Aging Adults: Serious Mental Illness and Co-occurring Disorders
Introduction
What is SAMHSA?

• The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

• Our main operational divisions are the:
  • Office of the Assistance Secretary – Elinore McCance-Katz, MD, PhD
  • Center for Substance Abuse Treatment
  • Center for Substance Abuse Prevention
  • Center for Mental Health Services
  • Center for Behavioral Health Quality and Statistics (CBHSQ)
  • Policy Lab

• Final FY 2018 budget $5.66 billion (including increases for opioid use disorder prevention and treatment) – FY19 is similar
Block Grants

- Mental Health Block Grant
  - Grant to all 50 states, DC, and territories
  - Focus on community treatment for adults with serious mental illness and children with serious emotional disturbances
  - Fund priority treatment services for those without insurance
  - Fund priority treatment and support services for low income individuals
  - Collect performance and outcome data to determine effectiveness
  - Fund treatment of early serious mental illness and first episode psychosis
  - Approximately $720 million in FY 18

- Substance Abuse Block Grant
  - Grant to all 50 states, DC, and territories
  - Focus on community treatment
  - Approximately $3.26 billion in FY 18
Treatment of Depression in Older Adults EBP Toolkit

• This kit offers information about an array of evidence-based practices for treatment and services to improve outcomes for older adults experiencing depression, including dysthymia. It considers planning, implementation, and maintenance.


• [https://www.dropbox.com/s/kvamvu9uks9u6eb/Treatment-of-Depression%20video%201.mp4?dl=0](https://www.dropbox.com/s/kvamvu9uks9u6eb/Treatment-of-Depression%20video%201.mp4?dl=0)
Background and Data
National Survey on Drug Use and Health (NSDUH) - 2017

• NSDUH is a comprehensive household interview survey of substance use, substance use disorders, mental health, and the receipt of treatment services for these disorders in the United States.

• NSDUH is collected face-to-face by field interviewers who read less sensitive questions to respondents and transition respondents to audio computer assisted self-interviewing for sensitive items.

• NSDUH covers the civilian, noninstitutionalized population, aged 12 or older:
  • Includes: Households, college dorms, homeless in shelters, civilians on military bases
  • Excludes: Active military, long-term hospital residents, prison populations, homeless not in shelters
  • Sample includes all 50 states and DC
  • Approximately 67,500 persons are interviewed annually
  • Data collected from January to December
Mental Health and Substance Use Disorders in America: 2016

- 14.5% (16.3 million) of people aged 50 or older had mental illness
  About 3% (3.1 million) of older adults have a serious mental illness

- The combined 2007 to 2016 National Survey on Drug Use and Health (NSDUH) data indicates that nearly 500,000 older adults used an illicit drug in the past month. NSDUH includes nine illicit drug categories: marijuana, cocaine (including crack), heroin, hallucinogens, and inhalants, as well as the nonmedical use of prescription-type pain relievers, tranquilizers, stimulants, and sedatives.
### Table 8.1B – Any Mental Illness in Past Year among Persons Aged 18 or Older, by Gender and Detailed Age Category: Percentages, 2016 and 2017

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Major Challenges of Our Time for Older Adults – Opioid Crisis

- In 2017, over 49,000 Americans died from opioid overdoses.
- In 2016, more than 7,000 opioid deaths were people aged 55 and older.
- In 2016, nearly 20,000 opioid deaths involved prescription opioid pain relievers.
- 43% of the 4,846 rural opioid deaths in 2016 occurred among adults ages 45 and older.
- The National Survey on Drug Use and Health (NSDUH) data indicates opioid misuse is increasing among older adults (50+). Opioid misuse among older adults increased from 1.1 percent in 2002 to 2.0 percent in 2014 and 3.1% by 2020 (5.7 million).
Higher drug use of the boomer generation

- 50-54 - lifetime illicit drug use = 60.1%
- 54-59 - lifetime illicit drug use = 60.9%
- 60-64 - lifetime illicit drug use = 53.6%
- 65+ - lifetime illicit drug use = 25.6%

2016 NSDUH Data
Number of admissions aged 65 or older admitted substance abuse treatment on an average day, by primary substance of abuse

Source: Treatment Episode Data Set (TEDS), 2012
About 1% of the population has a diagnosis of schizophrenia or similar mental health diagnosis and the rate is similar for older adults.

For all serious mental illnesses for older adults, rate is 3 – 4%.

For older adults in nursing homes, rate of schizophrenia and bipolar disorder estimated at 7-8% in 2009 study conducted by Brown University and prevalence of any mental illness in nursing homes was 56.8%.

State mental health systems do not serve older adults in proportion to their prevalence in the population – older adults typically comprise 2.5% - 7% of people using state mental health systems.
SMI Increasing

- 8% 2008: 2.3M
- 6% 2010: 4.8M
- 4% 2012: 1.2M
- 3.8% 2014: 4.8M
- 2.5% 2016: 5.6M
- 2% 2017: 7.5% 18-25 YEARS: 2.6M
- 6% 2012: 5.6M
- 4% 2014: 7.5% 26-49 YEARS: 2.7% 50+ YEARS: 3.0M
- 2% 2016: 7.5% 18-25 YEARS: 5.6% 26-49 YEARS: 2.7% 50+ YEARS: 3.0M

Substance Abuse and Mental Health Services Administration (SAMHSA)
Past year opioid misuse among adults aged 50 or older, by selected other characteristics: Percentage, 2011-2014

1 Significantly different from “Not poor” at p <0.05
2 Significantly different from “Good/excellent health” at p <0.05
3 Significantly different from “No MDE” at p <0.05
4 Significantly different from “No AUD” at p <0.05

NOTE: Opioid misuse refers to heroin use or nonmedical use of prescription pain relievers.
Older Adults, SMI, and Co-occurring

Level of Co-occurring Substance Use Disorder with Mental Illness in 50+ Population

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<td>Illicit Drugs or Alcohol with AMI</td>
<td>35</td>
<td>38</td>
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<tr>
<td>Illicit Drugs or Alcohol with SMI</td>
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<td>12</td>
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SAMHSA
Substance Abuse and Mental Health Services Administration
Older Adults, SMI, and Co-occurring

Level of Co-occurring Substance Use Disorder with Mental Illness in 50+ Population

- Illicit Drugs with AMI
- Illicit Drugs with SMI

Older Adult Behavioral Health Profiles

- Helps states and communities identify focus areas for behavioral health plans, select population-level goals, and coordinate and target services to address priority issues

- Compare state trends with those in the region and the nation

- State and community administrators, planners, and providers can use the profile information and their own data, knowledge, and experience to establish and implement policies
Older Adult Behavioral Health Profiles

Admissions to Substance Use Disorder Treatment Among Older Utahns

In 2012, there were 1,586 admissions of Utahns ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 218 per 100,000 people ages 50+. This rate was lower than the regional rate and the national average. Men made up 82.7 percent of these admissions. Of all admissions, 67.7 percent were White/Caucasian, 7.1 percent were Black/African American, and 13.3 percent were Hispanic.

The principal sources of referral to treatment among those ages 50 and older were:

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<th>Region 8</th>
<th>U.S.</th>
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<td>Self-Referral</td>
<td>375.1</td>
<td>1,132.1</td>
<td>383.2</td>
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<tr>
<td>Criminal Justice</td>
<td>72.5</td>
<td>246.4</td>
<td>120.3</td>
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<tr>
<td>Other</td>
<td>22.3%</td>
<td>22.3%</td>
<td>22.3%</td>
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Source: Treatment Episode Data Set (TEDS). 2012
Data include only those clients reported to SAMHSA.
Older Adult Behavioral Health Profiles

Older Utahns in SUD Treatment With Co-Occurring Mental Disorders

Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in Utah, Region 8, and the United States, 2012

The national literature shows a strong relationship between substance use and mental disorders. Studies show that 30–80 percent of individuals with a substance use or mental disorder also have a co-occurring disorder.

Exhibit 11 shows the proportion of SUD treatment admissions of Utahns ages 50+ with a co-occurring mental disorder. This rate is lower than the regional rate and the national average. However, state reporting practices are a factor in these results.

Source: TEDS, 2012
Data include only those clients reported to SAMHSA.
Older Adult Behavioral Health Profiles

Older Utahns Reporting Frequent Mental Distress

BRFSS, a household survey conducted in all 50 states and several territories, asks the following question: “Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?” Those individuals reporting 14 or more “Yes” days in response to this question experience frequent mental distress (FMD). Exhibit 12 shows that older Utahns experience FMD at a rate that is higher than the regional rate and lower than the national rates.

Exhibit 12. Individuals Reporting Frequent Mental Distress in Utah, Region 8, and the United States, 2013

Source: BRFSS, 2013

SAMHSA Substance Abuse and Mental Health Services Administration
Older Adult Behavioral Health Profiles

Other Measures of Mental Health

BRFSS collected other measures showing risk factors for mental and/or physical illness. These included:

- Social and Emotional Support (2010). BRFSS asked, “How often do you get the social and emotional support you need?” The possible responses were always, usually, sometimes, rarely, or never.

- Life Satisfaction (2010). BRFSS asked, “In general, how satisfied are you with your life?” The possible responses were very satisfied, satisfied, dissatisfied, or very dissatisfied.

Exhibit 14 presents the results of these surveys among older Utahns.

Exhibit 14. BRFSS Measures, 2010

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<th>Indicator</th>
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<th>Ages 50–64</th>
<th>Ages 65+</th>
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<tr>
<td>Rarely or never get social or emotional support</td>
<td>8.2%</td>
<td>6.9%</td>
<td>10.2%</td>
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<tr>
<td>Dissatisfied or very dissatisfied</td>
<td>4.2%</td>
<td>4.8%</td>
<td>3.2%</td>
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Source: BRFSS, 2010
MHBG Data for Utah

• Individuals ages 65+ comprise 10.5% of the population; 4.2% of those served, are served.
• Are there outreach services targeting seniors – age/access related competencies?
• From 2017 MHBG Survey Data
Depression of Depression in Older Adults EBP Toolkit

- This kit offers information about an array of evidence-based practices for treatment and services to improve outcomes for older adults experiencing depression, including dysthymia. It considers planning, implementation, and maintenance.


A model of behavioral health integration that enhances “usual” primary care by adding two key services: care management support for patients receiving behavioral health treatment; and regular psychiatric inter-specialty consultation to the primary care team, particularly regarding patients whose conditions are not improving.
CARE TEAM MEMBERS

- **Treating (Billing) Practitioner** – A physician and/or non-physician practitioner (PA, NP, CNS, CNM); typically primary care, but may be of another specialty (e.g., cardiology, oncology)

- **Behavioral Health Care Manager** – A designated individual with formal education or specialized training in behavioral health (including social work, nursing, or psychology), working under the oversight and direction of the billing practitioner

- **Psychiatric Consultant** – A medical professional trained in psychiatry and qualified to prescribe the full range of medications

- **Beneficiary** – The beneficiary is a member of the care team
Medicare Collaborative Care Billing


Suicide Rates by Age

- Although they comprise only 15.2 percent of the U.S. population, people age 65 and older accounted for 18.2 percent of suicide deaths in 2016 (U.S.A. Suicide: 2016 Official Final Data).
- In 2016, the highest suicide rate (19.7) was among adults between 45 and 54 years of age.
- The second highest rate (19.0) occurred in those 85 years or older.
- In 2016, adolescents and young adults aged 15 to 24 had a suicide rate of 13.15.
- Utah US Rank: 9, 620 deaths, Rate: 20.3.

http://suicideprevention.nv.gov/uploadedFiles/suicidepreventionnvgov/content/SP/CRSF/Mtgs/2018/2016_AAS_USA_data.pdf
Why Are Such Toolkits Important?

- Depression is not a normal part of aging
- Normal thoughts about death are different from suicidal thoughts
- It is important to reduce stigma associated with mental health disorders
- Treating depression and treating suicide takes different approaches
Framework for the Toolkits

• Whole Population - Promote the emotional health of all older adults

• At Risk - Recognize and respond to individuals at risk

• Crisis Response - Respond to a suicide attempt or death

Source: Langford, L. 2008. A Framework for Mental Health Promotion and Suicide Prevention in Senior Living Communities
There is Hope and Help

Protective Factors

- Appropriate assessment and care for physical and behavioral health issues
- Social connectedness
- Sense of purpose or meaning
- Resilience around change
Audience for the Toolkit

- Senior Center staff and volunteers
- Community service providers for older adults (e.g., meals on wheels, transportation, home care)
- Behavioral health professionals
Identify and Assist Individuals at Risk of Suicide

✓ Train staff and volunteers
✓ Refer to mental health providers
✓ Conduct screening
✓ Provide counseling
Providing Support after a Suicide

✓ Postvention protocols
✓ Community support meetings
✓ Mental health counseling
Resources in Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Centers

**TOOLS AND FACT SHEETS**

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**Information Form for Behavioral Health Resources**

- **Name of Organization/Program:**
- **Contact Person:**
- **Phone Number:**
- **E-Mail:**

1. **Do you currently provide services for older adults (ages 65+) with:**
   - Mental health issues: Yes ___ No ___
   - Substance abuse problems: Yes ___ No ___
2. **Are you able to take new clients that we would refer to your:**
   - Yes ___ No ___
3. **Do you accept health insurance?**
   - Yes ___ No ___
   - Medicare: ___ Medicaid: ___ Private insurance: ___ Other: ___
4. **What counseling and/or treatment programs do you provide?**
5. **What support groups do you provide?**
6. **Would you be available for consultation with our senior center staff about behavioral health issues?**
7. **What services could you provide at our senior center, for example:**
   - __________ Screening
   - __________ Counseling
   - __________ Support groups
   - __________ Speakers/instructional classes for: ___ Staff ___ Participants
   - __________ Other (please describe): ___

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**Tool 2: Assessment Checklist**

**Promoting Emotional Health and Preventing Suicide**

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<tr>
<th>Questions</th>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
<th>Get Help Now</th>
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<tr>
<td>Do your staff members and volunteers know what factors may increase the risk of suicide among older adults?</td>
<td>Yes</td>
<td>No</td>
<td>Don’t Know</td>
<td>Get Help Now</td>
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<tr>
<td>Do you have a list of the behavioral health contacts in your community?</td>
<td>Yes</td>
<td>No</td>
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**Getting Started**

**Promote Emotional Health**

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<th>Questions</th>
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<tr>
<td>Do you offer a variety of activities that promote intellectual, creative, spiritual, and physical well-being?</td>
<td>Yes</td>
<td>No</td>
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</tr>
<tr>
<td>Do you offer programs designed to promote social networks and community building?</td>
<td>Yes</td>
<td>No</td>
<td>Don’t Know</td>
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**Recognize and Respond to Suicide Risk**

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<tr>
<td>Have your staff and volunteers been trained in suicide prevention?</td>
<td>Yes</td>
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**Fact Sheet 2: Know the Warning Signs of Suicide**

- How have you heard someone make these statements? Have you thought that yourself?
  - “I’m the least important person in my family.”
  - “I’m all alone, nobody cares about me.”
  - “I don’t care if I live or die.”
  - “I’m not worth it.”
  - “I’m a failure.”

Some of the following descriptions sound like your feelings, or the feelings of someone you know.

- The person has been drinking more than usual. He or she doesn’t think he has any purpose now that he or she is retired. He or she uses alcohol to forget or escape.
- The person has talked about or made plans to kill himself or herself.
- The person has stepped out of cars or off elevators on high floors, unable to stop. He or she reports feeling hopeless and that nothing he or she does will ever improve.

**Know the warning signs of suicide**

- The following warning signs suggest that a person could be at immediate risk of suicide:
  - Talking about wanting to die or to harm oneself.
  - Talking to a trusted person about wanting to die or to harm oneself.
  - Looking for a way to kill oneself, such as searching online for ways of committing suicide.
  - Talking about feeling trapped or seeing no way out.
  - Feeling hopeless or seeing no reason to live.
  - Talking about feelings of worthlessness, hopelessness, or despair.
  - Talking about being a burden to others.
  - Talking about wanting to be killed or to kill herself or himself.
  - Acting anxious, agitated, or depressed.
  - Sleeping too little or too much.
  - Withdrawing or feeling isolated.
  - Show signs of anger or talk about wanting to harm others.
  - Displaying extreme mood swings.

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**SAMHSA**

Substance Abuse and Mental Health Services Administration
Resources
Get Connected Toolkit

• Linking Older Adults with Medication, Alcohol, and Mental Health Resources

• This toolkit helps service providers for the aging learn more about mental illness and substance abuse disorders in older adults, including focus on alcohol and medication use. It provides tools such as program coordinator’s guide, suggested curricula, and handouts.

Importance of the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC)

- To keep federal government focused on SMI needs

- To provide feedback about ongoing issues; participate in SAMHSA activities related to special topics in mental illness

- To help in urgent issues: working with SAMHSA leadership and staff on approaches to problems, media contacts/communications with the public, implementation/dissemination
SAMHSA views access to a sufficient and well-prepared clinicians as critical to meet the nation’s behavioral health needs. Current efforts to address the clinical and support staff needs, include:

• Developing a national network of training and technical assistance to assure professionals are equipped to meet patient needs:
  • Repository of evidence-based practices
  • Clinical Support System for SMI/Center of Excellence for Psychopharmacology
  • Regional network of local trainers to assist colleagues in their communities
  • Increase the behavioral health workforce – encourage more psychiatry residency training positions; loan repayment programs for behavioral health professionals

• SAMHSA has definitely heard the call from the Institute of Medicine study – “In Whose Hands” – and is actively working with our federal partners (ACL, HRSA, IHS, NIH (NIA and NIMH), and CMS)
SAMHSA’s Role with the Aging Network

Developing stronger ties with ACL and others in order to:

1. Provide Training and Technical Assistance (TTA) to Improve Service Delivery
2. Support Family Caregivers
3. Support the Workforce
4. Identify Evidence-Based Practices
5. Provide information to the public
SAMHSA’s Work Regarding Older Adults

1. Older Adult Evidence-based Mental Health Practices Panel – June 2017
2. Older Adults with SMI and the Behavioral Health Workforce – May 2018
3. Older Adult Mental Health Awareness Day – May 2018
4. ADRC and Older Adults with Serious Mental Illnesses Expert Panel – August 2018
5. Older Adult Peer Services Expert Panel – September 2018
Recommendations from OA EBP Expert Panel

1) having one or two federal agencies provide strong federal leadership in the area of recognition and dissemination of older adult evidence-based mental health practices

2) create strong public-private partnerships around evidence-based practice implementation;

3) provide TA to the behavioral health network around financing opportunities with guidance related to the new Medicare Collaborative Care Codes;

4) focus on training/cross-training and novel work force solutions (such as peers and ways to provide expert consultations) since it is unlikely there will ever be enough funding to have a work force of experts focused on geriatric behavioral health; and

5) re-establish an Older Adult Behavioral Health Technical Assistance and Training Resource Center. A full list of recommendations is included in the meeting report.
# Older Adults with SMI Panelists

<table>
<thead>
<tr>
<th>Name</th>
<th>Title and Institution</th>
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<tbody>
<tr>
<td>Frederic Blow, PhD</td>
<td>Professor of Psychiatry, University of Michigan</td>
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<tr>
<td>Michael Hoge, PhD</td>
<td>Professor of Psychiatry, Yale School of Medicine</td>
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<tr>
<td>Paul Emrich, PhD</td>
<td>Under Secretary, Chickasaw Nation</td>
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<tr>
<td>Susan Lehmann, MD</td>
<td>Associate Professor, Johns Hopkins University</td>
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<td>Clayton Chau, MD, PhD</td>
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<tr>
<td>Maria Llorente, MD</td>
<td>Deputy Chief of Staff, DC VA Medical Center</td>
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Plus many others
Increasingly Diverse and Aging Population

U.S. Population Will Become Increasingly Diverse

- Hispanic Origin
- Asian, Native Hawaiian, and Pacific Islander
- Two or More Races
- Black
- American Indian and Alaska Native
- White

Recommendations from OA with SMI Expert Panel

Michael A. Hoge, Ph.D., Professor Psychiatry, Yale School of Medicine and Special Advisor to the Annapolis Coalition

- Goal 1: Expand workforce roles for patients and families.
- Goal 2: Expand workforce roles for community groups.
- Goal 3: Expand the roles for health and social service professionals.
- Goal 4: Recruitment and retention.
- Goal 5: Training relevance, effectiveness, and accessibility.
- Goal 6: Leadership and supervisor development.
- Goal 7: Infrastructure.
- Goal 8: Evaluation and research.
- Goal 9: Financing.
Recommendations from OA with SMI Expert Panel

• Train everyone in Mental Health First Aid.
• Engage professional organizations in the long-term ethical responsibility of creating a workforce that meets the broad needs of the population, not just white adults in suburban areas.
• Develop geriatric curricula and competencies for a variety of professional stakeholders.
• Improve access to the current workforce.
• Increase opportunities for specialization.
• Raise the standards for training.
• Promote workforce options.
Recommendations from OA with SMI Expert Panel

- Increase the education of the broad spectrum of providers.
- Increase the group of experts in the field.
- Include geriatric content in accreditation standards.
- Get the state licensing bodies to require a set number of hours of training to renew a license.
- Resurrect information from the IOM report and the Annapolis Coalition Report.
- Create a focused, intermediate, and long-term plan with specific desired outcomes and link the plan to an implementation structure housed within SAMHSA, or SAMHSA and its partners, and tie it to a budget.
Older Adult with SMI and NWD/ADRCs and Peer Support

- Connecticut Asset Mapping
- Work to integrate systems horizontally and vertically
- Build mental health and substance use screening into various systems (it is already in the MDS – is it in the screening for home delivered meals or aging services case management?)
- Consider ways to incorporate screenings and treatment into apps and other technology – both as assists for consumers and providers
- Develop co-occurring treatment competence
- Support and fund evidence based clinical and community based practices
- Develop adult peer support programs and train older adult peers
- Ask if aging adults you work with are veterans, help them connect to local, state, and federal programs for veterans
Other Co-occurring Considerations

• The intersection of older adults with SMI and cognitive impairment/dementia

• Supports for people with aging adults with developmental disabilities and intellectual disabilities and SMI
Medication Management in Older Adults

• Brownbag Toolkit
  • Ohio Hospital Association Medication Safety Page
  • https://www.ohiohospitals.org/Patient-Safety-Quality/Ohio-Patient-Safety-Institute-OPSI/Professional-Resources/Medication-Safety.aspx

• SAMHSA-HRSA Center for Integrated Health Solutions
  • https://www.integration.samhsa.gov/
  • Growing Older: Providing Integrated Care for and Aging Population
    • https://store.samhsa.gov/shin/content//SMA16-4982/SMA16-4982.pdf
Revised TIP: *Treating Addiction in Older Adults*

- TIPs are guidelines to ensure provision of the best evidence-based treatments for substance use disorders
- Each TIP conveys current, relevant information in an accessible, user-friendly, toolkit format
- Each TIP has 5-10 core documents, roughly 10-20 pages in length, that can be used individually or in conjunction with one another
- Consensus process used for creating or revising TIPs:
  - Nonfederal panel of clinical, research, administrative, and client advocacy experts participate in consensus-based development of each TIP’s content
  - Review and refine the draft outline and supporting annotated bibliography until a consensus is reached regarding best practices and practically applicable information
- TIP will be available in late 2019 on SAMHSA’s Store
These guidelines are intended to help health care providers improve patient outcomes when providing this treatment, including avoiding potential adverse outcomes associated with the use of opioids to treat pain.
SAMHSA Helplines and Treatment Locators

https://findtreatment.samhsa.gov/

https://suicidepreventionlifeline.org/

https://www.samhsa.gov/find-help/national-helpline
SAMHSA Materials

- Get Connected Toolkit
- Treatment of Depression in Older Adults
- Promoting Emotional Health and Preventing Suicide – senior housing
- Promoting Emotional Health and Preventing Suicide – senior centers
- Growing Older: Providing Integrated Care for an Aging Population – SAMHSA-HRSA
- Good Mental Health is Ageless – brochure
- Aging Medicines and Alcohol – brochure
- Older Adult Behavioral Health Profiles – SAMHSA-ACL
Depression of Depression in Older Adults EBP Toolkit

• This kit offers information about an array of evidence-based practices for treatment and services to improve outcomes for older adults experiencing depression, including dysthymia. It considers planning, implementation, and maintenance.


[https://www.dropbox.com/s/ne0jfvj1wqwl65f/Treatment-of-Depression%20video%203.mp4?dl=0](https://www.dropbox.com/s/ne0jfvj1wqwl65f/Treatment-of-Depression%20video%203.mp4?dl=0)
Attitude

• Mental Health is Essential to Health
• Prevention Works
• Treatment is Effective
• People Recover
SAMHSA Tribal Training and Technical Assistance Center

- SAMHSA Tribal Training and Technical Assistance Center
- [https://www.samhsa.gov/tribal-ttac](https://www.samhsa.gov/tribal-ttac)

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