

State Advisory Council on Aging  
2006 Annual Report  
to the  
Michigan Commission on Services to the Aging

## **Mental Health for Older Persons**

Commissioner Annette Guilfoyle, Chairperson

**April 2006**



JENNIFER M. GRANHOLM  
GOVERNOR

STATE OF MICHIGAN  
OFFICE OF SERVICES TO THE AGING  
LANSING

SHARON L. GIRL  
DIRECTOR

April 6, 2006

Dear Chairperson Kennedy and fellow Commissioners:

I am pleased to transmit the 2006 Annual Report of the State Advisory Council on Aging. In response to the Commission's charge for this term, the Council has explored and discussed mental health service issues for older adults. We have benefited from the presentations and discussions and are pleased to share our recommendation and report with you.

During the year, we continued to work with the other organizations to promote and create "elder-friendly/livable" communities. While "livable communities" were addressed in the 2004 report, the Council remains interested and active in this important initiative.

The issue of meeting the mental health needs of Michigan's older population is especially challenging and I hope you find this report useful. The Council appreciates your consideration of our recommendation.

On behalf of the Council, I wish to express our thanks to Director Sharon Gire and the staff of the Office of Services to the Aging for their assistance and support during the year. The Office demonstrated its dedication to mental health issues for older adults. I also wish to thank Commissioners Bollinger, Dooha, Rau, Walters and Verma for attending Council meetings. Finally, thanks to the Commission for allowing me the opportunity to work with State Advisory Council on Aging. The Council deeply appreciates your interest and support.

Sincerely,

  
Commissioner Annette Guilfoyle  
Chairperson, State Advisory Council



**2006 ANNUAL REPORT  
STATE ADVISORY COUNCIL ON AGING**

**MENTAL HEALTH**

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## EXECUTIVE SUMMARY and RECOMMENDATIONS

The scope of concerns about mental health in late life is broad and mixed. First, there are research studies that confirm older adults are less likely to experience major depression, but more likely to experience minor depression. There are changes in the funding and priorities of the publicly funded mental health system that make it less likely older adults will be served, unless they meet serious mental illness criterion and are not on Medicare. There is a growing awareness of the link between physical health and mental health from public health professionals, those studying healthy aging and those reimbursing health care providers. People with untreated mental health problems consume more health care resources. Depression, a common problem, is treatable. Nationally and federally, the focus on mental health has re-emerged. There are numerous reports on mental health, older adults and the impact of stigma in dealing with mental illness.

Throughout the discussion, several key points remained constant: mental illness is treatable and treatment can relieve symptoms, if not provide a cure. Yet the fear of stigma for receiving mental health treatment prevents many people from seeking help. If this were diabetes or hypertension, there would be a public outcry denouncing discrimination against people with those diseases and support for those who seek treatment. Age bias combines with mental health stigma and reduces the likelihood of receiving treatment. And finally, there are behavioral-cognitive approaches, medications, and social support that improve the quality of life for older adults with mental health problems. These research-based interventions provide an array of services. Even physical exercise such as walking can improve one's mood. Hopelessness is a symptom of depression, not an accurate perception of mental health care.

The Council identified several areas for action to address the mental health needs of older adults. Stigma is a key factor that impedes people from being diagnosed and treated. The report lists many anti-stigma resources and asks the aging network to reduce stigma in its language, policies and programs. Stigma is supported by assumptions about older adults and mental illness that create the classic "catch-22:" if you are miserable and seek help, you could be socially ostracized for seeking help to end your misery. Society uses stigma to entrap people with mental illness and then to punish them for trying to get better.

Finally, the Council recognizes that even if an older person is aware of depression and willing to overcome the stigma to seek help, there are insufficient mental health resources to use. As noted in the U.S. Surgeon General's report on mental health, for older adults, the most frequent source of mental health assistance is the primary care physician. The public mental health system has evolved over the past decade to focus on people with serious mental illness, a criterion that older adults generally fail to meet. For people in health plans, mental health services may be limited. For those on Medicare, the 50% co-pay may be a barrier.

**The State Advisory Council on Aging, therefore, recommends that the Commission on Services to the Aging and the MI Office of Services to the Aging develop a statewide older adult mental health initiative encompassing strategies of advocacy, education, programs and training.**

The State Advisory Council on Aging suggests the following action steps to implement this recommendation:

**Advocacy:**

- The Commission and the Office should lead or participate in activities to:
  - Promote mental health awareness across the state, including aging service providers, older adults and family caregivers;
  - Support a message of recovery, in conjunction with the Department of Community Health's Recovery Council;
  - Work to reduce the stigma of mental illness; and
  - Encourage access to mental health treatment and support services.

**Education:**

- The Commission and the Office should lead or participate in activities that educate the public about mental health and mental illness. Older adults and their families need information on common symptoms of mental illness, identification of depression, and resources that can provide assistance. Suggested methods include:
  - Brown bag forums held locally to provide information about mental health;
  - Public awareness campaign about depression;
  - Prepare and distribute a booklet on mental health concerns for the public and older adults;
  - Recruit older adults to share their stories with stigma and mental health treatment; and
  - Provide mental health information at health fairs, senior centers, faith organizations and community centers.

**Programs:**

- The Commission and the Office should be leaders in the development of strong programs that promote good mental and physical health for older adults. The aging network of services can play an essential role in creating positive opportunities for older adults and reducing the stigma of seeking treatment for mental health problems. The Council suggests:
  - Programs and agencies receiving funding from the Office of Services to the Aging be required to demonstrate successful outcomes from a mental health component, by increasing the identification of depression, coordination with mental health service providers and assessing depression as part of the physical functioning assessment.

**Training:**

- The Commission and the Office should lead or participate in activities that provide education and training to providers of older adult programs and services on mental health. Suggested activities include:
  - Provide health care providers and direct care staff with information on the link between physical and mental well-being in older adults;
  - Educate/inform professionals on depression as a disease to remove institutional-based stigma. The stigma of seeking help for depression prevents people from being treated;
  - Senior center and senior service staff should understand their role in reducing stigma, know how to recognize possible depression among older adults and what to do; and
  - Use long-term care and other health service discussions to educate health professionals on the need to identify and treat older adults with depression. Older adults have many interactions with health care systems.

## **State Advisory Council Meetings: 2005-2006**

### **Meeting Summary**

June 2005: The meeting included orientation to the Council and a report on the May Commission meeting. The Mayor's Office of the City of Detroit gave a presentation on the Mayor's Task Force on Dying Before Their Time, which addresses the urban health status of older adults in Detroit. This was a follow-up presentation from the previous year's Council work on healthy aging. The Council received updates on local planning for Elder Friendly Communities and the implementation of Medicare Part D. To plan for future meetings, Council members did a brainstorm exercise, listing their questions and concerns on mental health issues.

October 2005: The Council received updates on the Commission meetings, Medicare Part D outreach activities and the Michigan State University Elder Friendly Community Project. The Council received a presentation from the Public Health Administration of the Department of Community Health on depression as a public health problem. The director of the Mental Health and Aging Project at Lansing Community College, funded by the Department of Community Health, also described activities to support the mental health system in serving older adults.

December 2005: Two presentations on mental health services for older adults from a statewide perspective were the central to this meeting. The Older Adult specialist of the Mental Health and Substance Abuse Administration in the Department of Community Health gave an overview. The Director of the Michigan Association of Community Mental Health Boards gave the second. Both provided excellent information about existing services, legal mandates and funding. The Council also received updates on Medicare Part D enrollment and the MSU Elder Friendly Communities Project.

February 2006: Staff from Blue Cross/Blue Shield of Michigan presented their work in depression awareness to the Council. The Council also received a report about the Department of Community Health's Recovery Council, on which a Council member serves. Other reports include: updates on OSA's Healthy Aging activities, the development of the Elder Friendly Communities assessment tools and Medicare Part D implementation information. The Council began to identify issues and questions for the annual report.

March 2006: The Director of the Institute of Gerontology, Wayne State University discussed recent research in late-life depression, providing a clinical framework and new findings. Council members developed the annual report's recommendation and planned for the April joint meeting with the Commission on Services to the Aging.

## Mental Health and Aging

**The State Advisory Council on Aging recommends that the Commission on Services to the Aging and the MI Office of Services to the Aging develop a statewide older adult mental health initiative encompassing strategies of advocacy, education, programs and training.**

In 2005, the Council reported on the importance of health promotion and disease prevention. In the intervening year, the focus on healthy choices and lifestyles has increased. People desire good health, yet good health cannot be achieved without mental health. Mental health is an important issue, regardless of age.

In 2005-2006, the Council examined mental health issues for older adults. After spending a year discussing mental health, the Council realized that, in fact, most of time was spent discussing mental illness. The U.S. Surgeon General's 1999 report defines mental health as "the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and cope with adversity." This includes:

- a sense of well-being;
- resiliency – being able to deal with life's stresses and bounce back from adversity;
- flexibility – the ability to change, grow;
- self-confidence and good self-esteem.

People with good mental health enjoy being with family and friends; are willing to help others; lead a mostly tension free life; laugh often; accept that other people are different from them; don't try to change others and approach problems as part of life.

Unlike many physical health problems, mental health problems carry a social stigma. Despite a growing sophistication about mental illness, its causes, treatment and recovery, people continue to express negative views about persons in need of mental health services. The important aspect about stigma is that "fear of stigma, and the resulting discrimination, discourages individuals and their families from getting the help they need." (SAMHSA, 1999).

To use the physical health analogy, this is like society discouraging people from having their blood sugar level taken and being treated for diabetes because it is a serious illness that could impact the person's functioning. The consequences for not being diagnosed or treated are dire, yet stigma is placed on the person for seeking assistance. Mental health professionals state that diabetes and depression are the same: both conditions are diagnosable, treatable and able to be managed with appropriate care.

Older adults have an additional burden. A youth-oriented society tends to value youth. Age bias combines with the stigma about mental illness and creates "double jeopardy."

A recently issued U.S. Department of Health and Human Services report on older Americans and the stigma of having a mental illness cites three types of stigma: self-stigma; public stigma and institutional stigma. Self-stigma occurs when older adults are fearful of acknowledging their own mental illness. Public stigma refers to the general view of older adults with mental illness as being people who are not able to improve or are unworthy of treatment. Institutional stigma occurs when assumptions about older adults with mental illnesses are incorporated into public policy, funding decisions or other means of discriminating against these individuals. ("Mentally Healthy Aging: A Report on Overcoming Stigma for Older Americans," SAMHSA, 2005.) Information on this report, other resources and an Anti-Stigma fact sheet can be found in this report.

Throughout the various presentations, information, reports and research about mental health issues for older adults, the issue of stigma was a constant. It is, perhaps, the greatest barrier to improving the quality of life for older adults with mental illness. To fund mental health programs for older adults will provide limited impact, if older adults are not able to recognize a need for the services and are unwilling to seek professional intervention.

The Council noted a recent media campaign on depression ([www.DepressionHurts.com](http://www.DepressionHurts.com)) This message exemplifies a key issue: people with depression and those around them are affected by the symptoms of a disease that is treatable. Also, there are a growing number of celebrities acknowledging their experiences with depression. Their message is the same: depression is a disease and can be treated.

Below is a summary of the issues the Council explored and discussed. Throughout the presentations, the impact of stigma is evident. On behalf of older adults experiencing mental illness without treatment or medication, the Council encourages advocacy to reduce the stigma of mental illness.

### DEPRESSION AS A PUBLIC HEALTH ISSUE

National and state statistics indicate that about 20% of older adults (age 65+) have depressive symptoms. As noted in the U.S. Surgeon General's report on Mental Health, major depressive disorder, the most common type of major depression in adults, is characterized by one or more episodes that include the following symptoms: depressed mood, loss of interest or pleasure in activities, significant weight loss or gain, sleep disturbance, psychomotor agitation or retardation, fatigue, feelings of worthlessness, loss of concentration, and recurrent thoughts of death or suicide. Most older adults do not experience major depression, but experience depressive symptoms as part of a minor depression. That is, they have some, but not all of the symptoms and often there is an identifiable source for the depressed mood.

When researchers look at major depression among people of all ages, both prevalence and incidence studies that rely on DSM-based diagnosis of major depression suggest a decline with age, whereas symptom-based assessment studies show increased rates of depression among older adults, especially women. Although older people are less likely to experience a major depression than younger adults, they are more likely to exhibit the symptoms of depression that interfere with life activities.

The Council received information on the public health perspective on depression; public health is interested in factors such as prevalence and opportunities for prevention and control. They are also interested in conditions that affect broad population. Public Health staff had read articles and research that linked physical and mental health, especially the occurrence of depression in people with heart disease and whether depression can cause heart disease.

Awareness of links between mental and physical health is growing. Studies have found that depression is a risk factor for chronic illness and contributes to higher symptom burden, complications and mortality. Chronic illness is a risk factor for depression and each factor complicates the other. These findings are supported by the U.S. the Surgeon General's Report on Mental Health (1999) and the President's New Freedom Commission on Mental Health (2003). Both documents support the idea of promoting mental health as essential to overall health.

National studies reported that among those with chronic illness, especially with ischemic heart disease, stroke, cancer, chronic lung disease, arthritis, Alzheimer's disease, and Parkinson's disease, the prevalence of clinically significant depression in later life is estimated to be highest—approximately 25 percent.



At a one-day meeting on depression in 2005, Michigan experts on depression across the life span shared research findings, ideas and developed a list of recommended actions. Public health functions included collecting statewide data, organizing efforts to resolve the problems and improving access to needed services. The recommended actions on depression in late life include:

- Promote healthful lifestyle choices
- Mobilize partners to help older adults adopt healthful behaviors
- Collaborate to conduct ongoing public education targeting older adults and their significant others
- Promote ways to decrease social isolation
- Expand access to home based support
- Identify high-risk populations and ways to reach them
- Implement evidence-based gatekeeper models.
- Train and prepare partners to identify and reduce barriers to assessment and referral
- Screen for depression at each primary care encounter and manage or refer appropriately
- Improve quality of depression management services
- Convene multidisciplinary group of public/private partners to guide efforts and advocate solutions
- Educate policymakers, purchasers, payers about problems and potential solutions
- Advocate for mental health parity.

#### MENTAL HEALTH AND AGING PROJECT

The Department of Community Health has supported a statewide program for many years to help mental health staff better serve older adults. The Mental Health & Aging Project has an array of activities designed to assist local community mental health service agencies and aging services to better meet the needs of older adults. The project provides training, resources through a lending library, a newsletter, and information sheets on caring. Project staff coordinates an annual mental health and aging conference, funded by the Department and attended by both community mental health and aging services staff. Throughout the year, they hold regional meetings for mental health staff and aging services.

#### MENTAL HEALTH SERVICES: THE PUBLIC SYSTEM

The public mental health service system has changed over the past decade. Since 1995, there has been an updated Mental Health Code, the creation of the Department of Community Health and a clear focus within the mental health system to direct services to those with serious mental illness and those eligible for Medicaid. In previous years, older adults accounted for less than 1% of consumers of community mental health services. This situation has not changed. Only 9,652 persons age 65+ were served by mental health services during FY 2004. The total number of people served for mental illness was 144,435. This means that people age 65+ were only .07% of the service population for mental illness.

The Council received a report on the factors that guide the operation of the state mental health system and local community mental health service agencies. Previously, the community mental health system provided an array of clinical services, most frequently, face to face counseling. Services were available to people experiencing a range of mental health issues. In the past decade,

the mental health system has focused on serving people with the most serious types of mental illness and the least amount of resources. Funding streams, contracts and service eligibility all support this focus.

The Council received information about late life depression that indicated older adults were less likely to experience a major depression, which is a serious mental illness, and more likely to experience a minor depression, a disorder with the same symptoms, but less severity. The public mental health system's mandate to serve individuals with the most serious mental illness and least resources further reduces service options for older adults.

There are gaps in our knowledge about older adults' receipt of services from community mental health agencies. First, it is estimated that about 25,000 people over the age of 65 could meet the serious mental illness criteria. This number is based on studies done in other parts of the country. While over 9000 people age 65+ received mental health services in FY 2004, little is known about the people who were not served. Where do they live? Are they receiving care from other sources? Have they sought services?

The difficulties older people face with the public mental health system are known; yet, there is little data about private services from primary care physicians, psychiatrists, psychologists and clinical social workers. Older adults on Medicaid may be enrolled in a Medicaid health plan that includes a number of clinical sessions, but older people, at age 65, are Medicare beneficiaries and must rely on the "fee for services" system. Medicare provides a mental health benefit that has improved over the years. However, Medicare requires 50% co-pay for outpatient mental health. According to providers, this can be \$100+ per session for a psychiatrist. The Council was unable to locate any data on the amount of outpatient mental health services provided under Medicare coverage. As noted in the U.S. Surgeon General's Report on Mental Health, it is estimated that most psychoactive medications, e.g., antidepressants, anti-anxiety, etc., are prescribed by older adults' primary care physicians, not by mental health professionals. There is no stigma for visits to the primary care physician.

An epidemiological study of persons with serious mental illness was used to estimate the number of people in Michigan. In the 55-64 age group, about 46,902 individuals have SMI. Of those age 65+, about 25,256 have SMI. These numbers are based on the percentages found in studies done in other parts of the country. The department's trend report on services indicated that there was a slight increase for older adults served in the late 1990's but this has returned to the current level of .07% for the past few years.

Recovery in mental illness is a major initiative for DCH. Recovery is described as positive individual expectations and looks beyond symptoms. In February 2006, the Substance Abuse and Mental Health Services Administration issued a consensus document with the 10 fundamental principles of recovery (see page 19-20). Recovery seeks to strengthen the policy and programs of the public mental health system by supporting consumer-focused programs, such as consumer choice and control and person centered planning. The Department of Community Health has convened the Recovery Council to assist in the implementation of the Recovery principles. A member of the State Advisory Council on Aging has been appointed to the Recovery Council to represent older adults; at least 75% of the Recovery Council members are either primary or secondary consumers.

Outreach to older adults has been supported through the federal block grant program for mental health services. The Department of Community Health receives an annual allocation from the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services, U.S. Department of Health and Human Services. The federal block grant funds are used for grants to community mental health agencies to develop new services. For older adults, one of the model programs is the Gatekeeper program, developed in the 1980's as an outreach program to older

adults. The Gatekeeper program uses community members, such as postal workers and utility workers, to identify older adults with mental health service needs.

### A National and State Perspective

Mental health issues are a national concern. There are two key documents that support mental health services in general and for older adults. The 1999 U.S. Surgeon General Report on Mental Health was a landmark document and devoted a chapter to the issues and needs of older adults. The President's New Freedom Commission Report also established a framework for system transformation for mental health services. The Michigan Mental Health Commission's Final Report (2004) contained 70+ recommendations for improving the public mental health system. The Michigan Association of Community Mental Health Boards did a crosswalk of these key documents and identified some common themes.

1. Stigma is a significant barrier to receiving services, regardless of age and diagnosis.
2. Consumer involvement is essential; in Michigan, consumers must have a third of the membership on the CMHSP boards. Programs, such as person centered planning and self-determination are important.
3. Interface with primary care is important for substance abuse and mental health treatment. It is now recognized that mental illnesses have a biological factor and treatment needs to be coordinated with primary care providers.
4. Multiple funding streams are confusing, yet rampant. Medicare, Medicaid, general fund, MICHild, adult waiver, federal block grants: each of these funding streams has its own requirements and eligibility. The multiplicity of funding sources complicates the coordination of care.
5. Impact of early intervention. Studies have shown that early intervention and prevention can pay off in the long run.

It was noted that two groups have the most difficult access to basic mental health care: young children and people age 65 and better. For older adults, most of their mental health care doesn't occur through the public mental health system. Older adults may be enrolled in a Medicaid service plan, which provides 20 visits for mental health care. Those aged 65 and better who are eligible for Medicare are unable to access these 20 visits and are required to use "fee for services" providers through Medicare. It is estimated that there are about 216,000 dual eligibles (Medicaid and Medicare) with severe mental illness in Michigan.

The MACMHB recognizes the impact of stigma and has been working with advocacy associations on anti-stigma campaigns. (See list of Anti-Stigma resources on page 18.)

### "The Blues"

Blue Cross/Blue Shield of Michigan (BCBSM) has sponsored depression awareness activities since 2001. Activities to improve depression awareness and treatment for older adults include: an annual grant program for depression awareness campaigns; sponsoring educational programs on depression for caregivers; participation on National Depression Screening Day events; sponsoring physician and healthcare professional education on depression awareness; poster campaign; and public service announcements.

Their message is: "Depression. Real. Common. Treatable."

The Council learned that depression screening through the National Depression Screening Day resulted in a 2% increase of older adults receiving treatment for depression. As part of the screening and identification, referrals were made to various organizations and professionals, listed as health resources by BCBSM.

Council members learned that various local agencies had received depression awareness grants from BCBSM to provide information to older adults and caregivers.

### Late Life Depression

Of the various mental illnesses, depression emerged as a specific concern, primarily since depression is linked to suicide and older adults have the highest rate of completed suicide of any age group. Media reports of elderly husband-wife murder/suicides are not uncommon and there is a growing use of firearms among older adults committing suicide.

Depression in late life is especially difficult to detect. First, many of the vegetative symptoms of depression occur in people with physical health problems or in post-hospitalization, e.g., loss of interest in activities, sleep problems, appetite changes, slower physical mobility and decreased energy. While researchers have noted that major depression is less likely among older adults, there is considerable evidence that minor depression is common.

People living alone are among the group of people least likely to have depression detected. The least detected groups are men ages 64-75 and everyone age 85 and better.

Findings presented to the Council indicate that depression impacts mortality and physical functioning. Older adults with depression were found to have increased risk of death, increased disabilities, lower perception of social support and poorer recovery from disability even when in a rehabilitation program.

Of particular interest were the research findings on exercise interventions for older adults with either major or minor depression. Weight lifting and lectures were compared over several weeks with a group of older adults diagnosed with depression. Weight training decreased depression symptoms and the improvement persisted beyond the initial timeframe. In a study of aerobics, resistance workouts and educational sessions, aerobics did best at reducing depression and improving physical functioning. In the 2005 Council report, "sedentary death syndrome" was discussed. It is clear from new studies with older adults that physical activities not only benefit physical health, but also have positive effects on people with depression.

There are several causes of depression and more than one cause may be at work in the older person. Whether there are changes in neurotransmitters, anatomical degeneration in the brain, changes in function, behavioral reward changes and/or loss and grief, there are treatments for depression. Medications, behavioral interventions, grief and loss counseling and medical management of physical conditions can contribute to improved physical functioning, better mood, improved social functioning and greater life satisfaction.

## STATE ADVISORY COUNCIL MEMBERS' ACTIVITIES

Members of the State Advisory Council tend to be active participants in many organizations and initiatives. Below are a few of the activities Council members reported as supporting the goals of the State Advisory Council.

As the Webmaster for a public website on aging <http://seniors.tcnet.org/>, Council activities are often posted by this member. This council member also has a local radio show with many older listeners. The show's topic is not aging; however, information gained at Council meetings is frequently woven into the program. As a multimedia person, this member writes a monthly column in the Traverse Area District Library newsletter, and when applicable, Council topics are included.

A member of the State Advisory Council was appointed to serve on the Mental Health Recovery Council, convened by the Department of Community Health.

The North Ottawa County Council on Aging hosts a monthly TV show, "Older Americans Today," on the public access channel. This past year, a show titled "Transitions" addressed life's transitions and how changes can cause depression. The program included information on identification of depression, how to find help and what individuals can do to prevent depression.

The Grand Haven Senior Activities Center hosts an exercise class 4 days a week. Line Dancing, Tai Chi, and stretching classes. During the warmer months, a walking class is active. These activities are offered to help older adults maintain good physical and mental health.

Several members serve on Area Agencies on Aging advisory boards. These members report on the State Advisory Council meetings on a regular schedule as a standing agenda item.

Members report various advocacy activities on behalf of older adults: assisting with Medicare Part D implementation, either as a Medicare/Medicaid Assistance Program counselor, or in conjunction with local outreach events. Some members are reviewing local senior millages and working with County Commissioners to keep them informed of aging issues.

Several council members report to their colleagues and co-workers about Council activities. Social worker Council members report using information gained through the Council in their work with older people their family members.

Michigan State University Cooperative Extension's Vital Aging Think Tank and the Office of Services to the Aging continue to collaborate on activities to help communities become elder friendly. The North Ottawa County Council on Aging will be part of a second pilot of this project. This model will operate with people age 60 and better on the community task force, rather than service providers. The pilot encompasses two cities, a village, and two townships. A grant award will launch the program.

In another part of Michigan, AARP recently awarded Traverse City with \$125,000 for their project to make elder friendly improvements in the community.

The City of Wyoming Senior Center received a Blue Cross/Blue Shield of Michigan grant and provided health and wellness programs to older adults through a variety of fitness resources, including exercise clubs, low impact exercise class and rehabilitation/fitness equipment.

## **ELDER FRIENDLY COMMUNITIES: UPDATE**

In the Council's 2004 Annual Report, the Council reported on the importance of creating elder friendly communities. The concept had already been implemented in various parts of the United States and Canada in recognition of the global trend of aging.

As follow-up to the Council's report, the Commission agreed to support elderly friendly projects in Michigan by working in partnership with other organizations. The Commission and the Office of Services to the Aging designated the State Advisory Council as the entity to provide guidance to the creation of a statewide community recognition program.

The Vital Aging Think Tank, which is convened through the Michigan State University Extension Service, has been beta testing the Elder Friendly Communities certification program throughout 2005. After considerable thought and public input, the name has been changed to "A Community for a Lifetime: Creating Elder Friendly Communities in Michigan".

As the assessment documents and certification process have been drafted, MSU staff has presented the information to the Council. Council members have provided on-going feedback and input into the process.

There are two communities engaged in working with the Vital Aging Community for a Lifetime project. Gaylord MI has been the first beta testing site. North Ottawa County will be the second beta test community. Gaylord started during the past year; North Ottawa County is just beginning. Comments and concerns from the participants in the Gaylord program have been helpful in designing the recognition award levels. The levels are now: Basic: Elder Friendly Community Team Member. Level 1: Community in Progress. Level 2: Making Significant Strides. Level 3: Committed to Success. Level 4: A Community for a Lifetime.

The required assets fall into the following categories:

- Walkability/bikability,
- Supportive community systems,
- Access to health care,
- Safety and security,
- Housing,
- Public transportation,
- Commerce,
- Enrichment, and
- Inclusion.

The Vital Aging Think Tank will be reviewing each of the categories and the requirements within the categories in the coming months and bringing information to the Council for review. A final recommendation will be coming to the Council before the end of 2006.

**2005-2006**  
**STATE ADVISORY COUNCIL ON AGING**

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# STATE ADVISORY COUNCIL ON AGING

## Presenters and Guests

### Presenters:

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Mayor's Office  
City of Detroit

Paul Bridgewater  
Detroit Area Agency on Aging

Carol Callaghan  
Chronic Injury and Control  
Public Health  
Michigan Department of Community Health

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## Anti-Stigma: Do You Know the Facts?

Stigma is not just a matter of using the wrong word or action. Stigma is about disrespect. It is the use of negative labels to identify a person living with mental illness. Stigma is a barrier. Fear of stigma, and the resulting discrimination, discourages individuals and their families from getting the help they need. An estimated 22 to 23 percent of the U.S. population experiences a mental disorder in any given year, but almost half of these individuals do not seek treatment (U.S. Department of Health and Human Services, 2002; U.S. Surgeon General, 2001). The educational information on this web site encourages the use of positive images to refer to people with mental illness and underscores the reality that mental illness can be successfully treated.

- **Do you know that** an estimated 44 million Americans experience a mental disorder in any given year?
- **Do you know that** stigma is not a matter of using the wrong word or action?
- **Do you know that** stigma is about disrespect and using negative labels to identify a person living with mental illness?
- **Do you know that** stigma is a barrier that discourages individuals and their families from seeking help?
- **Do you know that** many people would rather tell employers they committed a petty crime and served time in jail, than admit to being in a psychiatric hospital?
- **Do you know that** stigma can result in inadequate insurance coverage for mental health services?
- **Do you know that** stigma leads to fear, mistrust, and violence against people living with mental illness and their families?
- **Do you know that** stigma can cause families and friends to turn their backs on people with mental illness?
- **Do you know that** stigma can prevent people from getting access to needed mental health services?

### DO'S

**Do use** respectful language

**Do emphasize** abilities, not limitations

**Do tell** someone if they express a stigmatizing attitude

### DONT'S

**Don't portray** successful persons with disabilities as superhuman

**Don't use** generic labels such as retarded, or the mentally ill

**Don't use** terms like crazy, lunatic, manic-depressive, or slow functioning

02/03

Source: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Available at: <http://www.mentalhealth.samhsa.gov/publications/allpubs/OEL99-0004/default.asp>

## Resources to End Stigma

Many National and State groups have begun projects and campaigns to reverse stigma. These groups offer a range of programs and materials, from speakers bureaus to training programs for mental health professionals. To get involved, call them. And to learn more about mental health, call SAMHSA's National Mental Health Information Center at 800-789-CMHS (2647).

Substance Abuse and Mental Health Services Administration, National Mental Health Information Center  
P.O. Box 42557  
Washington, DC 20015  
800-789-CMHS (2647)  
<http://www.mentalhealth.samhsa.gov>  
E-mail: [info@mentalhealth.org/](mailto:info@mentalhealth.org/)  
Resource Center to Address Discrimination and Stigma Associated with Mental Illness: [www.stopstigma.samhsa.gov](http://www.stopstigma.samhsa.gov)

Older Adult Consumer Mental Health Alliance  
Bazelon Center for Mental Health Law  
1101 15th St. N.W.  
Suite 1202  
Washington, DC 2005  
(202) 467-5730 Ext. 140  
Office e-mail: [OACMHA@aol.com](mailto:OACMHA@aol.com)  
<http://www.oacmha.com>

The Anti-Stigma Project  
1521 South Edgewood Street, Suite C  
Baltimore, MD 21227  
Phone 410-646-0262, 800-704-0262, or  
Fax 410-646-0264

Depression and Bipolar Support Alliance (DBSA)  
730 North Franklin Street, Suite 501  
Chicago, IL 60610  
800-826-3632

The National Mental Health Association Information Center  
2001 N. Beauregard Street - 12th Floor  
Alexandria, VA 22311  
800-969-NMHA  
The National Mental Health Consumers' Self-Help Clearinghouse  
1211 Chestnut Street, Suite 1000  
Philadelphia, PA 19107  
800-553-4539

Erasing the Stigma of Mental Illness Serving Hands International  
4607 Mission Gorge Place  
San Diego, CA 92120  
800-219-4854

## SAMHSA Issues Consensus Statement on Mental Health Recovery

The Substance Abuse and Mental Health Services Administration today unveiled a consensus statement outlining principles necessary to achieve mental health recovery. The consensus statement was developed through deliberations by over 110 expert panelists representing mental health consumers, families, providers, advocates, researchers, managed care organizations, state and local public officials and others.

“Recovery must be the common, recognized outcome of the services we support,” SAMHSA Administrator Charles Curie said. “This consensus statement on mental health recovery provides essential guidance that helps us move towards operationalizing recovery from a public policy and public financing standpoint. Individuals, families, communities, providers, organizations, and systems can use these principles to build resilience and facilitate recovery.”

The 10 Fundamental Components of Recovery include:

- **Self-Direction:** Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
- **Individualized and Person-Centered:** There are multiple pathways to recovery based on an individual’s unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.
- **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
- **Holistic:** Recovery encompasses an individual’s whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services (such as recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial

roles in creating and maintaining meaningful opportunities for consumer access to these supports.

- **Non-Linear:** Recovery is not a step-by step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

- **Strengths-Based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

- **Peer Support:** Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

- **Respect:** Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

- **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

**Hope:** Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

The National Consensus Statement on Mental Health Recovery is available at SAMHSA's National Mental Health Information Center at [www.mentalhealth.samhsa.gov](http://www.mentalhealth.samhsa.gov) or 1-800-789-2647.

## RESOURCES

- Department of Community Health <http://www.michigan.gov/mdch>
- National Institute of Mental Health [www.nimh.nih.gov/](http://www.nimh.nih.gov/)
- *The Michigan Mental Health Commission's Final Report (2004) and Transforming Mental Health Care in Michigan (2005)* are available at: <http://www.michigan.gov/mentalhealth>

- *Mentally Healthy Aging: A Report on Overcoming Stigma for Older Americans*. DHHS Pub. No. (SMA) 05-3988. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2005.

This publication may be accessed electronically through the following Internet World Wide Web connection: [www.samhsa.gov](http://www.samhsa.gov) . For additional free copies of this document, please call SAMHSA's National Mental Health Information Center at 1-800-789-2647 or 1-866-889-2647 (TDD).

- U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Metal Health, 1999.

This publication may be accessed electronically through following Internet World Wide Web connection: [www.surgeongeneral.gov/library/mentalhealth/home.html](http://www.surgeongeneral.gov/library/mentalhealth/home.html). For additional copies of this document, please contact SAMHSA's National Mental Health Information Center at 1-800-789-7954 or P.O. Box 42490, Washington, DC 20015.

- *Older Adults: Depression and Suicide Facts*. NIH Pub. No. 03-4593. Bethesda, MD: National Institute of Mental Health, National Institute of Health, 2003.

This publication may be accessed electronically through following Internet World Wide Web connection: [www.nimh.nih.gov/publicat/elderlydepsuicide.cfm](http://www.nimh.nih.gov/publicat/elderlydepsuicide.cfm). For additional copies of this document, please contact the NIMH Information Center at 1-866-615-6464 or at [nimhinfo@nih.gov](mailto:nimhinfo@nih.gov).

- New Freedom Commission on Mental Health, Final Report. *Achieving the Promise: Transforming Mental Health Care in America*. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

This publication may be accessed electronically through the following Internet World Wide Web connection: [www.mentalhealthcommission.gov](http://www.mentalhealthcommission.gov) or [www.mentalhealth.samhsa.gov](http://www.mentalhealth.samhsa.gov). For additional free copies of this document please call SAMHSA's National Mental Health Information Center at 1-800-662-4357 or 1-800-228-0427 (TTD).

## LATE LIFE DEPRESSION RESEARCH

Lichtenberg, P.A., Kimbarow, M.L., Wall, J.R., Roth, R.E. & MacNeill, S.E. (1998). Depression in Geriatric Medical and Nursing Home Patients: A Treatment Manual. Wayne State University Press: Detroit, MI.

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Available at: [www.miseniors.net](http://www.miseniors.net)

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