hope provides evaluations and assessments, case management, basic needs referrals, and counseling for individuals and families. The RIS model implemented in Senior Hope emphasizes social connectedness and relationship-building skills as recovery tools that staff model in their interactions with each other and clients.

Senior Peer Program

Health care providers, family members, and friends refer adults 60 years or older to the program. Older adults can also self-refer. Staff conduct a needs assessment and connect older adults to community resources as needed. The peer volunteers, also at least 60 years old, then connect with program participants. Staff and volunteers lead support groups and conduct presentations on topics of relevance for older adults. The Senior Peer Program relies upon peer volunteers to conduct in-home visits, link older adults to community resources, and support the resource and referral linkages provided by staff. All services are provided at no cost to participants.

Conclusions

Older adult behavioral health determinants include eight key factors: lifelong mental health patterns, independence, access to healthcare, physical health status, financial security, housing, social connection, and transportation. The older adult population in Mat-Su continues to grow and become more diverse. Older adults are especially vulnerable to economic downturns and unexpected community or personal financial events because most live on a fixed income. This vulnerability can affect their housing and transportation status. Their physical health naturally declines with age, and their social circles often become smaller. Housing needs and ways of living change as older adults' physical and cognitive status change. Many organizations and churches in Mat-Su have a keen sense of the struggles that older adults face to meet their daily needs (including social connection).

To understand the behavioral health status of Mat-Su's older adults, we pieced together data from many different data sources. The picture that emerged was one of some older adults experiencing pre-existing behavioral health challenges, along with depression, anxiety, and grief, due to their life circumstances. The current statewide funding system does not support the development of geriatric behavioral health services or parity of physical /mental health care and integration. Local behavioral health services reflect that omission. The lack of older adult-focused behavioral health services compounds the generational stigma regarding seeking help.

Mat-Su providers for older adults, church staff, and older adults themselves have offered suggestions on how existing efforts can be amplified to further meet the needs of Mat-Su's older adults and fill some current gaps. Mat-Su Tribal providers offer some exciting services and physical and mental health care integration that could be replicated in the non-Tribal service delivery system. As one church staff said, "It takes a village to care for a senior." It is especially important to build up that supportive community and a wide array of older adult-focused behavioral health services to keep up with the growth of the older adult population in Mat-Su, which is projected to grow by 73% by 2050.

Appendix A: References

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Appendix B: ICD-10 Codes for hospital and ED discharge data

The following are the ICD-10 codes that were used to categorize the hospital inpatient and emergency department discharges for Mat-Su older adults. The State of Alaska Health Analytics and Vital Records Section prepared the data.

ICD-10-CM SUD codes

Code	Definition
F11	Opioid related disorders
F11.1	Opioid abuse
F11.10	Opioid abuse, in remission
F11.12	Opioid abuse with intoxication
F11.14	Opioid abuse with opioid-induced mood disorder
F11.15	Opioid abuse with opioid-induced psychotic disorder
F11.18	Opioid abuse with opioid induced disorder
F11.2	Opioid dependence
F11.9	Opioid use, unspecified
F12	Cannabis related disorders
F12.1	Cannabis abuse
F12.2	Cannabis dependence
12.9	Cannabis use, unspecified
F13	Sedative, hypnotic, or anxiolytic related disorders
F13.1	Sedative, hypnotic or anxiolytic-related abuse
F13.2	Sedative, hypnotic or anxiolytic-related dependence
F13.9	Sedative, hypnotic, or anxiolytic-related use, unspecified
F14	Cocaine related disorders
F14.1	Cocaine abuse
F14.2	Cocaine dependence
F14.9	Cocaine use, unspecified
F15	Other stimulant related disorders
F15.1	Other stimulant abuse
F15.2	Other stimulant dependence
F15.9	Other stimulant use, unspecified
F16	Hallucinogen related disorders
F16.1	Hallucinogen abuse
F16.9	Hallucinogen use, unspecified
F17	Nicotine dependence
F17.2	Nicotine dependence
F18	Inhalant related disorders
F18.1	Inhalant abuse
F18.2	Inhalant dependence
F18.9	Inhalant use, unspecified
F19	Other psychoactive substance related disorders
F19.1	Other psychoactive substance abuse
F19.2	Other psychoactive substance dependence
F19.27	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
F19.9	Other psychoactive substance use, unspecified

F19.97 Other psychoactive substance use, unspecified with psychoactive substance-induced dementia
T36-T50 This range of codes includes all poisoning by, adverse effect of and underdosing of drugs, medicaments and biological substances.
R781-R786 This range of codes refers to drug substances found in blood. (R781 - Finding of opiate drug in blood; R782 - Finding of cocaine in blood; R783 - Finding of hallucinogen in blood; R784 - Finding of other drugs of addictive potential in blood; R785 - Finding of other psychotropic drug in blood; R786 - Finding of steroid agent in blood)

ICD-10-CM Alcohol codes (F10 - F10.9)

Code	Definition
F10	Alcohol related disorders
F10.1	Alcohol abuse
F10.2	Alcohol dependence, uncomplicated
F10.27	Alcohol dependence with alcohol-induced persisting dementia
F10.9	Alcohol use, unspecified
E244	Alcohol-induced pseudo-Cushing's syndrome
F101	Alcohol abuse
F102	Alcohol dependence, uncomplicated
F109	Alcohol use, unspecified
G312	Degeneration of nervous system due to alcohol
G621	Alcoholic polyneuropathy
G721	Alcoholic myopathy
I426	Alcoholic cardiomyopathy
K292	Alcoholic gastritis
K70	Alcoholic liver disease
K852	Alcohol induced acute pancreatitis
K860	Alcohol-induced chronic pancreatitis

ICD-10-CM Behavioral Health codes (F01 - F99)

Code	Definition
F06	Other mental disorders due to known physiological condition, includes mood disorders / anxiety
F07	Personality and behavioral disorders due to known physiological condition
F09	Unspecified mental disorder due to known physiological condition
F11 - F19, see SUD codes	
F20	Schizophrenia
F20.2	Paranoid schizophrenia
F20.2	Catatonic schizophrenia
F20.3	Undifferentiated schizophrenia
F20.5	Residual Schizophrenia
F20.9	Schizophrenia, unspecified
F21	Schizotypal disorder
F22	Delusional disorder
F23	Brief psychotic disorder
F24	Shared psychotic disorder
F25	Schizoaffective disorders
F28	Other psychotic disorder not due to substance or physiological condition
F29	Unspecified psychosis not due to substance or physiological condition

F30 Manic episode
F30.1 Manic episode without psychotic sx
F30.2 Manic episode, severe with psychotic sx
F31 Bipolar disorder
F31.0 Bipolar disorder, current episode hypomanic
F31.1 Bipolar disorder, current episode manic without psychotic features
F31.2 Bipolar disorder, current episode manic without psychotic features, moderate
F31.3 Bipolar disorder, current episode manic without psychotic features, severe
F31.4 Bipolar disorder, current episode depressed, severe without psychotic features
F31.5 Bipolar disorder, current episode depressed, severe with psychotic features
F31.6 Bipolar disorder, current episode mixed
F31.7 Bipolar disorder, remission
F31.8 Other Bipolar disorders
F31.9 Bipolar disorder, unspecified
F32 Major depressive disorder, single episode
F33 Major depressive disorder, recurrent
F34 Persistent mood (affective) disorders
F39 Unspecified mood (affective) disorder
F40 Phobic anxiety disorders
F41 Other anxiety disorders
F42 Obsessive compulsive disorder
F43 Reaction to severe stress, adjustment disorders (includes PTSD)
F44 Dissociative and conversion disorders
F45 Somatoform disorders
F48 Other nonpsychotic mental disorders
F50 Eating disorders
F51 Sleep disorders
F52 Sexual dysfunction not due to substance or physiological condition
F53 Perpetual psychosis
F54 Psychological and behavioral factors associated with disorders or diseases classified elsewhere
F55 Abuse of non-psychoactive substances (vitamins, laxatives, herbal remedies)
F59 Unspecified behavioral syndromes associated with psychological disturbances/physical factors
F60 Specific Personality Disorders
F63 Impulse disorders
F64 Gender identity disorders
F65 Paraphilias
F66 Other sexual disorders
F68 Other disorders of adult personality and behavior
F69 Unspecified disorder of adult personality and behavior
F70 Mild intellectual disabilities
F71 Moderate intellectual disabilities
F72 Severe intellectual disabilities
F73 Profound intellectual disabilities
F78 Other intellectual disabilities
F79 Unspecified intellectual disabilities
F80 Specific developmental disorders of speech and language
F81 Specific developmental disorders of scholastic skills
F82 Specific developmental disorder of motor function

F84 Pervasive developmental disorders
F88 Other disorders of psychological development
F89 Unspecified disorder of psychological development
F90 - F98 Behavioral and emotional disorders with onset usually occurring in childhood/adolescence
F99 Unspecified mental disorder

Appendix C: Model Programs that Address Adult Behavioral Health and Determinants

The programs were found in a literature review of older adult behavioral health and determinants. They may serve as examples of services that could be helpful for Mat-Su older adults.

Elder Home Repair and Maintenance Program, Central Massachusetts Housing Alliance

Population Served: Low-income older adults living in Worcester, Massachusetts, and surrounding towns.

Settings: Homes of older adults.

Program Administration: The Central Massachusetts Housing Alliance administers the home repairs and maintenance program for low-income older adults. Staff include a certified Aging in Place specialist and a certified builder.

Description of the Program: Within its mission to prevent homelessness, the Central Massachusetts Housing Alliance addresses the unique needs of low-income aging homeowners unable to independently maintain their homes with limited financial resources. Referrals for older adult home repair and maintenance services come from health and human service agencies. Clients may also self-refer. The Central Massachusetts Housing Alliance covers the labor costs for repairs necessary for a home to be safe for habitation. Clients pay for the materials for the repairs. Older adult homeowners of Worcester also have access to home maintenance services such as snow shoveling and removal, gutter cleaning, grass mowing, and other routine maintenance needs. Provision of these additional services is determined on a case-by-case basis to take into account the urgency of the need and to preserve other networks of support.

Goals: Make Aging in Place feasible for economically disadvantaged older adult populations by providing home repair and maintenance services to low-income older adults for whom the costs of these services would be prohibitive; protect the health of older adults by maintaining healthy and safe home environments for them; reduce early admissions to assisted living facilities caused by inadequate housing.

Outcomes: Housing interventions for aging populations range from intentional community designs to supports for retaining older adults in their original homes. Multiple studies and surveys indicate that older adults overwhelmingly prefer to remain in their homes as they age. Home repair and maintenance services for low-income older adults are significantly more cost-effective than long-term care facility placements, reduce rates of reverse mortgage borrowing by older adults, and increase the quality of life for older adults through greater social connectedness in their communities.

Funding: The Central Massachusetts Agency on Aging provides most of the funding for the Elder Home Maintenance Services program. Additional support comes from Saint Gobain, Elder Services of Worcester, and the City of Worcester Division of Elder Affairs.

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Collaborative Care Management (CoCM) for Seniors

Population Served: Older Adult Patients of Primary Care Clinics

Settings: Participating clinics, primarily Federally Qualified Health Centers (FQHCs).

Program Administration: Leaders of FQHCs, tribal, and other health organizations collaborate with primary care providers and staff to build professional capacity in CoCM implementation. Supervised care management, regular assessments of depression and anxiety symptoms with validated psychometric tools, and systematic case reviews form the central components of CoCM. To evaluate CoCM, individual patient assessment data is reported in aggregate form, documenting depression and anxiety symptoms of the clinic population over time. Rather than seeing all patients individually for behavioral health care, licensed medical and behavioral health professionals utilize their expertise to supervise Behavioral Health Care Managers for most patients.

Description of the Program: Collaborative Care Management for Seniors aims to make behavioral health care more accessible to populations facing health inequities by centering treatment options in one location. Pharmacologic and psychotherapeutic interventions for common mental health disorders such as depression and anxiety are integrated into primary care settings with a team-based model of care like those for chronic illness management. Patients interact primarily with their Behavioral Health Care Managers who provide Behavioral Activation and Problem-Solving psychotherapies, conduct follow-up check-ins available at home, administer the assessments, present cases in systematic case reviews, and communicate with the primary care providers who provide prescriptions for pharmacological treatments when needed. Psychiatric consultants, usually psychiatrists or psychiatric mental health nurse practitioners, perform systematic case reviews.

Goals: Expand access to behavioral health care for low-income older adult populations; address the shortage of behavioral health care professionals within FQHCs; build a behavioral health care management workforce to meet the demand for care with a less costly professional compensation system; support communication between the professionally diverse care providers for older adults; increase access to care for depression and anxiety, conditions that disproportionately affect Native Americans and Alaska Natives.

Outcomes: Clinic populations of older adult patients of all ethnicities with anxiety and depression who receive care at clinics practicing CoCM for Seniors have been found to have significant lasting reductions in depression and anxiety symptoms. Notably, Alaska Natives and American Indians experienced symptom reduction levels equivalent to white patients at clinics participating in a 2020 study. Supporting behavioral health care managers in their multiple roles contributes to the model's long-term sustainability.

Funding: Federal funding for FQHCs supports the implementation of CoCM for Seniors. Private foundations such as the Social Innovation Fund also support the implementation of CoCM for Seniors in some clinics. The Indian Health Service funds numerous tribal health organizations operating health care facilities that implement CoCM.

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Healthy IDEAS, Identifying Depression and Empowering Activities for Seniors

Population Served: Older adults who are experiencing symptoms of depression and have regular contact with staff within a health or human service agency.

Settings: Health and human service agencies serving older adults

Program Administration: The Healthy Living Center of Excellence, housed within Elder Services of the Merrimack Valley in Massachusetts, conducts Healthy IDEAS trainings and provides ongoing technical assistance. Agencies contract with Healthy IDEAS to train their administrative and case management staff. Healthy IDEAS provides ongoing support to administrators and case managers for the length of the contract.

Description of the Program: Health and human service agencies interested in Healthy IDEAS first complete a self-readiness tool that helps them determine if the program is a good fit. Healthy IDEAS is a program for professionals who interact with older adults as case managers, care coordinators, or in similar roles and have regular contact with a given client for at least three months. Following the initiation of a contract, professionals are trained to identify symptoms of depression in their clients and provide specific interventions to increase daily activity levels and social engagement behaviors. Agency staff complete a curriculum in which they learn to administer validated measures of depressive symptoms, provide psychoeducation about depression and treatment options, refer clients to mental health care, engage clients in Behavioral Activation, and follow up with clients over time. Behavioral Activation, a short-term intervention focused on increasing activity levels and social interactions, can be implemented by multiple groups of professionals to assist older adults with depression in maintaining their engagement with relationships and life moments that they enjoy. Local behavioral health professionals serve as coaches to case managers and other agency staff, providing information and guidance to clients.

Goals: Increase health and human service agency capacity in identifying symptoms of depression in older adults and providing short-term interventions; expand supportive networks for older adults with depression to include agencies with which they regularly interact; facilitate an integrated approach to depression care for older adults in which meeting their daily living needs includes addressing depressive symptoms.

Outcomes: Case managers expressed satisfaction with the Healthy IDEAS training and curriculum, saying it provided useful support and information and increased self-efficacy in identifying depressive symptoms in clients. Internal administrators and staff champions for the program's implementation proved essential to successfully integrating the program into agency protocols. Ongoing mentoring and supportive supervision of the coaches contributed to their retention in those roles.

Funding: Healthy IDEAS operates largely from local agency program fees, especially senior centers that utilize case management funding from their state's Area Agencies on Aging to pay for the program. Funding has also been obtained within the budgets of Older Americans Act Family Caregiver Support Programs, Medicaid home- and community-based services, and private foundation grants.

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Intergenerational Programs to Promote Social Connections for Older Adults

Populations Served: Older and younger residents of communities.

Settings: Locations accessible to adults of all ages, including older adults, children, and youth. Examples are community centers, churches, schools, childcare centers, public parks and recreational facilities, intentional housing neighborhoods, and senior centers.

Program Administration: Urban planners, local governments, nonprofit leaders, and other community members design and maintain intergenerational environments in public spaces. Structured intergenerational programs linking children with older adults are usually held within schools and other child- and youth-centered community venues and are led by volunteers, educators, and administrators. Senior center administrators host structured intergenerational programs that usually link older adults with younger adult volunteers and professional students.

Description of the Program: Intergenerational programs combine the designs of child- and age-friendly public spaces and programs to facilitate opportunities for spontaneous intergenerational interactions between older adults and diverse age groups. Rather than segregating environments and activities by age, the needs and preferences of older adults, such as walking on paved paths instead of swinging or engaging in water play, are met within proximity of those areas preferred by younger adults, children, and youth. For example, playgrounds built near outdoor fitness areas accessible to older adults with trees, seating, and shade support spontaneous, multigenerational social engagement. In intergenerational spaces, diverse age groups can safely navigate all areas and connect with one another. Structured intergenerational programming also brings together the accumulated knowledge of child- and age-based best practices to create opportunities for older adults to share their knowledge through volunteering or teaching and to learn from younger generations about topics such as technology. Examples of structured initiatives include "Time After Time" in the UK that integrated storytelling, classroom activities, and a choir of diverse ages, as well as school-based co-learning programs such as "Bridges Growing Together" in the Massachusetts town of Sudbury in which older adults learn about the generational realities of fourth graders who complete interview assignments with older adults who also participate in weekly group discussions with the children.

Goals: Strengthen older adult social inclusion, reduce stigma towards older and younger persons by increasing spontaneous and organized contacts between generations, advance community development, support neighborhood cohesion, build stronger social connections between diverse age groups, facilitate the development of feelings of value and human connections for all ages, especially older adults.

Outcomes: Intergenerational environments promote individual and community health, improve older adult mental health outcomes, and support intergenerational solidarity. Intergenerational environments promote multigenerational gatherings and cohabitation through their inclusiveness of the needs of the population's oldest and youngest. The intergenerational activities "Time After Time" and "Bridges Growing Together" resulted in positive emotional outcomes for older participants and reduced stigma towards older adults. Over 88% of older adult participants in the intergenerational "Time After Time" program reported that their emotional well-being improved through their participation and that they felt a greater

sense of belonging to their community. The fourth-grade students who participated in "Bridges Growing Together" reported significantly more positive images of older adults as high school students than those who did not participate in the program.

Funding: The venues in which planners incorporate environmental intergenerational initiatives, such as public parks, walkways, public libraries, and greenspaces, are funded by grants and local and federal taxes. Structured interpersonal programs receive funding from grants, tax revenues, and logistical support from child- and youth-centered institutions and senior centers.

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Mental Health First Aid (MHFA) for Older Adults

Population Served: Adults seeking training to support older adults undergoing a mental health crisis, manifesting substance use disorders, or are at the onset of a mental health condition.

Settings: MHFA for Older Adults training courses are offered nationally by the National Council for Mental Wellbeing in collaboration with local partners.

Program Administration: The National Council for Mental Wellbeing and the Missouri Department of Mental Health produce the MHFA curricula, certify trainers, provide resources online, including a registry of MHFA courses for all age groups, and form partnerships with local entities to administer the MHFA courses.

Description of the Program: The MHFA courses center on implementing an action plan to provide informed support to individuals experiencing symptoms of depression and other mood disorders, including anxiety disorders, trauma, psychosis, and substance use disorders. The MFHA courses also cover how to respond to crises stemming from these conditions. Upon completion, participants will be able to implement the MHFA action plan in which they **A**ssess for suicide risk or harm, **L**isten nonjudgmentally, **G**ive reassurance and information, **E**ncourage appropriate professional help, and **E**ncourage self-help and other support strategies (ALGEE). The MHFA for Older Adults curriculum also includes information on supporting older adults with stressors of aging, such as bereavement and physical health concerns. Local professionals are trained to teach the MHFA for Older Adults courses. The local trainers grant certificates of course participation upon completion of the training curriculum.

Goals: Build national networks of paraprofessional peer specialists trained to provide support to older adults experiencing stress from mental health conditions or substance use disorders; reduce the stigma

associated with mental illness in older adults; improve law enforcement capacity in ALGEE interventions to respond appropriately to episodic mental health crises; increase access to mental health resources for older adults living with mental health or substance use disorder challenges and their caregivers.

Outcomes: For all age groups, participation in MHFA courses has increased participants' knowledge of mental health and their self-efficacy to intervene to prevent or reduce the severity of crises. In addition, MHFA courses reduce reported levels of stigma for persons with mental illness and increase the willingness to provide support for persons experiencing stress from a mental health condition.

Funding: The U.S. Department of Housing and Urban Development supports the national dissemination of the MHFA curricula as part of the Biden-Harris Administration's initiative to address mental health needs nationally within the Unity Agenda launched in 2022. Currently, MHFA continues to receive logistical and financial support from the State of Missouri and the National Council for Mental Wellbeing, as well as from program fees.

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Older Adult Services Program for Assertive Community Treatment (OAS PACT)

Population Served: Community-dwelling older adults at least 60 years of age living in Orange County, California, with serious and persistent mental illness (SPMI) with symptom levels that hinder their community interactions. Most participants have faced difficulties accessing traditional intervention designs or have not benefited from them.

Settings: OAS PACT services are delivered in community settings, including homes and public venues as needed, and within public health clinic sites.

Program Administration: The Orange County Health Care Agency (HCA) directs OAS PACT programs within the Full-Service Partnership that provides PACT for adults with SPMI at risk for homelessness in coordination with the HCA Older Adult Wellness and Prevention Services unit. As the accredited public health department for Orange County, the HCA ensures equal access to older adults to the preventive community interventions available to all county residents, promoting individual and community health.

Description of the Program: OAS PACT staff provide services designed specifically for older adults, including ongoing case management, client advocacy, assistance in medication management, and substance use interventions and recovery supports. For home-bound older adults, behavioral health clinicians within the OAS PACT Senior Health Outreach and Prevention Program(SHOPP) conduct field-based client assessments, crisis interventions, resource and referral counseling linking them to other

community services, as well as psychoeducation for caregivers and families. SHOPP staff assist home-bound older adults in addressing logistical challenges they may face, such as transportation, when seeking services designed for the general population. Parallel to SHOPP, the OAS PACT Substance Abuse Resource Team (START) provides in-home treatments designed for older adults with both mental illness and substance use disorders, including brief and long-term interventions, care coordination, and linkage to inpatient treatment programs.

Goals: Provide supportive services for older adults with SPMI so that they can remain in community settings; prevent suicide; reduce psychiatric hospitalizations and long-term care placements of older adults with SPMI; educate caregivers and community members about mental health, illness, and recovery; create a socially inclusive county environment in which those living with SPMI can participate in community life; maintain behavioral health infrastructures that advance population mental health.

Outcomes: Older adults with SPMI who received Assertive Community Treatment have been found to have higher levels of treatment retention than those in traditional clinic-based interventions, indicating the potential for greater engagement in behavioral health interventions.

Funding: OAS PACT within the HCA is funded by Orange County taxes, federal and state funds, and private foundations.

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Program to Encourage Active Rewarding Lives (PEARLS)

Population Served: Older adults who are experiencing symptoms of depression and who can be served by a community-based organization in which staff have ongoing contact with clients. A diagnosis of depression is not required for participation.

Settings: Community-based organizations, clients' homes, health and human service agencies serving older adults.

Program Administration: The University of Washington Health Promotion Research Center developed PEARLS and administers all aspects of its implementation nationwide.

Description of the Program: PEARLS addresses depression in older adults as a community issue to be handled by paraprofessionals and behavioral health professional community members. The agencies integrating PEARLS into their programs first train interested staff to serve as coaches. Staff are not required to have a mental health background. Upon completion of the coach courses, staff obtain materials and questionnaires from a PEARLS implementation kit. The University of Washington Health Promotion Research Center provides technical assistance and monthly support calls at no cost. Older adult clients whom staff feel would benefit from the program are matched with a PEARLS coach who meets with them for 6-8 sessions over 4-5 months, conducting the present-focused approaches of Problem-Solving treatments and Behavioral Activation. Clients participate in the sessions in the venue of their choice. The agency hires licensed behavioral health professionals to serve as the clinical supervisors for the coaches.

Evaluation data consists of aggregate reports of the accumulated baseline and final PEARLS questionnaires, the session questionnaires, and the Patient Healthcare Questionnaires (PHQ-9) administered in each session to track symptom levels. The PEARLS curriculum is available in multiple languages and was designed to be culturally adaptable.

Goals: Make depression care accessible to communities for which behavioral health systems are out-of-reach or inappropriate; address depression in older adults as a community issue; increase the social connectedness of older adults; strengthen older adults' capacity to solve problems contributing to depression; provide older adults with psychoeducation about depression.

Outcomes: PEARLS provides a successful avenue for non-behavioral professionals to support older adults with depression. In one study, older adults participating in PEARLS increased their social engagement and expressed greater satisfaction with their social support, reduced their social isolation and loneliness, and reduced their levels of depressive symptoms. Participants who were low-income or living in poverty experienced lesser gains in overall well-being. Six months after completing PEARLS, those who lowered their levels of depression symptoms reported continued increases in social engagement.

Funding: Housed within the University of Washington that provides logistical support, PEARLS is funded primarily by fees for the Coach and the Train-the-Trainer courses.

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Senior Hope, Compassionate Chemical Dependency Care for Seniors and their Families

Population Served: Adults 50 years and older with substance use disorders and co-occurring disorders living in the Tri-Cities region of New York (Albany, Troy, and Schenectady).

Settings: Senior Hope provides outpatient services in its Albany clinic.

Program Administration: A Chief Executive Officer leads the organization together with a Medical Director, the Assistant Clinical Director, and the Assistant Director of Operations. As a not-for-profit clinic, the ultimate decisions for the agency are the responsibility of Senior Hope's Board of Directors. The clinic is licensed by the New York State Office of Alcoholism and Substance Abuse Services.

Description of the Program: Senior Hope provides individual and group substance use disorder treatments designed for older adults within the trauma-informed Restorative Integral Support (RIS) model, a whole-person approach in which the client addresses substance use disorders within the context of the effects of lifetime events, especially Adverse Childhood Experiences (ACEs). In addition to hosting a range of specialized group sessions, including Alcoholics Anonymous, Senior Hope provides evaluation and assessments, case management and basic needs referrals, and counseling for individuals and families. The RIS model implemented in Senior Hope emphasizes social connectedness and relationship-building skills as recovery tools that staff model in their interactions with each other and clients.

Goals: Provide ACE- and RIS-informed treatments for the vulnerable population of older adults with co-occurring substance use and trauma-related disorders; strengthen resilience and recovery capacity within these older adults; address gaps in research and practice that would support evidence-based interventions for an underserved population of older adults; build restorative self-care practices for staff and clients into daily operations; promote healthy aging for a vulnerable population; serve as a community educational resource on trauma, adversity, resilience, and recovery.

Outcomes: Senior Hope is the first clinic in the U.S. to provide ACE-informed RIS treatments for older adults with substance use disorders and other co-occurring disorders. Senior Hope promotes research towards developing evidence-based practices that can contribute to testing the effectiveness of RIS to address ACEs' long-term effects and facilitate recovery as a primary step towards regaining healthy aging processes for older adult populations with substance use disorders and co-occurring disorders.

Funding: Senior Hope receives financial support from the State of New York, private foundations, and donations.

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Senior Peer Program

Population Served: Adults at least 60 years old residing in Prescott, Prescott Valley, Chino Valley, and Dewey-Humboldt, Arizona.

Settings: Office space for the Senior Peer Program is within the West Yavapai Guidance Clinic. Senior Peer visits take place within community and home settings.

Program Administration: The Senior Peer Program salaried staff of two consists of a Manager and a Volunteer and Participant Liaison. Peer volunteers handle other responsibilities.

Description of the Program: Health care providers, family members, and friends refer adults 60 years or older to the program. Older adults can also self-refer. Staff conduct a needs assessment and connect older adults to community resources as needed. The peer volunteers, also at least 60 years old, then connect with program participants. Staff and volunteers lead support groups and conduct presentations on topics of relevance for older adults. The Senior Peer Program relies upon peer volunteers to conduct in-home visits, link older adults to community resources, and support the resource and referral linkages provided by staff. All services are provided at no cost to participants.

Goals: Build self-efficacy within the older adult volunteer population as they reach out to help others; link isolated older adults with peers; reduce social isolation; increase social inclusion of older adults; provide community education on topics related to older adults.

Outcomes: Peer-to-peer programs that match older adult volunteers with older adult clients are effective in improving mental health outcomes for the volunteers as well as for the clients. Older adult volunteers report increased self-efficacy as helpers and a sense of well-being from contributing to their community. Older adult clients of these programs report greater levels of social connectedness, increased physical activity, lower levels of depressive symptoms, and improvements in their overall mental well-being.

Funding: Housed within the West Yavapai Guidance Clinic, the Senior Peer Program receives logistical support. Staff salaries are funded from donations and grant funds.

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Technology Services to Facilitate Older Adult Social Engagement and Increase Health Care Access

Population Served: Older adults, their families, and caregivers.

Settings: Public libraries, senior centers, homes of older adults, and other community settings

Program Administration: Federal policymakers determine the availability of funding for broadband access nationally for low-income and rural populations, thereby determining internet availability for significant numbers of older adults. Agencies funded by the Older Americans Act of 1965 serve as crucial hubs facilitating access to those funds and providing training to promote the informed use of the internet for older adults. A range of other local service agencies design digital capacity-building programs offered specifically for older adults as well as intergenerationally. Individual states regulate Medicaid funding for telehealth, whereas Medicare funding for telehealth is determined federally.

Description of the Program: Digital inclusion programs for older adult populations range from linking older adults to funding for internet access, building capacity in technology use, helping older adults maintain relationships via technology, providing access to telehealth, and creating lifelong learning opportunities. Federal resources supporting broadband access for low-income populations are available through initiatives such as the Affordable Connectivity Program and the Tribal Broadband Access Program (TBAP) that rely upon local service agencies to facilitate enrollment. (In 2022, the Alaska Federation of Natives received a federal award from the TBAP that funds 73 Alaska Native Tribal organizations to subsidize broadband services and provide digital skill-building courses as well as equip Alaskan tribal health care organizations with the technology necessary to provide telehealth services.) Technological capacity-building programs for older adults are often administered through public libraries and designed by national not-for-profit organizations such as the Older Adults Technology Services (OATS) program. For example, OATS designed a Website Basics for Older Adults course for the New York Public Library system that was jointly taught on-site by librarians and a Computer Basics for Older Adults course. Library staff trained by OATS now offer these courses year-round. Through its Senior Planet program, older adult community groups can apply for OATS to provide digital training and resources to utilize technology to improve their financial security, social engagement, creative expression, health and wellness, as well as their civic involvement in projects that address community needs. OATS also provided training and hotline support for the distribution of free tablet computers to 10,000 older adults in public housing during the social isolation phases of the COVID-19 pandemic. Many programs that teach skills for maintaining relationships via technology are offered by a range of smaller organizations, such as The Long-Distance Grandparent, for fees and at no cost for participants in programs sponsored by organizations such as OATS.

Goals: Promote the digital inclusion of older adults; strengthen intergenerational connectivity with technology; reduce health disparities for low-income or rural isolated older adults through increased

access to online health information and healthcare through telehealth; promote technology as a tool for older adult social and civic engagement.

Outcomes: Internet use is associated with increased social connectedness for older adults. While in the U.S., approximately 75% of adults 65 and older use cell phones, computers, or tablets, digital disparities exist for low-income older adults and those in rural areas with limited broadband access. For older adults, tablets and video calls can provide a greater quality of communication than audio calls, allowing for visual connections that elicit emotional expression. Participating in training courses on digital connectivity platforms boosts positive social engagement outcomes for older adults. Older adults who are physically isolated due to illness, lack of transportation, or living in rural areas particularly benefit from internet access.

Funding: Federal agencies allocate funding for broadband access as determined by each administration. Local and state taxes, grants, and program fees support libraries and not-for-profit organizations in offering digital capacity-building opportunities.

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