Developing or Enhancing Your State’s Older Adult Behavioral Health Services

A Behavioral Health Resource

SAMHSA’s State Technical Assistance Contract
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Overview

Using This Guide

States need data to make decisions about the development and implementation of behavioral health services for growing older adult populations. These data are important for assessing and reassessing processes and outcomes over time, introducing population-level changes that affect risk and resilience of older adults, focusing on prospective lifespan issues for older adults, and adopting a team approach across community and state care providers and policy leaders.

States are at varying stages in implementing programming for their older adult populations with behavioral health needs. Each state has unique strengths and challenges that it can use to enhance the provision of state-of-the-art programming for older adults who are at risk for, or have developed, problems related to their mental health and use of alcohol, drugs, or both. A systematic approach to enhancing behavioral health services requires determining which elements are working in the state, where implementation challenges exist, and the best way to provide needed services to older adults.

This guide provides state officials with information on how to develop and implement behavioral health services to specifically address the needs of older adults in their state. It describes useful tools for state planners and providers of prevention, substance use disorder, and mental health services. It also includes details on implementation and action steps, resources, evidence-based practices, and processes to best serve some of the nation’s most vulnerable citizens. State officials can use individual sections of the guide or the entire guide depending on their needs. It may be downloaded and reproduced for broad distribution to enhance collaboration.

The guide covers the following topics:

- Collaborating and planning
- Gathering and using data
- Selecting and implementing programs
- Attracting and training providers

Why Is Behavioral Health Service Enhancement Important Now?

America is aging. The population of Americans ages 65 and older has increased from 36.2 million in 2004 to 46.2 million in 2014, an increase of 28 percent. On the basis of this increase, the U.S. Census Bureau projects the population of Americans ages 65 and older to more than double to 98 million by 2060. An estimated 8 million Americans in this age group have at least one mental health or substance use condition. Fueled by differences in lifestyles and attitudes compared with earlier generations of older adults, along with the inevitable losses and transitions that accompany aging, this group of older adults is at risk for a host of negative outcomes. In particular:

- Hazardous and harmful alcohol consumption patterns are prevalent among older adults living in the community.
● Alcohol and medication misuse affects an estimated 19 percent of older Americans.4

● Older adults have the highest suicide rate of any age group; the greatest risk is associated with the presence of alcohol use and depressive symptoms.5

● Substance use and mental health problems among older adults are associated with increased disability and impairment, compromised quality of life, reduced independence and community-based functioning, increased caregiver stress, and increased mortality.5,6

Prevention and early intervention of alcohol, drug, and mental health problems among older adults can improve their health and well-being and lower healthcare costs. Although successful prevention and treatment programs exist, the workforce must prepare to meet the increasing needs of older Americans. The United States has fewer than 1,700 board-certified geriatric psychiatrists and only 7,428 geriatricians.7,8

Across health care in general, the focus has shifted to a public health approach that emphasizes prevention across the lifespan. This approach provides the opportunity to enhance training for providers and prevention specialists as well as services for older adults.9,10
Collaborating and Planning To Meet the Behavioral Health Needs of Older Adults

Collaborate To Serve the Whole Health Needs of Older Adults

Collaboration is challenging. There are few ways to fund it, little time to do it, and many competing demands. To help states improve their ability to form collaborations, the Substance Abuse and Mental Health Services Administration (SAMHSA) and Administration on Aging (AoA), both part of the U.S. Department of Health and Human Services (HHS), held a series of Policy Academy Regional meetings in 2013. Teams from 43 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands met to develop state-specific strategies to improve existing behavioral health service systems for older adults. This section draws on the successful collaboration strategies identified at that meeting and highlights ways that collaboration can:

- Select leaders and champions for the effort.
- Ensure broad participation.
- Analyze data to identify gaps.
- Develop and implement a strategic plan.
- Monitor progress and measure results.
- Address challenges.

Select a Key Champion

States that are successful in collaborating on the behavioral health needs of older adults have a leader or champion, frequently in either the state unit on aging or the state behavioral health authority. This individual spearheads the state’s efforts by getting buy-in from other top-level state officials, conducting outreach to key stakeholders, and galvanizing public support. Champions must be in a relatively high position in their organization, with the ability and authority to make necessary compromises and commit their agencies to action.

SUCCESSFUL COLLABORATIONS

Collaboration is a way for states, communities, agencies, and organizations to stretch their budgets by pooling human resources. In the field of prevention, collaboration is especially important because it reflects the point of view that, by working together, partners bring different perspectives to bear on a problem, thereby effecting change. There are a number of ways to enhance the effectiveness of collaborations:

- Involve communities that are already mobilized or ready to engage in state and community change. Include organizations that work with and provide services to older adults, such as senior centers and Meals on Wheels programs.

- Combine collaboration with communications and education strategies. This can increase public awareness of a particular issue or program, attract community support, reinforce prevention messages, and keep the public informed of program progress.

- Don’t reinvent the wheel! Look at what the people and organizations in the community are already doing to prevent substance misuse, depression, and suicide in older adults and build on these efforts. Learn from both successes and mistakes.

For more information, see Checklists for Assessing Readiness to Undertake Community Collaboration, compiled by SAMHSA’s Center for the Application of Prevention Technologies, and its companion piece, Components of an Effective Coalition.
Ensure Broad-based Participation

Collaboration partners should represent the populations, communities, cultures, and organizations that address the prevention, treatment, and recovery support needs of older adults. Diverse membership ensures ownership of plans and actions. It also increases awareness in states and communities about the needs of older adults and engages new partners. Collaborations should include funders or potential funders. Teams that participated in Policy Academy Regional meetings were most successful when they included high-level Medicaid representatives. Other partners may include, but not be limited to:

- Agency heads from state and local governments (e.g., governors, mayors)
- Agency heads from state and local departments (e.g., mental health, substance abuse, aging, Medicaid, public health)
- Area agencies on aging
- Community mental health centers
- Substance use disorder treatment providers
- Prevention programs/coalitions
- Federally qualified health centers
- Geriatric education centers
- Schools of nursing, social work, and public health
- Elected representatives
- Senior service centers
- Older adults
- Tribes
- Members of the business community
- Faith-based organizations

Analyze Data and Identify Gaps

Good planning is based on good data (see the companion piece in this series about collecting and using data). You can use data to obtain a comprehensive understanding of the prevalence of behavioral health problems among older adults, including regional and state-level similarities and differences. Data also indicate where people are not being served or are underserved in the system. You can use this information to create an asset map of existing services and a program inventory.

SAMHSA has developed the Strategic Planning Framework (SPF)—a resource to help states and agencies complete the planning process for developing services to prevent substance use and misuse. The effectiveness of the SPF is based on an understanding of community needs and involves community members in all planning stages. The steps in the SPF process include assessing needs, building capacity, planning, implementing, and evaluating. The SPF can be found at http://www.samhsa.gov/capt/applying-strategic-prevention-framework.

Develop a Strategic Plan

A good strategic plan begins with a shared vision. Partners should brainstorm to create a “preferred future.” They should not be constrained by current resources; the vision is the collaboration’s sense of where it wants to be when the plan is fully realized. Once the broad-based vision is developed, the partners determine specific details. This requires:

- Reviewing the data gathered and selecting two top priority issues for the team’s plan.
- Identifying one population-level goal for each top priority issue.
- Drafting two short-term (1 year) goals and two long-term (2 to 5 years) goals related to the population-level goals.
- Creating a plan with action items (up to three per goal) that includes responsible parties, other partners, available resources, target start and end dates, and items to measure.
Implement the Plan

Each state plan will be specific and identify the needs of older adults, selected goals, available resources, and key players involved. In general, states may use one or more of the following mechanisms to achieve their specific goals:

- Co-locate services
- Train and cross-train staff
- Create memorandums of understanding (MOUs)
- Implement interagency management information systems
- Use pooled or joint funding
- Develop uniform applications, eligibility criteria, and intake assessments
- Use interagency service delivery teams
- Make some flexible funding available
- Consider special waivers
- Consolidate programs or agencies

Monitor Progress and Measure Results

A strategic plan should have key milestones to monitor progress, review specific outcomes, and measure results. For example, is the plan in place by the specified date? If the goal is to reduce suicide rates by a specified percentage, have the targets been met? Assessing progress at regular intervals helps in making any necessary midcourse corrections and evaluating outcomes to determine whether additional resources are needed to achieve established goals.

Address Challenges

Three specific challenges may arise when developing a strategic plan: champions and ardent supporters of the effort may leave, the collaboration may need to address competing priorities, and funding sources may be difficult to secure.


**Champions Leave**

State-level and community changes, such as staff turnover and agency reorganization, may derail a team’s progress. To ensure continuity of effort during inevitable leadership transitions, successful collaborations develop a strong leadership base. An MOU that spells out clearly the responsibilities of each member agency or organization may keep efforts running smoothly when individual team members leave. The Pennsylvania Department of Aging and Office of Mental Health and Substance Abuse Services have published an MOU writing guide. The HHS Aging and Disability Resource Center maintains a list of sample MOUs related to aging and disability services.

**Competing Priorities Interfere**

States’ interagency planning efforts on behalf of older adults often encounter numerous competing priorities. These include budget cuts, staffing changes, staff shortages, and reorganization of state agencies. Behavioral health agencies may contend with state hospital closures, Medicaid reform, broader substance use problems (e.g., opioid misuse), and a focus on early intervention for youth and young adults. As noted below, some states have addressed these competing priorities by institutionalizing efforts on behalf of older adults through legislation or executive order.

States may find opportunities to focus on the behavioral health needs of older adults through health reform and other state initiatives (e.g., suicide prevention efforts). For example, as New York moves to Medicaid managed care, it has planned two specific older adult initiatives: a managed long-term care program to support older adults in the community and a managed care demonstration program using Medicaid and Medicare to integrate care for older adults with behavioral and physical health problems. The North Dakota Department of Human Services is planning to conduct a comprehensive, statewide behavioral health needs assessment; the department will use this opportunity to add a focus on older adults.

**Dedicated Funding Is Scarce**

Funding for collaboration on the behavioral health needs of older adults is often limited. In addition, behavioral health services for older adults are financed through a patchwork of sources, including Medicaid, Medicare, private insurance, and public and private programs. Public sources play a larger role in financing behavioral health care than they do in overall health care. In response, states use a number of innovative strategies to fund behavioral health services for older adults. They may choose to blend or braid funds. Blended funds are pooled from several sources. In contrast, braided funds remain in separate strands but are joined or “braided” at the client level.

Some states use funds from SAMHSA’s Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grants to fund initiatives for older adults. For instance, Michigan uses block grant funds for a project focused on the behavioral health needs of older Native Americans. Many states use
Medicaid waivers to support older adults with behavioral health conditions in the community. For example, Maryland’s Community Options Waiver (formerly Waiver for Older Adults) allows individuals who need nursing home care to receive services in their home or community setting instead. Medicaid.gov features information on Medicaid waivers, including those that fund long-term care services and supports.

Making it Work

New York State’s Geriatric Mental Health Act, passed in 2005 and expanded in 2008, established an interagency planning council, a geriatric service demonstration program, and a requirement for an annual report to the governor and state legislature. The Interagency Geriatric Mental Health and Chemical Dependency Planning Council is co-chaired by the commissioners of the Office of Mental Health and the Office of Alcoholism and Substance Abuse Services and by the directors of the Office for the Aging and the Division of Veterans’ Affairs.

Three rounds of grants have been awarded under the demonstration program, most focus on integrating physical and behavioral health care for older adults. To support grantees, New York State established a Geriatric Technical Assistance Center and published a planning guide titled Integrated Primary Care and Behavioral Health Services for Older Adults.

In Arizona, 26 percent of the state’s population will be older than 60 by 2020. More than a decade ago, the state had the foresight to begin planning for its aging population. Executive order 2004-07 required 14 state agencies to develop and implement plans to address the needs of the state’s older adults. Agencies developed initial plans, and state residents provided input at a series of 40 public forums. The plans were finalized into the Aging 2020 Plan, which includes specific goals and objectives for behavioral health for older adults and is updated annually.

Resources: Where To Learn More

- **Evidence-Based Practices for Effective Community Coalitions: A Summary of Current Research.** This paper by the Center for Prevention Research and Development at the University of Illinois Institute of Government and Public Affairs includes evidence-based principles and practices to guide formation, implementation, and assessment of interagency substance misuse prevention groups. Much of the material is applicable to collaborative efforts on behalf of older adults.

- **Creating a Business Plan for Evidence-Based Health Promotion Programs.** This ninth module in the National Council on Aging’s interactive training on evidence-based health promotion for older adults includes resources for strategic and business planning. The modules in this series are primarily for aging services providers but are applicable to those in other public health and human services agencies.

- **Building Effective Early Childhood Coalitions.** This document published by the Virginia Early Childhood Foundation includes a toolkit to guide
successful statewide interagency planning efforts. Although not specific to older adults, much of its advice is applicable to senior populations. The toolkit begins on page 109 and features links to planning tools, including a sample MOU.

- **CoalitionsWork.** The Tools & Resources page of this website includes free tools for coalition startup, planning, assessment and evaluation, and sustainability. Tools include a sample commitment letter, a member orientation packet, tips for retaining members, and a model of sustainability tasks.
Identify, Collect, and Use Comprehensive Health Data on Older Adults

Policymakers and program planners may encounter barriers when collecting data on older adults—including lack of coordination across all agencies serving older populations. This section highlights:

- Conducting individual and population-based needs assessment.
- Using data to evaluate efforts.
- Steps for successful coordination and cross-agency data collection.

Conduct Needs Assessments

Needs Assessment

Needs assessment is a process in which data are used to estimate the needs of an individual or group. A needs assessment should be the first step in defining the individual or population of focus, as well as understanding the needs of that individual or population. Data obtained can be used to accurately define the problem and guide the selection of appropriate programs and services for the most effective and efficient use of resources. In addition, longitudinal needs assessment data can provide a way to measure improvements in outcomes over time.

Policy Needs Assessment

An example of a general policy assessment tool that can be applied across topic areas is the Policy Assessment Implementation Tool from the Health Policy Initiative and available at http://www.healthpolicyinitiative.com/policyimplementation/files/1086_1_PIAT_Summary_Taking_the_Pulse_of_Policy_acc.pdf. The tool comprises two interview guides: one for policymakers and one for implementers. The interview guides cover seven dimensions that influence policy implementation: (1) the policy and its formulation and dissemination, (2) socioeconomic and political contexts, (3) leadership for implementation, (4) stakeholder involvement in policy implementation, (5) planning and resource mobilization, (6) operations and services, and (7) feedback on progress and results. Excel spreadsheets for organizing data are also available.

Older Adult Population Needs Assessment

To be useful, a behavioral health needs assessments for older adults must be comprehensive. The assessment should include demographic data, consequence rates, substance use behaviors and patterns, family and community norms, and system supports. In some areas, it may be difficult to collect all of the suggested data, but it is important to collect as much as possible.

Data Indicators and Sources

Large, national data sources are available that can assist states and communities in assessing the need for older adult behavioral health services such as the Centers for Medicare and Medicaid’s (CMS) Minimum Data Set (MDS) and the National Comorbidity Survey Replication (NCS-R).
Developing or Enhancing Your State’s Older Adult Behavioral Health Services

ASSESS THE BEHAVIORAL HEALTH NEEDS OF OLDER ADULTS

The Center for Medicare and Medicaid’s Minimum Data Set is a mandatory nursing home patient data collection and screening instrument to assess patient’s physical and mental health status (including the symptoms of dementia). MDS can provide a routine, regularly scheduled mechanism to:

- Identify specific mental health needs of individual residents.
- Identify appropriate mental health services that can be integrated into individual treatment protocols.
- Track improvements in resident care and mental health outcomes over time.

The National Comorbidity Survey Replication is an epidemiologic catchment area study that collected data on several DSM-IV diagnoses along with other correlates such as service use. The questions used in the survey are copyrighted, and permission to use or distribution them is required (http://www.hcp.med.harvard.edu/ncs/ftpdir/replication). The NCS-R found that 31 percent of people between ages 65 and 74 and 26 percent of people ages 75 and older said they would be embarrassed if their friends knew they were getting professional help for an emotional problem. On the basis of this finding, NCS-R data have identified a need for helping older adults feel more comfortable when seeking professional help for an emotional problem. This need can be addressed by implementing a campaign to change the perceived acceptability of receiving professional help for an emotional problem. When conducted on a regular basis (annually or biannually), NCS-R can provide a routine, regularly scheduled mechanism to evaluate the effectiveness of the campaign by comparing data over time on the percentage of individuals ages 65–74 and those ages 75 and older reporting that they would be embarrassed if their friends knew they were getting professional help for an emotional problem.

Suggested indicators and possible sources that can serve as the resource guide for a community needs analysis are presented in the table on following page.

In addition to collecting data using assessment instruments, states can use quarterly reports on all MDS items that CMS posts to its website (the latest data are from the first quarter of 2016): https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports/Minimum-Data-Set-3-0-Frequency-Report.html.

**Individual Assessment of Need for Services**

Several measures are available to guide state agencies in data collection. In addition to standardized
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Developing or Enhancing Your State’s Older Adult Behavioral Health Services

The National Institute on Alcohol Abuse and Alcoholism and SAMHSA’s Treatment Improvement Protocol (TIP) 26: Substance Abuse Among Older Adults* recommend lower levels of alcohol consumption for adults ages 65 and older to minimize risky or problem drinking and to prevent alcohol-related problems:

- Men: No more than seven drinks/week or one standard drink/day
- Women: Lower limits than seven drinks/week or one standard drink/day

Providers should work with policymakers to ensure that “over-serving laws” reflect the recommended levels of alcohol consumption for older adults.


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USE DATA TO STRENGTHEN POLICIES THAT AFFECT OLDER ADULT POPULATIONS

data that agencies collect and report to states, a number of measures help determine whether older adults are suffering from depression and anxiety, as well as alcohol and other drug misuse or problems (particularly prescription psychoactive medication misuse). The following validated, widely used screening instruments assess baseline symptoms and can be used to assess changes over time. By using standardized individual assessment instruments, agencies and providers can monitor progress and outcomes for older adults based on the interventions and treatments used.

**MAST:** The Michigan Alcoholism Screening Instrument-Geriatric Version was developed at the University of Michigan as an older adult alcoholism screening instrument for use in a variety of settings. MAST-G was the first major alcoholism screening measure to be developed with items unique and specific to older problem drinkers. The original MAST-G is a 24-item scale with good sensitivity and specificity in older adults. The Short Michigan Alcoholism Screening Test-Geriatric Version is a validated shortened form of the MAST-G containing only 10 items. https://www.ncbi.nlm.nih.gov/books/NBK64829/#A46031

**AUDIT:** The Alcohol Use Disorders Identification Test was developed by the World Health Organization (WHO). AUDIT is a 10-item scale that rates alcohol use based on the previous year’s behavior. http://www.markjayalcoholdetox.co.uk/audit.php

**AUDIT-C:** AUDIT-C measures alcohol use by collecting information on only the first three AUDIT questions: quantity, frequency, and binge drinking. http://www.integration.samhsa.gov/images/res/tool_auditc.pdf

**PHQ-9:** The Patient Health Questionnaire is a nine-item self-administered version of PRIME-MD. It collects information on mood, anxiety, alcohol, eating, and somatoform issues. http://www.med.umich.edu/1info/FHP/practiceguides/depress/phq-9.pdf

**GAD-7:** The Generalized Anxiety Disorder-Short Version was developed as a brief scale for anxiety. The GAD-7 scores seven common anxiety symptoms. https://www.uvm.edu/medicine/ahec/documents/Generalized_Anxiety_Disorder_Screener_GAD7.pdf

**NIDA ASSIST:** The National Institute on Drug Abuse-Alcohol, Smoking, and Substance Involvement Screening Test was adapted from the WHO’s version. It focuses on illegal drug and psychoactive medication use. Determining psychoactive medication use in older adults is particularly important in identifying substance misuse and potential drug-alcohol interactions. https://www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen
Coordinate Cross-Agency Data Collection

Many agencies, across different systems, collect important data for a comprehensive behavioral health needs assessment of older adults. However, accessing the needed data outside an agency can be challenging. The most efficient way to address this issue is to form a mutually beneficial collaborative with older adult behavioral health service system agencies that collect and maintain data. (See Section I, Collaborating and Planning to Meet the Behavioral Health Needs of Older Adults).

JOIN AN ESTABLISHED STATE COLLABORATIVE FOR ACCESSING OLDER ADULT DATA

Under a 2010 funding initiative, SAMHSA’s Center for Substance Abuse Prevention (CSAP) funded State Epidemiological Outcomes Workgroups (SEOWs) to help states and communities access mental, emotional, and behavioral (MEB) health data across the lifespan. SEOWs are composed of health agency professionals with analytical and other data competencies. SEOWs meet regularly to:

1. Share agency data and identify and fill in data gaps.
2. Conduct an annual assessment of the negative health consequences of substance use and MEB disorders and the factors that contribute to those problems.
3. Disseminate epidemiological data for needs assessment, planning, and evaluation.

Making It Work

Michigan collects substance use disorder treatment episode data, as well as prevalence and incidence data, for all individuals, including older adults. It uses these data to stratify needs (e.g., for treatment or prevention) by age group and to plan specific interventions. For example, because the data show an increased risk for suicide among older adults, Michigan is directing suicide prevention efforts toward this group.

Washington State is developing an integrated client database using administrative claims data and other sources of information from several agencies (e.g., aging, Medicaid, developmental disabilities, mental health, chemical dependence). These data will be used to develop performance measures for mental health and managed care contracts. In turn, the performance measures will be built into contracts for behavioral health organizations that will administer and purchase behavioral health services on a regional basis.

Resources: Where To Learn More

Policy:
● SAMHSA’s Community Integration Self-Assessment Tool: http://www.nri-inc.org/olmstead

Population:
● CDC’s Behavioral Risk Factor Surveillance System: http://www.cdc.gov/brfss
● U.S. Census Bureau’s data: http://www.census.gov/people
● SAMHSA’s DAWN: http://www.samhsa.gov/data/emergency-department-data-dawn)
● CMS’s MDS: http://www.cms.gov)
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- National Institute of Mental Health's NCS-R: http://www.nimh.nih.gov
- SAMHSA’s National Survey on Drug Use and Health: https://nsduhweb.rti.org/respw web/homepage.cfm
- SAMHSA’s SEOW: http://www.samhsa.gov/capt/tools-learning-resources/data-prevention-planning-seow
- SAMHSA’s TEDS: http://www.icpsr.umich.edu/icpsrweb/SAMHDA/
- SAMHSA’s URS: http://wwwdasis.samhsa.gov/dasis2/URS.htm

Individual:
- SAMHSA’s TIP 26, Substance Abuse Among Older Adults: http://store.samhsa.gov/product/TIP-26-Substance-Abuse-Among-Older-Adults/SMA12-3918
Selecting and Implementing Programs To Meet the Behavioral Health Needs of Older Adults

Choose Proven Practices for Identified Needs

Selection of an appropriate strategy is critical once needs assessment data have been reviewed and the behavioral health priority identified. This section highlights how to:

- Choose an intervention that best fits the needs of the state’s older adult populations.
- Determine whether such a practice is evidence-based and appropriate.
- Address key implementation issues.

Find Evidence-Based Practices

The word “practice” in the term “evidence-based practice” refers to particular prevention and treatment interventions. “Evidence-based practices are interventions for which there is consistent scientific evidence showing that they improve client outcomes.” Practices with the strongest evidence have “consistently positive results for the outcomes targeted under conditions that rule out competing explanations for the effects achieved.” Evidence-based practices are tested in randomized controlled trials in which the intervention groups show significant improvements in outcomes compared with the control groups. Evidence-based practices are standardized and replicable and are considered most effective when implemented with fidelity to the model (i.e., delivery of the intervention adheres to the original design). One of the greatest challenges regarding evidenced-based practices is understanding the degree to which an intervention can be adapted to fit a population while maintaining fidelity.

Numerous policy statements and funding requirements, including guidance provided by the Affordable Care Act, support the use of healthcare practices that are proved effective. For example, SAMHSA encourages grantees to choose and implement evidence-based practices in services grant programs. Since 2012, AoA has required that all Older Americans Act funds under Title IIIID, which supports state health and wellness programs for older adults, be spent on programs that meet AoA’s criteria for an evidence-based practice.

Some federal registries (see page 16) include a section called “IOM Prevention Category.” This refers to the three levels of prevention identified by the Institute of Medicine (IOM) in its seminal 1994 report Reducing Risks for Mental Disorders:

- **Universal preventive interventions** focus on the entire population. For example, to reduce risk of suicide among all older adults, strategies may include implementing depression screenings and limiting access to means of suicide, including firearms.
- **Selective preventive interventions** address groups of people who are at increased risk for negative outcomes. For example, older adults who have recently lost a spouse or who have a chronic illness may be at increased risk for depression. Selective
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interventions include those that address social isolation and enhance independent functioning.

• **Indicated preventive interventions** are for individuals who, by virtue of a specific risk factor or condition, are at high risk for a negative outcome. For example, older adults who have survived a suicide attempt are at high risk for suicide. Indicated interventions may include psychotherapy and medication, as well as home visits.

For vulnerable older adults, multilayered strategies that combine universal, selective, and indicated prevention may be most effective.

Finding and selecting an evidence-based practice to meet the prevention and treatment needs of older adults takes a combination of knowing where to look and what to look for. There are three key sources for this information: federal registries, peer-reviewed research, and other sources.15

**Federal Registries**

Several federal agencies maintain and update registries that use predetermined criteria and a formalized rating process to assess the effectiveness of interventions reviewed. These registries include information to help planners and program developers make decisions about the relevance and appropriateness of listed interventions. Selected practices deemed effective for mental health and substance misuse prevention and treatment are listed in SAMHSA’s National Registry of Evidence-based Programs and Practices (NREPP). NREPP includes information on the quality of research, readiness for dissemination, costs, replications, and contact information for the program developers or lead researchers.

The HHS Administration for Community Living maintains the Aging and Disability Evidence-Based Programs and Practices, a registry of programs specific to older adults and those with disabilities. CDC’s Compendium of Effective Fall Interventions includes interventions deemed effective in preventing falls among older adults living in the community. CDC’s Guide to Community Preventive Services houses the official collection of all HHS Community Preventive Services Task Force findings and the systematic reviews on which they are based. For additional information, see SAMHSA’s Guide to Evidence-based Practices.

The level of evidence needs to be assessed when examining interventions listed in registries. Some things to look for are:

• How many times the program or intervention has been replicated and whether the outcomes are similar each time.

• What percentage of participants show positive change in the expected direction.

• How long these positive changes last.

Additional considerations for assessing peer-reviewed research are spelled out below.

**Peer-Reviewed Research**

Digging into original research may yield information on practices that have not yet been listed in practice registries. Articles in peer-reviewed journals have
Choosing an “off-the-shelf” intervention designed for older adults with or at risk for substance misuse, suicide, or depression may be the quickest solution, but not always the best. Before choosing a program or intervention, answer three critical questions:

**Is it relevant?** Does the program or practice target the identified problem and the underlying factors that contribute to the problem? For example, if older adults are showing up in the emergency room because of drug–drug or drug–alcohol interactions, is the intervention designed to educate them and their caregivers about the dangers of mixing drugs and alcohol?

**Is it appropriate?** Does the program or practice fit the population, cultural context, and set of local circumstances? For example, if depression among older adult tribal members is the issue, does the intervention take into account the unique help-seeking practices and health beliefs of indigenous peoples?

**Is it effective?** Does the program or practice have documented evidence of effectiveness for the identified need? For example, if suicide is more prevalent among men older than 85, is the intervention proven effective for this specific group?

For more information on these steps, see the SAMHSA's Identifying and Selecting Evidence-Based Interventions.

been vetted by experts in the field. These articles should be reviewed first as well as all articles relevant to the specific intervention. Sometimes researchers have published a systematic review that examines many different research studies on the same topic or treatment; it may include a quantitative synthesis (meta-analysis), depending on the available data. The Cochrane Collaboration is well known for its systematic reviews on health-related topics. When reviewing original research, keep in mind the following questions, among others:

- How closely does the problem targeted by the intervention match the identified needs of the community?
- Are the structure and content of the intervention described in enough detail?
- How well does the study population match the target group?
- Does the study design rule out competing explanations for the findings?
- Does the article report and clearly describe findings and outcomes?
- Are the findings consistent with the theory or conceptual model and the study’s hypotheses?
- Are findings reported for all outcomes specified?

**Other Sources**

Sometimes it can be difficult to find a practice that meets the combination of identified needs, community resources, and proven effectiveness. Many practices have not been developed for all populations, service settings, or both. In such situations, knowing which elements of the practice are considered essential and which may be adapted for a particular population or setting is critical. The original researchers or program disseminators may be able to help; often, their contact information is listed in program registries.
Often fidelity to the core components of a practice can be maintained while being flexible about how these components are implemented. A key issue is determining that an intervention chosen is a good fit for the population and the organization’s capacity. Issues of culture, gender, and age need to be considered. States, organizations, and service providers may need to go outside the bounds of evidence-based practices to meet the identified needs for prevention and treatment among older adults. In choosing from what are considered less rigorous sources of information, CSAP recommends that any intervention meet all four of the following guidelines:

1. The intervention is based on a theory of change that is documented in a clear logic or conceptual model.
2. The intervention is similar in content and structure to interventions that appear in registries or the peer-reviewed literature.
3. The intervention is supported by documentation that it has been effectively implemented multiple times.
4. The intervention is reviewed and deemed appropriate by a panel of experts in the field.

**Making It Work**

Michigan has made education about and use of evidence-based practices a priority in its behavioral health care system. Supported by SAMHSA block grant and state funds, the website ImprovingMIP-practices provides information to practitioners and residents on evidence-based practices in mental health and substance misuse prevention and treatment. The site offers moderated online courses, supplemental training, and additional information for behavioral health professionals.

To ensure that the behavioral health needs of Michigan’s residents are met, the state requires regional behavioral health entities to submit strategic plans that cover prevention, treatment, and recovery. These plans must include epidemiological data that identify specific needs and highlight programs designed to address those needs.

For older adults, Michigan offers a number of modules within the Stanford University Chronic Disease Self-Management Program (CDSMP), including those for arthritis, diabetes, and general chronic illness. Many older adults with behavioral health disorders have these and other comorbid physical health conditions. The CDSMP is among the evidence-based programs approved for funding by AoA.

**Resources: Where To Learn More**

- BRITE (Brief Intervention and Treatment for Elders) is a substance misuse screening and intervention program for adults ages 55+ who are at risk for or experiencing alcohol misuse, prescription and over-the-counter drug misuse, or illicit drug use, accompanied by depressive symptoms.
- Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) is a program that integrates depression screening and assessment for frail, high-risk, ethnically, and socioeconomically diverse older adults into the services offered by community-based agencies.
Implementing evidence-based practices can be a complex process that often requires a need for organizational change.* The following steps may help ensure smooth adoption of a new practice or program:

**Communicate a vision and incentivize success.** Support adoption of evidence-based practices through contracts with providers, licensing requirements, and grant design and selection decisions. Use internal and external communication to create buy-in and make clear that the new practice is a priority.†

**Convene a statewide evidence-based practice workgroup.** Statewide groups review, categorize, and disseminate evidence-based behavioral health practices for use at state and regional levels. Some of these efforts are legislatively mandated (e.g., Washington State).

**Secure funding for services.** Reallocate funding from ineffective services to evidence-based practices. Support implementation of new programs and practices using the Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grants administered by SAMHSA. Consider additional sources of funding through the Older Americans Act, Medicaid, and the Affordable Care Act (e.g., health homes), among others.

**Educate, train, and support the workforce.** Help staff develop skills to adopt new practices. Curricula are helpful, but didactic training is not enough; field mentoring is a more effective approach to ensuring long-term skills development.‡

**Establish metrics to measure success.** Use data to determine what works, for whom it works, and in what type of setting it works, including an assessment of cost-effectiveness. Fidelity and outcome measures can be used for continuous quality improvement.**

**Choose a pilot or statewide rollout.** Mandate broad adoption of new practices through financial incentives and requests for proposals. Consider funding pilot projects that can be expanded statewide. Beginning small before taking a new program or practice to scale is well aligned with the incremental learning that occurs as part of the implementation process.††

For more information, see the National Implementation Research Network.

IMPACT (Improving Mood—Promoting Access to Collaborative Treatment) is an intervention for older adults with a diagnosis of depression or dysthymia (a mild form of depression), often with another major health problem, provided in a primary care setting.

PACE (Program for All-Inclusive Care for the Elderly) is an interdisciplinary program that develops customized physical and mental health services for adults ages 55+ in an adult day health setting, supplemented with in-home visits.

PEARLS (Program to Encourage Active, Rewarding Lives) is a behavioral health program for older adults with a diagnosis of depression or dysthymia, offered in a person’s home or other community setting, such as a senior center.

Prevention and Management of Alcohol Problems in Older Adults is a program that includes screening, assessment, brief intervention, and referral for adults ages 60+ with problem drinking.
Grow the Workforce To Meet Increasing Demand

As the U.S. population ages, the demand for individuals trained to work with older adults who have behavioral health problems will far outstrip the supply of trained professionals and paraprofessional staff available to provide care. This section highlights:

- The diversity of the current behavioral health workforce.
- The need for staff members dedicated to addressing older adult behavioral health.
- Strategies for educating and training providers who work with older adults.

Assemble a Diverse Workforce for a Growing Older Adult Population

The workforce that serves the behavioral health needs of seniors is as diverse as the members of the older adult population. Approximately 971,000 aging services providers reach more than 10 million adults each year. Social service providers, case managers, and senior center staff offer disease prevention, health promotion, and healthy aging services and supports. Geriatric psychiatrists, geriatricians, geriatric psychologists, and substance misuse prevention and treatment providers serve older adults with mental and substance use conditions and comorbid physical health problems. Direct care workers, including certified nurse assistants and psychiatric attendants, care for individuals at home and in nursing facilities. State mental health commissioners and SSA directors increasingly must address the needs of a growing older adult population.

Downsizing and consolidation at state and local levels mean that many professionals providing older adult behavioral health services do not have specific training in mental and substance use disorders in this population. Prevention and early intervention efforts often occur in care settings that serve older adults but do not have specific services for behavioral health conditions (e.g., adult day services centers, assisted living facilities, home health agencies, nursing homes). These professionals need to participate in state behavioral health training plans. Workforce shortages and changes in where services are provided can be expected for the foreseeable future. In response, states are adopting policies that expand the workforce available to serve older adults and are beginning to provide behavioral health training across all service settings.

Successful prevention and treatment efforts consider the situational risk factors that affect older adults. In particular, older adults frequently face a series of losses and life transitions that impact their health and well-being, including death of partners and friends, social isolation, change in social roles, declining health, impaired mobility, and preparing for end of life. Behavioral health services and their desired outcomes can be very different for older adults than they are for their younger counterparts. For example:

- **Medication and alcohol misuse:** Many older adults have multiple medical issues that require medication. Older adults have been shown to be at greater risk of adverse drug reactions from medications such as narcotics and benzodiazepines, especially when taken improperly or when used with each other and with alcohol. In addition, older adults often take many medications at one time, which can lead to drug–drug interactions and medication side effects that result in functional and cognitive impairments.

- To address these issues, states could include information in public documents and training materials on the risks for adverse
drug–drug and drug–alcohol reactions for this age group.

- **Complex diagnoses:** Diagnosing behavioral health conditions in older adults can be complicated by such factors as comorbid medical and behavioral health conditions, cognitive and functional impairments, behavioral and cognitive side effects of medications, and grieving and depression related to losses that often come with old age. Family members and professionals may mistakenly assume that depression is a normal part of aging.²⁴

- **Publically available information to senior services providers on comorbid mental and physical health conditions and the importance of screening for these conditions in older adults can be reminders to screen more systematically.**

- **Fear of discrimination and bias:** Older Americans cite stigma and the discrimination that results as a leading reason for not seeking behavioral health treatment.²⁴,²⁵

- **Stigma and bias felt by older adults, their providers, and caregivers can be addressed through education and champions (e.g., knowledgeable providers, well-known older adults who have experienced these negative attitudes).**

- **Limited resources:** Many older Americans either do not have the financial resources to seek behavioral health treatment or do not know how to access state and federal resources that are available to them.²⁴,²⁵

- **States can provide materials to agencies, providers, and the public on how older adults can access needed resources.**

- **Different outcome goals:** Older adults often have different goals for treatment outcomes than do younger people. Maintaining independence and “aging in place” by continuing to live in one’s own home, for example, are among the most important treatment goals for older adults, along with improved quality of life.²⁴,²⁶

- **Providers, senior service agency personnel, senior center staff, and others who work with older adults need training regarding client goals and best practice methods to work with clients on their behavioral health concerns.**

The needs of older adults with complex medical and behavioral health problems can be difficult to address, given the often complicated billing regulations. Individuals older than 65 are eligible for Medicare, which includes hospital, medical, and prescription drug coverage. Many individuals with serious mental illnesses have low incomes that qualify them for Medicaid; one in five people are dually eligible for both programs.²⁷ Some states do not allow health centers to bill Medicaid for the costs of providing multiple services to the same individual on the same day, such as a behavioral health session and a physical health service. Other states prohibit same-day billing for certain combinations of behavioral health services. Medicare released updated rules on same-day billing for mental health and primary care services in the Medicare fee-for-service program in 2013.²⁸ However, only 55 percent
of psychiatrists accept Medicare, compared with 86 percent of other specialties. These complex and sometimes conflicting regulations may impact decisions about the types of providers able and willing to serve older adults with behavioral health needs.

**Expand the Behavioral Health Workforce for Older Adults**

To address workforce shortages, states are cross-training behavioral health providers to work with older adults and training other healthcare practitioners to provide behavioral health services to their older patients. Older adults are being trained to serve their peers with behavioral health issues. This expanded workforce is beginning to fill some of the gaps for this population, as noted below.

**Behavioral Health Providers**

Mental health workers, ranging from psychiatrists to nursing assistants, often do not have specific training in working with older adults, although it is available in many fields (e.g., subspecialty certification in geriatric psychiatry, a gerontology specialty for social workers). Although subspecialty certification may be time intensive and costly, short continuing education programs focused on the needs of older adults may be a reasonable option for advanced practice professionals and direct care workers. The Geriatrics Workforce Enhancement Program of the Health Resources and Services Administration is a grant program that provides interdisciplinary education on working with older people to healthcare professionals. Eligible applicants include training programs in clinical psychology, social work, marriage and family therapy, and behavioral and mental health practice.

The substance use disorder treatment workforce includes providers from many different professions, including physicians, nurses, social workers, psychologists, counselors, case managers, and providers of recovery support services. Counselors are the backbone of the addictions treatment system; before the mid-1970s, many were individuals in recovery who received minimal training. Most treatment professionals are now licensed or certified. However, the treatment workforce is aging, compensation often is low, and turnover rates are high. Moreover, substance use disorder treatment of older adults is complicated by co-occurring physical health conditions, stigma, and ageism. SAMHSA’s TIP 26: *Substance Abuse Treatment Among Older Adults* provides important information about serving this vulnerable group.

**EXPAND THE BEHAVIORAL HEALTH WORKFORCE**

- Cross-train behavioral health staff in older adult issues and train healthcare providers in behavioral health issues relevant to older adults using a common training platform.
- Explore collaborative strategies with higher education and certification institutions, such as scholarships, loan forgiveness, and promotion of curriculum tracks for older adult issues.
- Advocate for Medicaid and Medicare revenue optimization in behavioral health services to expand the provider base willing to serve older adults.
- Incorporate older adult workforce recruitment and retention strategies into existing state behavioral health workforce development efforts, including service gap analysis and staff retention activities.
- Expand recruitment of an older adult workforce to include older adult peers and volunteers who can provide supportive services and examine programs that can serve multiple populations.
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Substance use disorder prevention specialists work with community and state organizations to change the environment in which substance misuse norms and behaviors exist. Like the rest of the behavioral health care workforce, the prevention workforce suffers from a shortage of mid-career professionals. Currently, many substance use disorder prevention specialists are focused on youth and young adults and may need training in translating population and programmatic strategies to the needs of older adults who have specific risk factors for late-life depression, substance misuse, and suicide.

**Primary Care Physicians and Providers**

Primary care is where most people first present with mental and substance use issues. Primary care and internal medicine practitioners are required to screen older adults for depression and cognitive impairment under Medicare’s Annual Wellness Visit program, but there is a shortage of professionals to whom these doctors can refer patients for follow-up. Training physicians and others who work in primary health settings—including nurses and nurse practitioners, physician assistants, allied healthcare professionals, and social workers/case managers—would begin to fill this gap. Additional education could be obtained through targeted continuing medical education/continuing education programs, such as Screening, Brief Intervention, and Referral to Treatment (SBIRT)—a substance misuse early intervention program specific to those in primary care. The National Institute on Alcohol Abuse and Alcoholism offers a number of alcohol misuse screening tools for use in primary care, such as AUDIT and CAGE (feeling the need to Cut down, Annoyed by criticism, Guilty about drinking, and need for an Eye-opener in the morning).

**Service Providers**

The barriers to recruiting new direct care workers specifically for older adults’ behavioral health needs range from the stigma associated to working with people at the end of life to low wages. Strategies to attract more people to the field include loan forgiveness, scholarships, and higher compensation. Providing education on behavioral health needs of older adults within the standard curriculum in training programs for direct care staff may increase the skills of staff members who interact with older adults on a regular basis.

Aging services providers, including those who work at senior centers, retirement communities, and Meals on Wheels programs, may be among the first to notice a behavioral health problem among older adults. AoA supports many of these efforts through Area Agencies on Aging and Aging Disability Resource Centers. To educate those who come in contact with older adults, the Question, Persuade, and Refer (QPR) Gatekeeper Training for Suicide Prevention is a brief educational program similar to programs teaching cardiopulmonary resuscitation; it provides training to non-clinicians how to recognize signs of increased risk of suicide in older adults. SAMHSA’s Get Connected! Linking Older Adults with Medication, Alcohol, and Mental Health Resources toolkit helps individuals learn about alcohol...
and medication misuse and mental health problems in older adults. It includes a program coordinator’s guide, suggested curricula, and handouts.

**Lay Community Health Workers and Peer Supporters**

Older adults themselves are an untapped resource. Training older adults in the behavioral health needs of their peers has proved effective in small programs in developing countries. This could be particularly helpful in minority and ethnic communities. The population of older adults in minority communities is expected to increase between 16 and 25 percent in the next 25 years. Cultural competence will become increasingly important. In addition, faith-based workers may be important resources.

Training programs include Mental Health First Aid, an 8-hour program that teaches participants how to identify, understand, and respond to signs of mental illnesses and substance use disorders. The Certified Older Adult Peer Specialists (COAPS) model was developed by the State of Pennsylvania with funds from a SAMHSA Transformation Transfer Initiative grant. COAPS trains peers to meet the health and wellness needs of older adults.

**Making It Work**

Michigan has partnered with several state universities to increase interest in and knowledge of behavioral health care for older adults. The Mental Health and Aging Project, funded by the Michigan Department of Community Health, is a program at Lansing Community College. The program offers education, training, and consultation for clinicians and other workers in Michigan’s community mental health system that provides services for older adults. The program has a robust library of resources and offers conferences and training. The state also has an Alzheimer’s disease education project through Eastern Michigan University and offers monthly grand rounds teleconference calls with the Geriatric Education Center of Michigan.

While Michigan has concentrated on enhancing training for professionals, Massachusetts has put programs in place to train nonprofessionals. Massachusetts’ COAPS program trains older adults to become peer support specialists. The Office of Elder Affairs plans to develop a training program for personal care and home health providers to work with people who have behavioral health disorders. In New Hampshire, the Department of Health and Human Services’ Bureau of Drug and Alcohol Services supports the Referral, Education, Assessment, and Prevention (REAP) statewide program for older adults and their families. The REAP program trains adult-serving agencies to screen, educate, and assess older adults to mitigate the potential danger associated with combined alcohol and prescription drug use. Families and other caregivers receive education about the dangers of mixing alcohol and prescription medication and assistance in managing their use.

**Resources: Where To Learn More**

- **Treatment of Depression in Older Adults Evidence-Based Practices KIT.** The toolkit offers information about an array of evidence-based practices for treatment and services to improve outcomes for older adults with depression.
- **Late Life Suicide Prevention Toolkit.** This educational program helps frontline providers, medical and mental health care clinicians, and healthcare trainees identify suicide warning signs, assess resiliency factors, and manage suicide risks among older adults.
- **Older Americans Behavioral Health: Issue Briefs.** SAMHSA and AoA developed this series and accompanying webinars for behavioral health and aging services providers to address behavioral health issues of older Americans, including alcohol misuse, prescription drug misuse, suicide, anxiety, and depression.
References


15 Center for Substance Abuse Prevention. (2009). Identifying and selecting evidence-based...


