Behavioral Health Services and Older Adults: Coordinating Care Across Systems and the Lifespan

2025

Part of the *Advancing Crisis Care and Beyond* series on next steps for promoting safety and fostering well-being

SAMHSA
Substance Abuse and Mental Health Services Administration

Behavioral Health Services and Older Adults: Coordinating Care Across Systems and the Lifespan

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Abstract

The number of older adults in the United States, and their share of the population, will continue to increase over the next several decades. The increase in the number of older adults with serious mental illness (SMI) will present new challenges to public mental health systems and systems on aging. This paper begins with a brief description of the shifting demographics of older adults in the United States and older adults served by the public mental health system. It continues with a discussion of ways in which state mental health agencies (SMHAs) can coordinate policy and care with other agencies, such as state units on aging and area agencies on aging. The paper presents several examples—from Colorado, Indiana, New York, Oregon, and Tennessee—of innovative ways to coordinate treatment, improve the workforce serving older adults, and ensure that crisis services are capable of meeting the needs of older adults.

Highlights

- Older adults represent a growing percentage of the U.S. population, with the share of those over age 85 increasing the fastest. This demographic shift necessitates a tailored approach to the behavioral health needs of older adults.
- States are pursuing innovative paths to improve the coordination of behavioral health care for older adults. These innovations can occur at state and local levels and include coordinating policy between state agencies and coordinating care between different providers and systems.
- To ensure that older adults with behavioral health needs are effectively supported, services designed to serve older adults must be equipped to address behavioral health needs, and services designed to serve people with behavioral health needs must be equipped to address the specific needs of older adults.
- Most older adults, including those with behavioral health conditions, prefer to age in place (i.e., at home). Care plans should prioritize these preferences to the extent possible.

Recommendations

1. People with SMI have a significantly higher rate of premature mortality and experience significant health decline at an earlier age compared to people without SMI. Therefore, older adult mental health services may consider focusing on people younger than age 65, because people with SMI may already show significant age-related disabilities at ages 50–55. Prevention of chronic disease and care coordination efforts may be more effective when targeting people with SMI who are even younger, such as those ages 45–50.
2. Older adults with behavioral health conditions should be involved in all aspects of improving the planning, implementation, and evaluation of behavioral health services. This involvement includes the expansion of older adult peer specialist programs.
3. SMHAs should have regular high-level communication with the state unit on aging, single state agencies for substance use, and the state Medicaid agency to establish a framework through which to coordinate policy that facilitates behavioral health care for older adults. This framework can set the stage for behavioral healthcare providers to develop deeper ties with area agencies on aging to coordinate care for older adults with SMI.
4. SMHAs may consider clarifying for their state who is responsible for older adult behavioral health services. They should empower this person to be a champion for the specific needs of older adults and to work with other state agencies on coordinating policy and developing contracts for providers that meet the needs of older adults with SMI, including those with co-occurring substance use disorders.
5. Caregivers play an important role in enabling older adults with SMI to remain in the community. SMHAs should consider identifying means to support these caregivers with education and connect them with other supports outside the mental health system.
6. SMHAs should ensure that as they build greater crisis system capacity, services coming online are able to serve older adults effectively. This can help divert older adults with SMI from higher levels of care.

Introduction

The U.S. population is aging, and older adults represent a growing percentage of the total population due to a variety of factors, including increased life expectancy and the aging of the baby boomer generation. The number of older adults with serious mental illness (SMI)* is expected to similarly increase and will therefore present new challenges to public mental health systems and systems on aging. The definition of "older adults" can be inconsistent across various systems, resulting in service gaps and fragmentation. For example, Medicare serves nondisabled people ages 65 and older, but other programs with federal funding sources (such as the Older Americans Act [OAA], see page 13) serve people ages 60 and above, while some states offer older adult services to adults who are even younger.

The issue of distinguishing at what age someone becomes an older adult is discussed further below, but the question is especially relevant in the context of SMI, since, as one multistate study showed, people with SMI die on average between 13.5 and 32.2 years earlier than the general population.[1] More recent studies have confirmed the premature mortality of people with mental illness, with one study in Michigan determining that people with SMI die on average 16 years earlier than the general population, while those with both SMI and substance use disorder (SUD) die on average 31 years earlier.[2] However, a recent retrospective cohort study that followed individuals served by a large private health system across 8 years found that those with SMI and/or SUD died 6.3 years earlier than comparison groups.[3]

These sobering statistics about early mortality—and similar findings documenting an increased burden of social isolation—among people with SMI and SUD call attention to the need to create clearer pathways toward care and prevention. Yet, the services that can help adults as they age are spread across several state and federal systems with multiple funding sources that each have their own target populations and eligibility requirements. Since state mental health authorities (SMHAs) may not have deep relationships with the state and local agencies that provide services to older adults, effective service coordination can be challenging. As this paper shows, several states have begun to bridge this coordination gap.

One important consideration for states, particularly when planning services or coordinating with other agencies, is how social determinants of health impact older adults' behavioral health. Housing, food insecurity, social isolation, access to quality health care, and nonhazardous working conditions are among the social determinants of health that states should address in their plans for older adult behavioral health. SMHAs should review the definitions of these determinants to ensure their relevancy and appropriateness in the context of older adults. Taking housing as an example, SMHAs should ensure that older adults have access to housing that is appropriate for aging in place. With an increasing number of older adults continuing to work (or going back to work),[4] SMHAs should also examine the employment supports they offer older adults. The Substance Abuse and Mental Health

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* According to the legal definition (Substance Abuse and Mental Health Services Administration, 58 Fed. Reg. 29425 [1993]), "adults with serious mental illness" are persons

- age 18 and over,
- who currently or at any time during the past year,
- have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R [and subsequent revisions],
- that has resulted in functional impairment which substantially interferes with or limits one or more life activities.

Services Administration (SAMHSA) provides financial supports to states and providers, such as Projects for Assistance in Transition from Homelessness (PATH), and funds other initiatives, such as the Homeless and Housing Resource Center, that SMHAs can use to support the housing needs of older adults. In addition, as this paper discusses, the OAA provides resources and mandates a service delivery structure that addresses several social determinants of health, including housing supports, access to food, and social isolation.

To provide context for these issues and to help SMHAs better understand the existing landscape of aging services and coordinate services more effectively, this paper describes the projected size of the older adult population and its proportion of the overall population through 2050; examines the evidence for the prevalence of SMI among older adults; provides an overview of relevant legislation, including the OAA, and outlines the key state and local agencies that serve older adults, including state units on aging (SUAs) and area agencies on aging (AAAs); and describes some state initiatives that provide innovative and coordinated care to older adults, including through crisis services. The paper ends with case studies from Colorado, Indiana, New York, Oregon, and Tennessee, describing their activities to improve the mental health of older adults.

Behavioral Health Services and Older Adults: Coordinating Care Across Systems and the Lifespan is part of the FY2024 Technical Assistance Coalition paper series "Advancing Crisis Care and Beyond: Next Steps for Fostering Well-Being and Promoting Safety." This series aims to build upon the work being done to implement the 988 Suicide & Crisis Lifeline and the behavioral health services continuum that complements it, while pushing forward progress in prevention, safety, resiliency, and recovery. Beginning with the "umbrella paper" that covers leading policy themes related to each of the subsequent papers, the series highlights key areas of consideration and puts forth recommendations for specific strategies to advance crisis care, promote personal and community safety, and foster well-being.

This paper reviews existing literature to identify key challenges within the behavioral health system related to providing services for older adults. Using data from SAMHSA and other sources, the paper outlines the demographics of older adults as part of the overall population, as well as the demographics of older adults who access behavioral health services, including crisis services. The paper briefly reviews legal issues that may mediate or otherwise impact how older adults access these services.

The authors introduced the concept behind this paper to states during a National Association of State Mental Health Program Directors (NASMHPD) Older Adults Division meeting and incorporated feedback to refine key ideas and inform the development of the paper. Based on their knowledge of innovative programs, the authors also conducted semistructured interviews with leaders of older adult initiatives in five states: Colorado, Indiana, New York, Oregon, and Tennessee. Interview questions explored state definitions of older adults; innovative behavioral health services for older adults in the state; older adult services in inpatient and community settings, including crisis services; and legal issues related to older adult behavioral health services. The state-specific case studies that emerged from these interviews helped inform the recommendations of this paper by providing concrete examples of innovative approaches to address the behavioral health needs of older adults.

Overview of older adults and SMI

THE TRANSITION TO OLDER ADULTHOOD

Helping people transition to older adulthood by maintaining their physical and mental health, social connections, and skills enables them to thrive within the community. As noted above, the age at which a person is considered to become an older adult varies across systems. The OAA specifies that SUAs and AAAs should serve people who are 60 years of age and over, since many of the services funded by the OAA are social supports that seek to prevent premature mortality. Medicare becomes available as a health insurance payor for most people at age 65, and the Census Bureau and other government agencies use that age as the lower bound when discussing older adults. It is also an age often associated with retirement, although for persons born in 1960 and later, the Social Security Administration now defines full retirement age as 67. The varying definitions of older adults across systems and programs result in challenges to healthcare delivery, including fragmentation and service disruptions due to coverage factors related to eligibility.

States may provide older adult mental health services to people as young as 55 or even 50. These services rely on funding sources that are not tied to age, such as state general revenue funds or SAMHSA Community Mental Health Services Block Grant (MHBG) dollars. Providing behavioral health services to transition-age older adults is essential, given the reduced life expectancy of adults with SMI, who experience increased rates of early mortality linked to inadequately managed co-occurring chronic conditions such as hypertension, heart disease, diabetes mellitus, asthma, and emphysema.[5] For this reason, when states plan behavioral health services for older adults, they often use a lower bound that is under 65 years of age. In fact, AAAs have a mandate to provide services to people 55 and older.

This paper does not assume a single definition of older adults but will, when possible, specify what the working definition of older adults is in each given circumstance. However, most data related to older adults is predicated on a conception of older adults as age 65 and older.

PREVALENCE AND DEMOGRAPHICS OF OLDER ADULTS

People ages 55 and older made up 21.1 percent of the population in 2000, 24.9 percent in 2010, and 30.1 percent in 2023; the respective figures for those ages 65 and older were 12.4 percent, 13.0 percent, and 17.5 percent (**Figure 1**).[6,7,8] The percentages for both groups are expected to continue to grow in the foreseeable future, although the age distribution among older adults will change over time.

Figure 1: Percentage of the U.S. Population 55+ and 65+ in 2000, 2010, and 2023

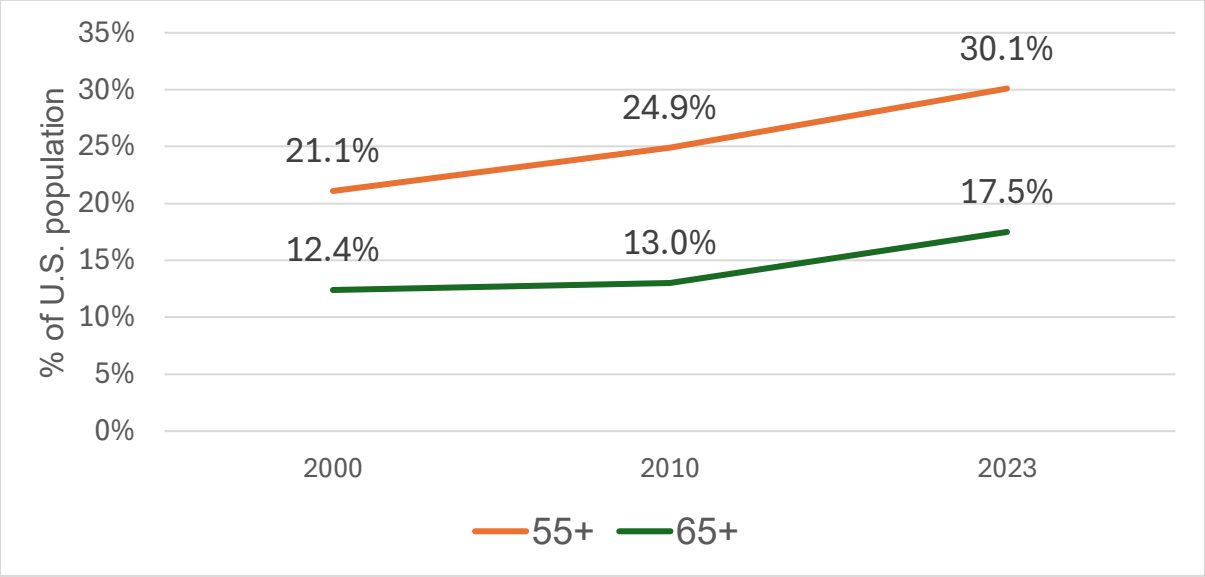


Figure 2 shows the population pyramid for the United States in 2022, which is the baseline figure for Census population predictions.[9] This pyramid already demonstrates the effect of the baby boomer generation (individuals born between 1946 and 1964) on the proportion of the population who are older adults. Within a population pyramid, the total percentages across all age groups and sexes add up to 100 percent; thus, changes in the proportions between age groups change the shape of the "pyramid."[†] In 2022, the modal age group was 30 to 34 and the median age in the country was within this age group.

[†] In fact, the term "pyramid" is a relic from a time when the population structure had not undergone a demographic transition; a high birth rate was paired with a lower survival rate into older adulthood, resulting in a chart in which, except in the event of significant effects of war and disease, each succeeding age group made up a smaller percentage of the population and thus produced the overall shape of a triangle, or pyramid.

Figure 2: 2022 Population Pyramid (Estimates Baseline)

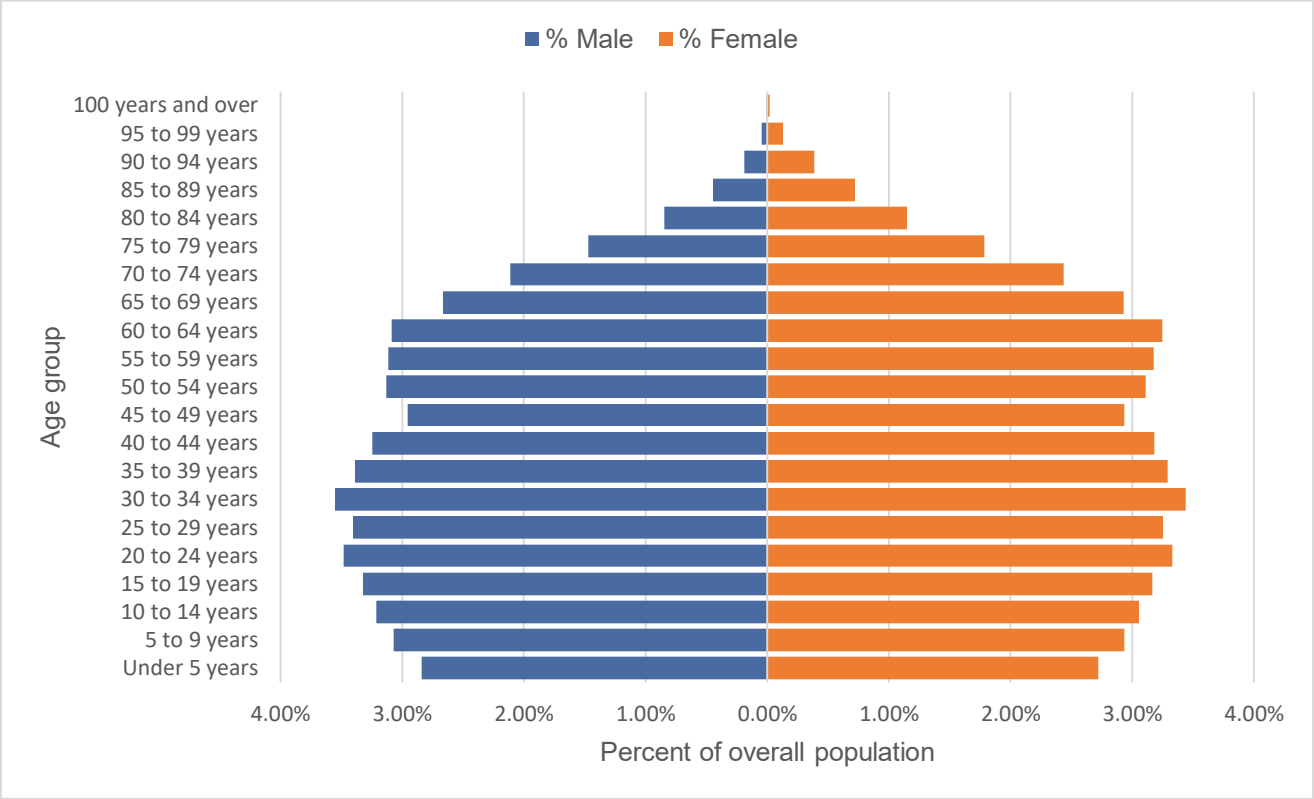
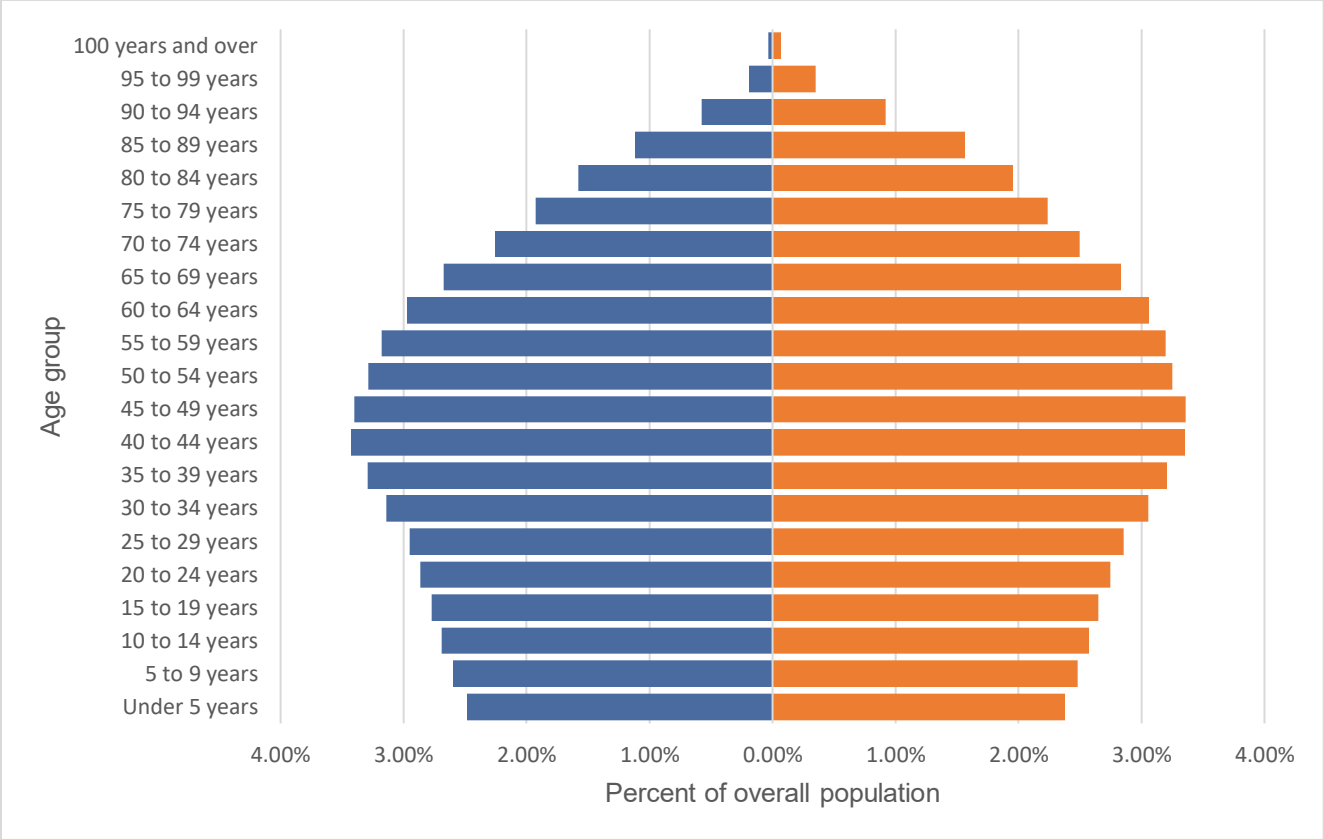


Figure 3 shows the predicted population pyramid for 2050. Across a total population of 360.6 million, the progressive aging of the population continues, with the age of the modal age group rising to 40 to 44.[10] From 2022 to 2050, almost all age groups above age 40 will see increases in their percentage of the population, with the exception of men and women ages 60 to 64 and women ages 65 to 69. The age groups 80 to 84 and 85 to 89, which include the youngest baby boomers, will increase their percentage the most. If mortality among the large base of older adults decreases leading up to 2050 due to improvements in medical technology, this pyramid could show a pronounced increase in the percentage of the population in the oldest age groups.

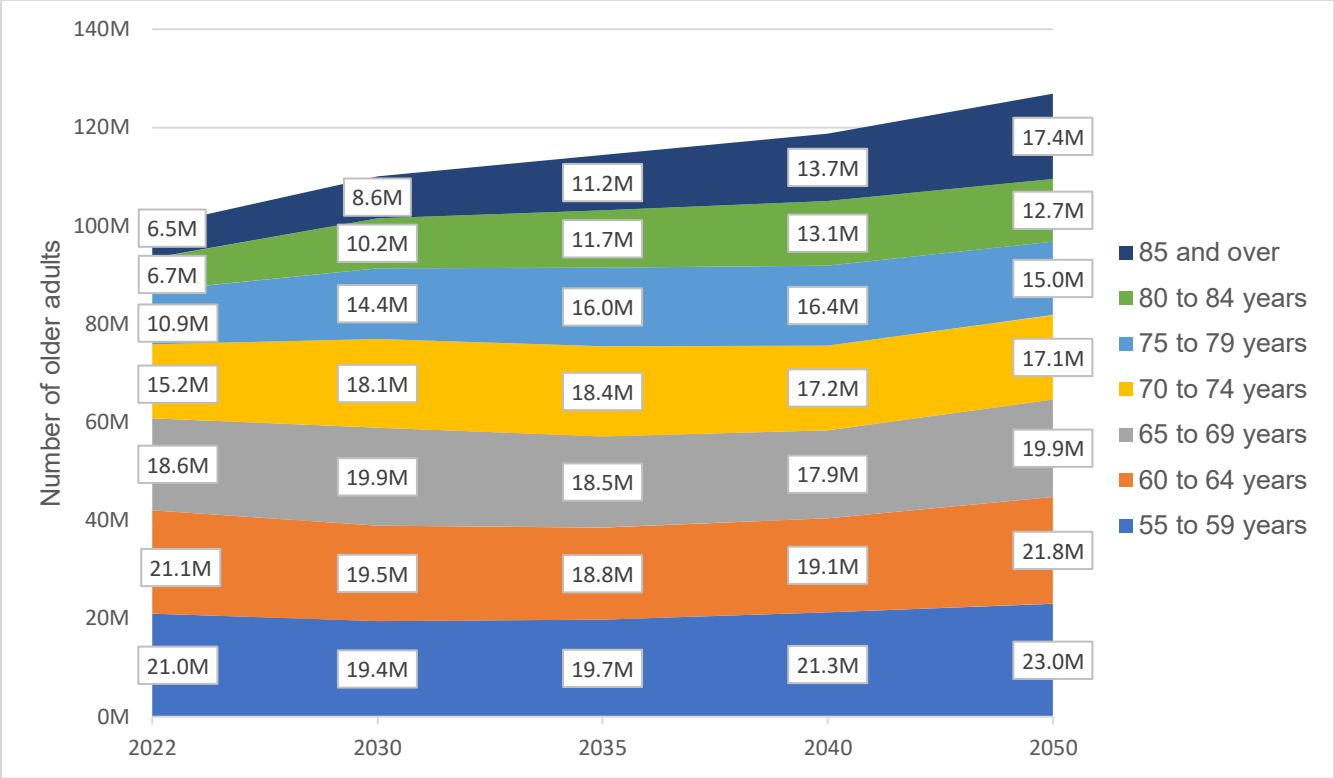
Figure 3: 2050 Population Pyramid (Projection)



Changes will not be even across all older age groups. **Figure 4** shows how the oldest age groups will grow the most quickly, while younger age groups will shrink before starting to grow again.[11] This phenomenon shows the youngest baby boomers progressing through the age groups in question. The population share of individuals ages 55 to 69 will increase by 2050 as millennials—people born between 1981 and 1996—enter older adulthood.

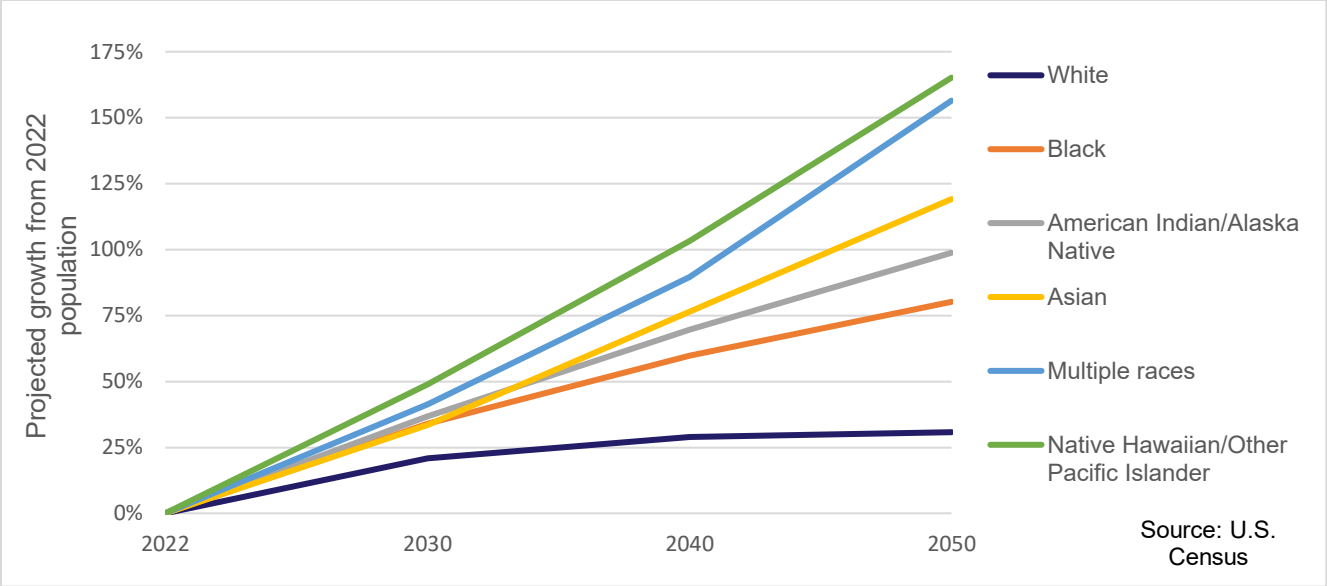
The number of the oldest adults, ages 85 and older, will increase the most, from 6.5 million in 2022 to 17.4 million in 2050. The number of adults ages 80 to 84 will almost double in this time period, while the number of adults ages 75 to 79 increases by nearly 50 percent. Other age groups will also increase from 2022 to 2050, but not as much as the oldest age groups. These changes are visible in the population pyramids above as well, although there the low absolute population of the oldest age groups (85-plus) obscures the increase in the percentage of the overall population that these groups represent over time.

Figure 4: Changes in Projected Population of Older Adults Over Time, by Age Group of Older Adults



A demographic shift among older adults is expected between now and 2050. **Figure 5** shows the projected increase in the number of older adults by race from 2022 to 2030, 2040, and 2050 as a percentage of the 2022 population of each race. While all races will see population growth across these years, the growth of the 65-plus White population, projected at 31 percent between 2022 and 2050, is expected to be slower than the growth of the populations of other races. The 65-plus Black population will grow 80 percent by 2050, while the 65-plus American Indian / Alaska Native population will double and the 65-plus Asian population will increase almost 120 percent during the same time frame. The number of 65-plus individuals who identify as belonging to more than one race will increase even more quickly, growing 156 percent by 2050. Finally, the Census Bureau projects that the population of Native Hawaiians and Other Pacific Islanders who are 65-plus will increase at the highest rate of any racial group, seeing 165 percent growth between 2022 and 2050. However, the number of older adults (65-plus) of all races who identify as Hispanic will increase faster than any racial group, growing 182 percent from 2022 to 2050.

Figure 5: Projected Growth in the Population 65+ From 2022 to 2050, by Race



OLDER ADULTS WITH SMI

SMI affects older adults differently than younger adults, as age intersects with social determinants of health to create personal and social situations that impact all aspects of a person's life. Older adulthood often brings an increased risk of social isolation and the presence of one or more chronic health conditions. Older adults are more likely than younger adults to live alone and to have lost one or more loved ones. Loneliness, social isolation, and social disconnection are linked to declines in cognitive function over time and increased risk of suicide.[12,13] Chronic health conditions are associated with a higher probability of developing depression.[14] Conversely, having an SMI is also associated with a higher chance of developing other chronic health conditions.[15]

Remaining in the community and having access to quality housing are important determinants of health for older adults, affecting health outcomes and social isolation. Yet, older adults with SMI are more likely to have experienced houselessness by age 50 and are more likely to continue to experience houselessness as older adults.[16] Older adults with SMI are also at increased risk of being admitted to a nursing home.[17]

One study found statistically significant higher rates of medical emergency department visits and longer lengths of medical hospitalizations in older adults with SMI in comparison to controls without SMI, even when adjusting for comorbidities and other relevant covariates.[18] Additionally, the odds of being diagnosed with dementia and the prevalence of dementia diagnoses are higher among older adults with SMI.[19]

EXTENT OF SMI AMONG OLDER ADULTS

Estimates of the prevalence of SMI among older adults show significant variation. The National Comorbidity Survey Replication (NCS-R), from 2002–2003, found that 1.2 percent of Americans ages 65 and older met the criteria for having SMI.[20] However, according to a more recent report utilizing

diagnostic codes, over 22.7 percent of Medicare enrollees had SMI.[21] The Medicare population is not directly comparable to the overall population because it includes people under the age of 65 who have been eligible for Social Security Disability Insurance (SSDI) for 24 months or more; in 2021, 21.2 percent of these individuals were eligible for SSDI due to SMI.[22]

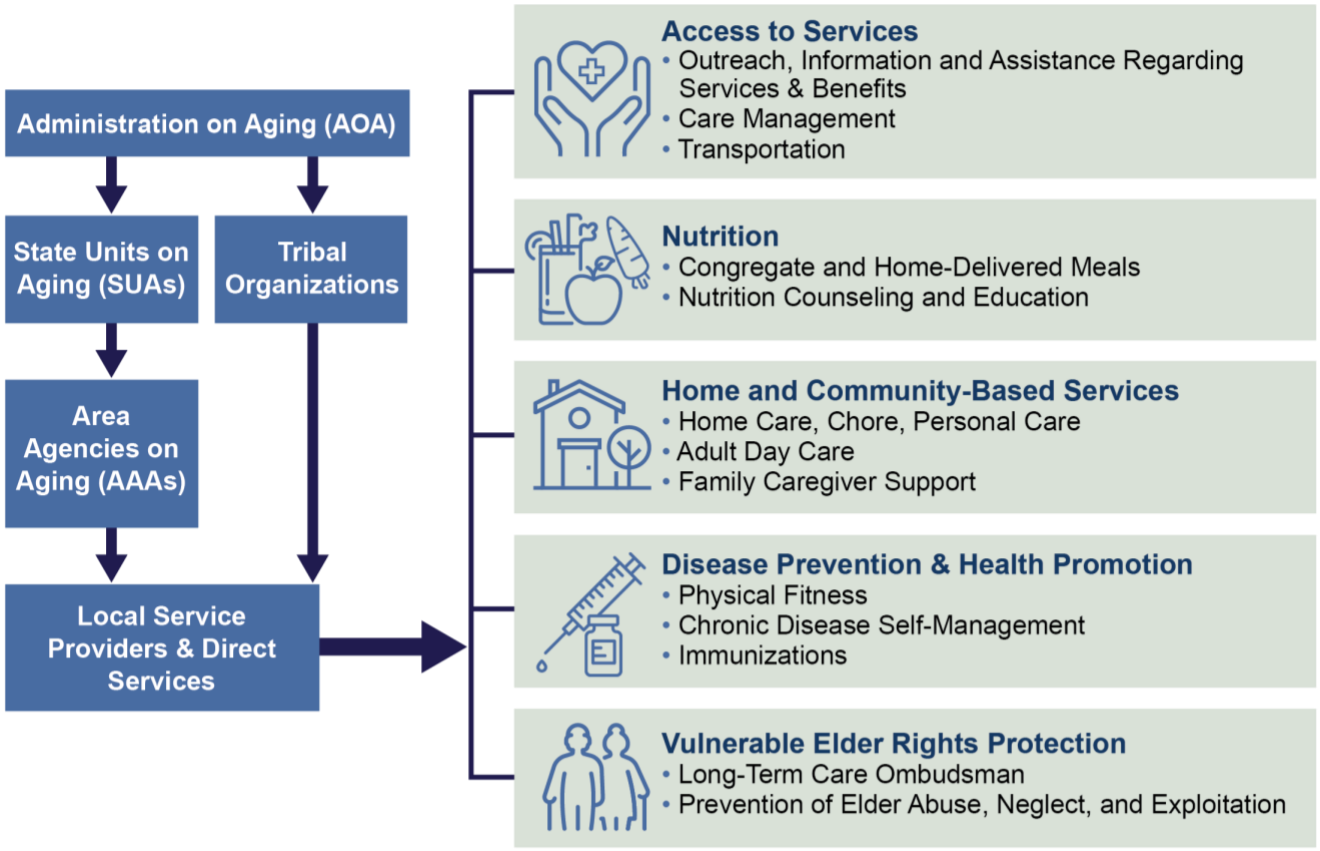
The 2021–2022 National Survey on Drug Use and Health (NSDUH) estimated that 1.9 percent of adults ages 60 and older had SMI, including 2.6 percent of women and 1.1 percent of men.[23] The NSDUH also estimated that 12.5 percent of adults ages 60 and older had any mental illness, including 14.8 percent of women and 9.8 percent of men. An estimated 3.5 percent of adults 60 and older had experienced a major depressive episode, with 4.5 percent of women experiencing an episode and 2.4 percent of men.[24] Among adults 60 and older, 1.7 percent had had serious thoughts of suicide, with similar rates for men and women.[25] Both older men and older women attempted suicide at similar rates, 0.2 percent, but the rates of those who died by suicide were much higher for males (30.2 per 100,000) than for females (5.6 per 100,000).[26] However, according to the NSDUH, among adults ages 65 and older who reported having had a substance use or mental health problem, 82.5 percent identified as being in recovery, a higher rate than among other age groups.[27]

State structure of services for older adults

Multiple state and substate agencies fund and provide services for older adults, including behavioral health services, and coordination between aging and behavioral health systems is of paramount importance to the quality and completeness of care provided for older adults with SMI.

SUAs and AAAs play important roles in determining the availability and location of services for older adults. Similar to SMHAs, SUAs are legally designated agencies that have specific obligations toward the aging populations of their state, with access to federal funding appropriated specifically to meet those obligations. AAAs are substate entities designated by the SUA and recognized federally as recipients of OAA funding from the Administration on Aging. AAAs provide services directly or contract with local providers to deliver services in their service area (**Figure 6**).

Figure 6: The Structure of OAA-Funded Aging Services



Source: Colello, K. J., & Napili, A. (2024). *Older Americans Act: Overview and funding* (Congressional Research Service Publication No. R43414). https://crsreports.congress.gov/product/pdf/R/R43414

Most services, even those originally targeted toward older adults, are not provided exclusively to older adults. SUAs and AAAs can serve people of all ages who have a disability, especially if they need long-term care. SUAs and AAAs also provide services to caretakers of all ages. Around three-fourths of AAAs serve these two populations in addition to older adults, and around half of AAAs serve people with dementia even if they are under 60 years old.[28] Among both SMHAs and SUAs, combining older adults and people with disabilities into a single service population is common. Typically, entities designated as SUAs are aging and disabilities agencies,‡ with a focus on long-term services and supports. Across the SMHAs interviewed for this report, the individual responsible for older adult services in the state is often in charge of the Preadmission Screening and Resident Review (PASRR), which is the screening tool used for nursing home placements. This role also highlights the connection between disability and older adult services within the organizational structure of the SMHA.

‡ This is why the National Association of State Units on Aging changed its name to ADvancing States in 2019.

THE OLDER AMERICANS ACT

In 1965, Congress passed the OAA in order to strengthen services for older adults in the community through grants to state, local, and tribal agencies. Grants can cover social services for older adults, research projects, and training for staff who work with older adults.[29] The act established the Administration on Aging, which is now housed within the federal Department of Health and Human Services' Administration for Community Living and administers all OAA grants. The OAA defines older adults as persons ages 60 and over. The OAA was reauthorized in 2020 and was due to be reauthorized again in 2024.

Congress has amended the OAA with each reauthorization, and the 2020 version of the act includes mental health as a core goal, as highlighted in the second objective:

> *"The best possible physical and mental health (including access to person-centered, trauma-informed services as appropriate) which science can make available and without regard to economic status."*[30]

The OAA authorizes supports for income, housing, transportation, and social connection, which can be important social determinants of health. A significant majority of older adults wish to stay within their communities as they age, and the OAA aims to support older adults to do that. Services funded by the OAA are an important complement to older adult behavioral health services provided by SMHAs and offer an opportunity to support interventions addressing social determinants of health that can be difficult to fund through other sources.

Since its reauthorization in 1973, the OAA has stipulated that states work with local organizations and governments to designate AAAs, which are associated with a specific geographic area within the state and may be a local government, a nonprofit agency, or a collaborative agency involving more than one local government.

For more information about funding social determinants of health interventions, see the 2024 Technical Assistance Coalition paper *Financial Strategies to Enhance the Scope of Care Provided in Crisis Services and Stabilization by Addressing Social Determinants of Health and Health-Related Social Needs*.

From the perspective of SMHAs seeking to understand how the OAA complements behavioral health services, it is useful to consider how OAA funding is invested. In fiscal year 2021, 44.8 percent ($951.8 million of $2,125 million) of OAA funding was directed to nutrition supports for older adults.[31] Nutrition support programs fund meals for seniors to be delivered to their homes or consumed in congregate settings. Another 19.1 percent ($405.0 million of $2,125 million) of OAA funding supported job opportunities for adults 55 years of age or older.[32] A further 18.5 percent ($392.5 million of $2,125 million) funded a wide range of supportive services, including case management, information and referral assistance, transportation, and homecare services.[33] Finally, 8.9 percent ($188.9 million of $2,125 million) provided supports to caregivers.[34] The mix of services available in any given location, particularly for supportive services and supports for caregivers, will vary depending on local needs and the capabilities of the providers that the AAA contracts with.

AREA AGENCIES ON AGING

Every state is divided geographically into AAAs. The AAA designation makes the entity eligible for OAA funds and provides the authority to expend these funds. However, such a designation does not specify the structure of the AAA. According to USAging, 42 percent of AAAs are independent, nonprofit agencies; 31 percent are part of city or county government; 23 percent are part of a council of governments or a regional planning and development agency; and 4 percent have some other structure.[35] These structures vary regionally across the country, with some regions, such as New England and the Great Lakes states, relying almost exclusively on nonprofits to function as AAAs, while other regions, such as the South, rely much more heavily on councils of government and regional planning and development agencies to serve as AAAs.[36]

The Administration for Community Living provides funds directly to the more than 600 AAAs across the country.[37] Funding of AAAs is complex, with many potential sources of funding and great differences in the payor mix across states. According to USAging, OAA is the single largest funding source across AAAs, with all AAAs receiving at least some OAA funding and some AAAs receiving all their funding from the OAA. A majority of AAAs also receive state and local funding. Recently, over 80 percent of AAAs also received COVID-19 relief and American Rescue Plan Act funds. Less than half of AAAs receive Medicaid funds, but Medicaid represents the second-largest amount of funding across all AAAs.[38]

The organization USAging represents AAAs and OAA Title VI programs. Its website contains an abundance of information and data about all OAA-funded organizations and programs, their roles, and the challenges they face.

STATE UNITS ON AGING

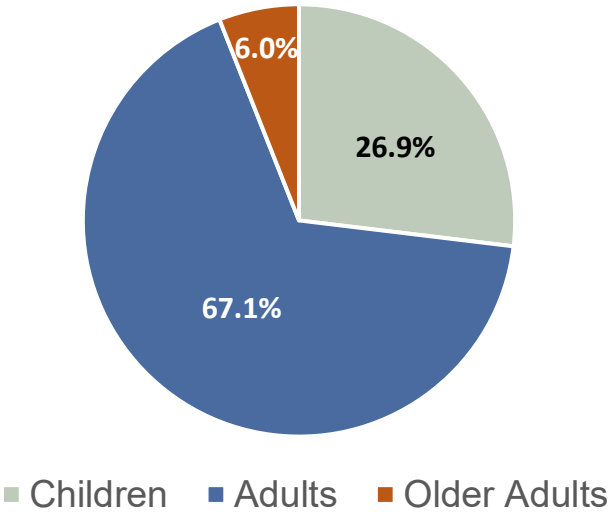
Every state has a designated SUA, which has specific responsibilities regarding the OAA. One of the requirements of the OAA is that every SUA maintain a State Plan on Aging, which is a multiyear plan that spells out the structure of services for older adults in the state (including those funded by the OAA), state intentions to improve services, and state plans to change services in order to accommodate changes in the demographics of older adults. Specifically, the plan addresses items relevant to the core programs of the OAA, home- and community-based services, caregivers, and state efforts to improve service delivery access and older adult outcomes. In addition, the State Plan on Aging must specify how the state will prioritize serving older adults with the greatest economic and greatest social need. States work closely with community members, individuals served, providers, and others to formulate their plans and can choose to write a plan that lasts 2, 3, or 4 years. SUAs are responsible for designating AAAs within their state, and in small and/or sparsely populated states SUAs have the option to operate as the AAA for their state.

More information about SUAs can be found at the website for ADvancing States, which represents the directors of the 56 state and territorial units on aging.

STATE MENTAL HEALTH AGENCIES AND OLDER ADULTS

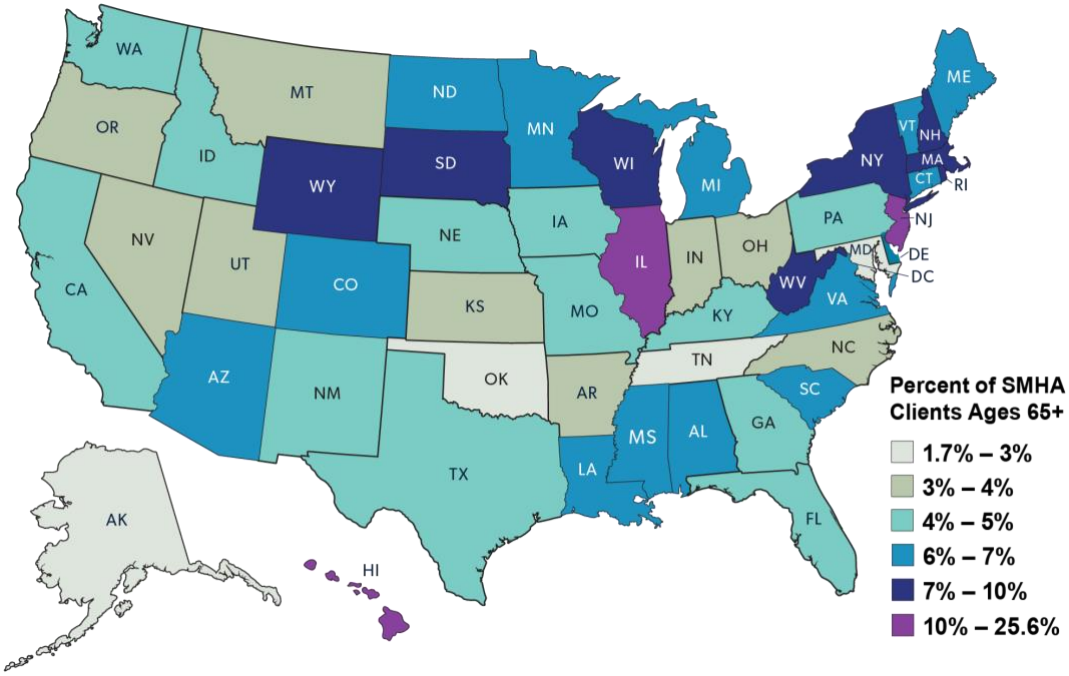
According to 2022 data from the Uniform Reporting System, to which states must report in order to receive the MHBG, adults ages 65 and older accounted for only 6 percent of individuals served by the public mental health system (**Figure 7**).[39]

Figure 7: Percentage of Children, Adults, and Older Adults Served by the Public Mental Health System, 2022



Map 1 shows the variation in the percentages of individuals served by SMHA who are ages 65 and older across states. While some differences between states may be due to differences in older adult population size, state policy and system structure may also play a role. Across states, the lowest percentage of older adults among individuals served by SMHAs was 1.7 percent, in Maryland, and the highest was 25.8 percent, in New Jersey, even though Maryland and New Jersey have similar older adult population sizes. The median percentage of older adults served across states was 5.2 percent.

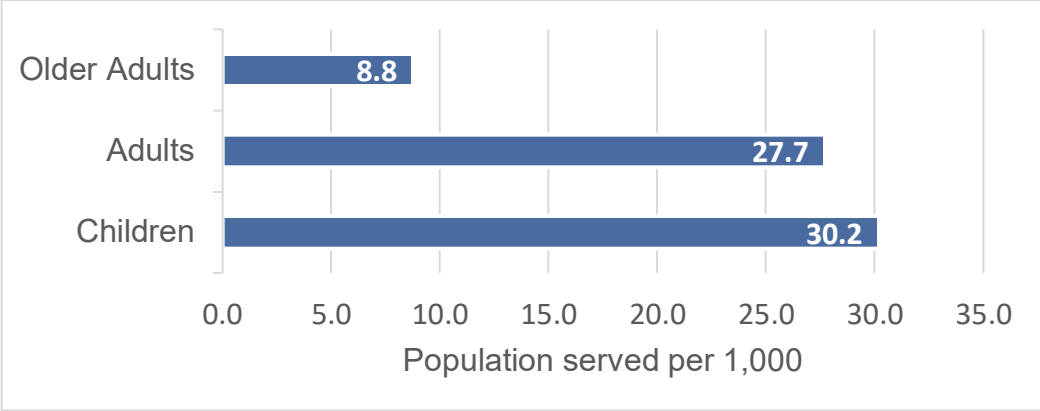
Map 1: Percentage of Adults Ages 65 and Above Among Individuals Served by SMHAs



Source: Substance Abuse and Mental Health Services Administration. (2023). *Uniform Reporting System*. U.S. Department of Health and Human Services.

Figure 8 displays the rates of public mental health system utilization per 1,000 total population. Adults ages 65 and older were served at lower rates than adults ages 18 to 64 and children. Across states, the lowest rate of older adults served was 1.1 per 1,000 population, in Nevada, while the highest was 56.2, in New Jersey. The median rate of older adults served per 1,000 population across states was 6.7.

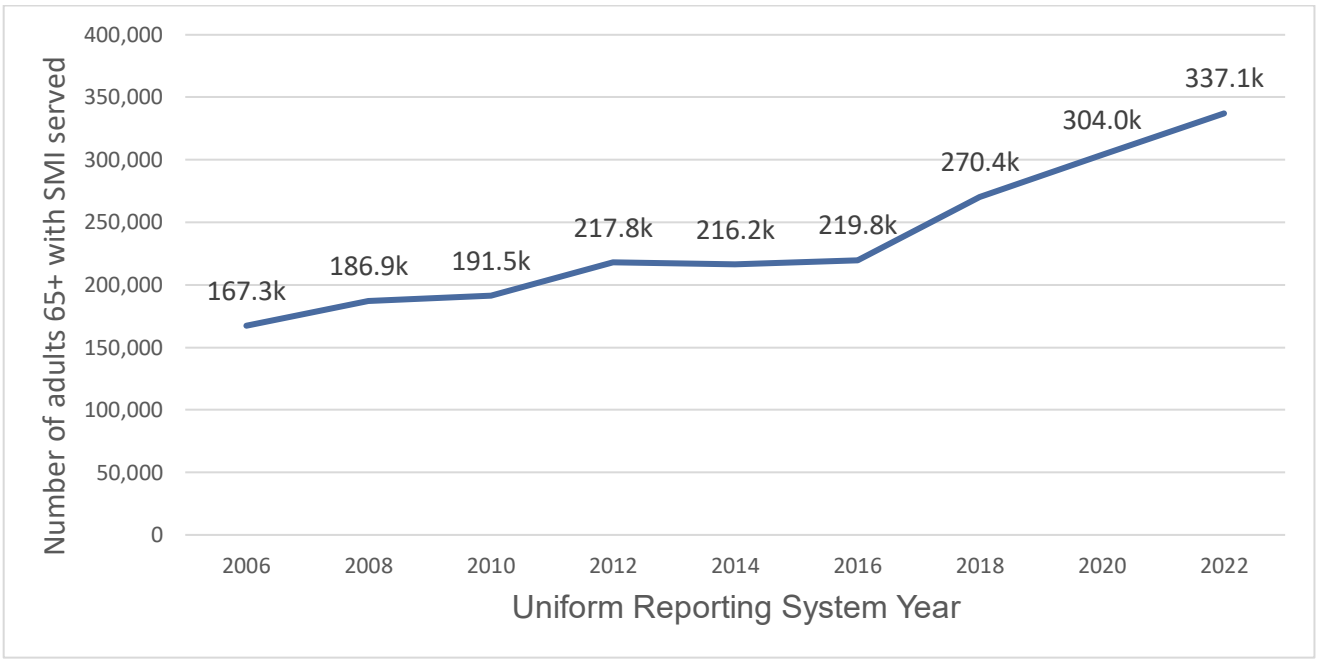
Figure 8: Utilization Rate for Children, Adults, and Older Adults, 2022



Source: Substance Abuse and Mental Health Services Administration. (2023). *Uniform Reporting System*. U.S. Department of Health and Human Services.

However, as **Figure 9** shows, the number of older adults served by the public mental health system has increased significantly over time, growing from 167,300 individuals served in 2006 to 337,100 in 2022, an increase of 101 percent.

Figure 9: Number of Older Adults With SMI Served by the Public Mental Health System, 2006–2022



Source: Substance Abuse and Mental Health Services Administration. (2023). *Uniform Reporting System*. U.S. Department of Health and Human Services.

SMHAs are serving increasing numbers of older adults, and shifting demographics make this trend likely to continue through the middle of this century. SMHAs and their partners need to be able to effectively coordinate behavioral health care for older adults and address the specific needs of older adults across care settings, including in crisis services. The next section will discuss innovative ways in which SMHAs are approaching this challenge.

Community mental health system opportunities

COORDINATING BEHAVIORAL HEALTH CARE FOR OLDER ADULTS

A review of the literature reveals the opportunities and challenges older adults encounter in the pursuit of behavioral health services as well as the gaps in current behavioral health and aging systems. Since multiple state and local agencies are responsible for aspects of supporting older adults, including overseeing or funding specific behavioral health services, care coordination can require working across administrative "siloes." These siloes may present challenges to the integration of policy and resources at the state level and to the coordination of treatment at the provider and individual level. Further complicating this coordination is the significance of Medicare as a payor for many older adults and the differences in service coverage between Medicare and Medicaid. However, many older adults are dually eligible for both Medicare and Medicaid and thus able to benefit from the coverage options of both systems.[40] States can approach behavioral health care for older adults with different levels of top-down requirements for interagency coordination.

Following are specific examples from a few selected states. More information can be found in the detailed state reviews at the end of this paper.

- New York has established legislative requirements for the coordination of behavioral health for older adults. Since 2005, the Office of Mental Health (OMH) and other state agencies have been required to work together to coordinate care and policy for older adults in need of behavioral health services. The agencies coordinate via a planning council, which can decide on the recipients of multiyear demonstration grants to foster coordinated and innovative care; the council is required to report annually to the governor on the activities and results of the council and the grants.
- Indiana's Division of Mental Health and Addiction (DMHA) is housed within the Family and Social Service Administration, which also includes the Division of Aging. DMHA recently hired an Older Persons Initiatives and Supported Employment Director to coordinate behavioral health care for older adults across Indiana's social service agencies. In 2023, DMHA provided funding to 16 AAAs across the state to improve the identification of older adults with behavioral health issues and their connection to treatment. More broadly, this funding seeks to ensure coordinated care for older adult behavioral health issues within the AAAs, improve knowledge of behavioral health among AAA staff members, and identify gaps and opportunities in the provision of behavioral health care to older adults.
- Oregon has taken a different approach to the coordination of behavioral health care for older adults. Recognizing the lack of coordination of clinical care for individual older adults at the local level and the lack of connection between local behavioral health agencies and providers and the AAAs, Oregon's Behavioral Health Authority, as part of its Older Adult Behavioral Health

Initiative, created a new position of older adult behavioral health specialist. The 26 behavioral health specialists, who each serve one or more counties, directly coordinate the care of complex cases as part of a multidisciplinary team and provide training to behavioral healthcare providers on older adult issues and to the staff of assisted living facilities and nursing homes on behavioral health care.

SUPPORTING PEOPLE LIVING WITH BEHAVIORAL HEALTH CONDITIONS IN LONG-TERM CARE SETTINGS

Interviewed states reported that facilities that serve older adults who need help with activities of daily living (ADLs), such as assisted living facilities and nursing homes, are frequently unable to provide necessary supports to individuals with behavioral health issues. As a result, older adults living in assisted living facilities or nursing homes who experience an exacerbation of psychiatric symptoms are often sent to hospital emergency departments for evaluation, which frequently results in the individual being admitted to a psychiatric unit. States report that staff in assisted living facilities and nursing homes lack training in behavioral health conditions, and facilities may not have policies in place regarding how to address certain issues, such as behavioral health crises, thus leading to overuse of emergency departments. In addition to providing increased training, states should also consider ways to divert older adults from long-term care settings, such as through the use of health homes. The health home model can improve access to quality primary care and effective management of chronic disease.[41] Health homes are not just for older adults, and their availability across the lifespan, especially in the decades preceding older adulthood, could allow older adults with SMI to avoid a level of disease burden that requires long-term care.

Oregon is working to address this issue by ensuring that every county has a designated older adult behavioral health specialist who can train assisted living facility and nursing home staff on how to manage behavioral health issues in older adults. Colorado is modifying Medicaid contracts to require that assisted living facilities and nursing homes in the state be able to provide for the behavioral health needs of older adults. In support of this effort, Colorado's SMHA is creating training modules that assisted living facility and nursing home staff can use to improve their skills and confidence in working with older adults who have behavioral health conditions.

States can direct nursing facility administrators and staff to the resources available at the SAMHSA-funded Center of Excellence for Behavioral Health in Nursing Facilities. This center provides accredited live and recorded training to nursing facility staff on how to serve individuals with SMI in long-term care settings. The center also offers nursing facility staff the opportunity to participate in a more comprehensive six-session training program with other facilities in their region. In addition, nursing facilities can request tailored technical assistance if they are facing an issue not addressed by existing training and resources.

ENSURING THAT CRISIS SERVICES CAN MEET THE NEEDS OF OLDER ADULTS

Crisis services designed to meet the needs of the general adult population may not meet the specific needs of older adults. Crisis call center staff, mobile crisis teams, and crisis receiving and stabilization facilities staff may benefit from training on how mental health symptoms may manifest in older adults and how to serve older adults with co-occurring behavioral health and other medical conditions. Neurocognitive disorders can complicate the assessment and communication process, making it difficult for crisis responders to accurately determine the severity and nature of the crisis. Physical

health issues, such as mobility limitations and chronic illnesses, may require responders to have specialized medical knowledge and equipment, such as accessibly designed transportation and facilities to accommodate wheelchairs. Other challenges, such as hearing and sight impairments, and dental problems, may further exacerbate communication barriers. Moreover, older adults may have limited social support, increasing their isolation and vulnerability during crises. As part of their screening and assessment of an older adult, states should include a determination of whether the individual has a psychiatric advance directive or wellness recovery action plan that includes a designee who could assist behavioral healthcare providers during interventions and act as a temporary decision maker for consent, if needed.

Coordination between emergency services, mental health professionals, and healthcare providers is crucial but often lacking, which can hinder the effectiveness of the crisis response. The scarcity of behavioral health services that are equipped to help with ADLs also complicates the crisis system's ability to serve some older adults in the least restrictive setting possible.

Orange County, California, has developed an Adult In-Home Crisis Stabilization Program that allows for crisis services to be provided to adults, including older adults, at home, avoiding many of the difficulties encountered when serving individuals who need help with ADLs at behavioral health facilities. As Oregon determined, for older adults with complex, co-occurring medical and behavioral health conditions, the most effective care requires a multidisciplinary team.

In its curriculum for crisis call center employees, Indiana includes a module on helping older adults in crisis. As mentioned, one potential complication in addressing crises in older adults is the presence of co-occurring neurocognitive conditions. To address this intersection, Colorado has created a "Supporting People With Dementia in Crisis" training module. It is part of the free online Crisis Professional Curriculum that Colorado's Behavioral Health Administration created to facilitate entry into careers in the crisis services workforce.[42]

These state initiatives seek to address the need for enhanced training for crisis call center staff, mobile crisis teams, and crisis receiving and stabilization facilities staff on the specific needs of older adults, including managing cognitive impairments and chronic health conditions. Another opportunity to improve crisis outcomes for older adults involves developing stronger partnerships with AAAs to ensure a more coordinated and integrated response. As providing education and training for caregivers and family members of older adults is a role of the AAAs, the SMHA can work with the AAAs to provide training for caregivers on the skills needed to manage and support older adults during and after a crisis, as well as provide information about how to access resources in a complex system of multiple agencies and types of support.

State Initiatives to Address the Behavioral Health Needs of Older Adults

The following state case studies were informed by interviews the authors conducted with representatives from each state's SMHA during the spring of 2024, along with supporting materials related to each state's initiatives, either provided by the state or obtained online.

COLORADO

The Colorado Behavioral Health Administration is working to improve the availability of behavioral health services for older adults by expanding the potential workforce, increasing the number of services billable to Medicare, and ensuring that behavioral healthcare providers and assisted living facilities are equipped to provide care to persons who need help with ADLs and persons with SMI, respectively.

Challenges faced by the state include many behavioral health inpatient facilities' inability and/or unwillingness to accept individuals who have chronic health conditions and who need help with ADLs. In addition, the Medicare behavioral health services reimbursement rate is lower than the Medicaid rate, which may discourage new providers from serving older adults. Medicare also does not cover many of the services that Medicaid does, such as peer support.

Colorado is currently renegotiating Medicaid contracts with providers and adding language to ensure that community providers, assisted living facilities, and other long-term care settings are capable of providing for the behavioral health needs of older adults. Recognizing a gap in these providers' knowledge about the unique needs of older adults with SMI, the Behavioral Health Administration is creating training modules for providers about behavioral health assessments and interventions for older adults that will be available via the agency's learning management system.

Colorado also has two state-level initiatives aimed at improving the lives of older adults, both of which were established in view of the significant growth in the older adult population that will occur over the next decade in the state. The first, Colorado's Strategic Action Plan on Aging, chartered by the Colorado State Assembly[43] established eight goals centered on ensuring the independence of older adults in Colorado, supporting their ability to live in the community and to engage in the workforce and volunteering sector for as long as possible. The plan also covers the needs of caregivers and recognizes the importance of expanding the workforce serving older adults through improved compensation. The plan further lays out the need for state and local governments in Colorado to strengthen efforts to meet their commitments to older adults in their communities. Finally, the plan emphasizes efforts to better protect older adults from abuse and neglect.

In 2022, building on the strategic plan, the Colorado Commission on Aging (CCOA) was redesigned. This redesign expanded membership of the CCOA to include representation from state agencies and also led to the creation of the Lifelong Colorado initiative,[44] which encourages cities and towns to become age-friendly and livable communities that are "characterized by access to reliable transportation, safe and affordable housing, economic opportunities in later life, social engagement, and access to health care…"[45] Lifelong Colorado created a set of action steps and indicators to gauge the success of the implementation of the strategic plan and identified key partners within state and local governments for each goal. Communities throughout the state have already made progress on becoming age-friendly by coordinating existing services and identifying gaps. Some of the services that have emerged from these gap analyses include improved transportation for older adults in rural areas and ensuring that more trails are wheelchair accessible or more appropriate for persons with reduced mobility. While Lifelong Colorado does not explicitly target the behavioral health needs of older adults, it seeks to improve social determinants of health across the state and recognizes a wholistic vision of successful aging within the community.

INDIANA

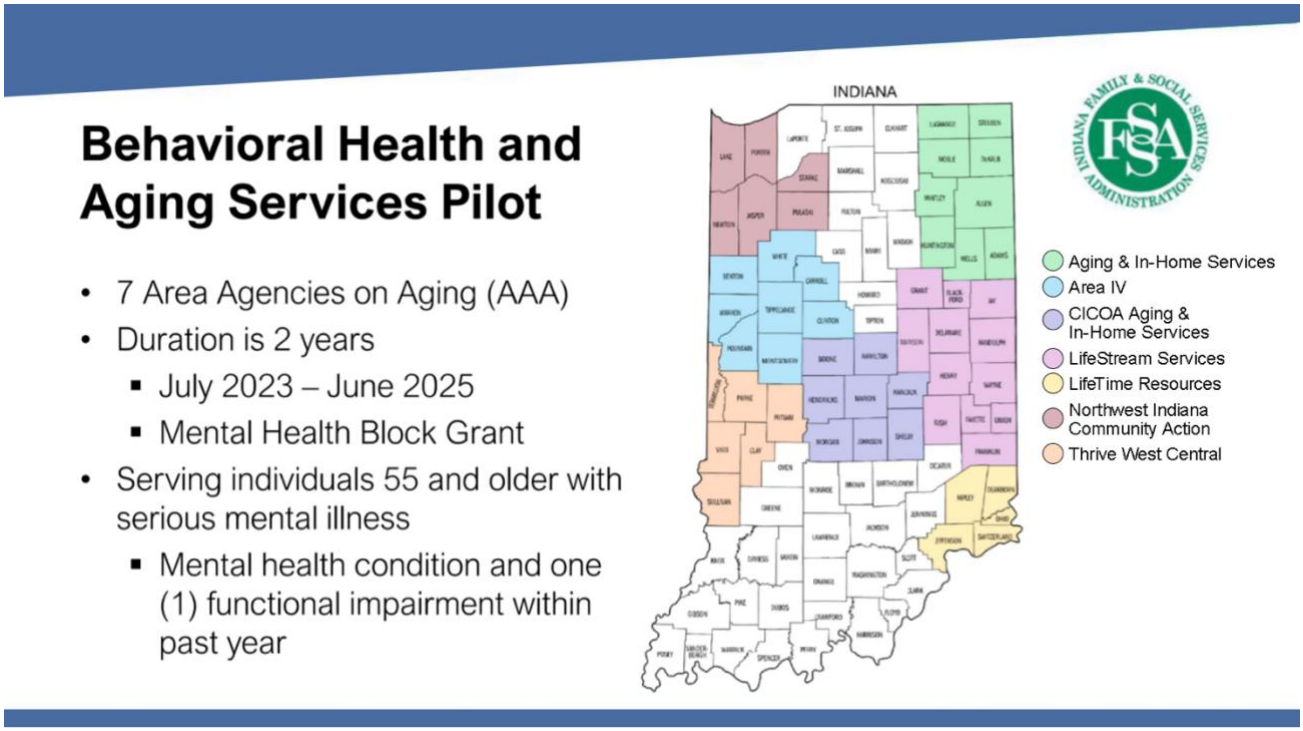
In Indiana, the Family and Social Services Administration (FSSA) comprises the Division of Family Resources; the Division of Disability, Aging, and Rehabilitative Services (DDARS); the Division of Mental Health and Addiction (DMHA); and the Office of Medicaid Policy and Planning. In 2022, Indiana created an Older Persons Initiatives and Supported Employment Director position, housed within DMHA.

In 2023, DMHA, in partnership with DDARS, began a 2-year initiative in conjunction with 7 of Indiana's 15 AAAs to improve the coordination and provision of behavioral health care for older adults within their service areas (**Figure 10**). Using $4 million in MHBG funding, each of the 7 participating AAAs will provide five core services:

1. Identification of members with behavioral health needs
2. Connection of these members to behavioral health services
3. Coordination with other providers
4. Increasing AAA staff knowledge of behavioral health
5. Identification of opportunities and gaps in behavioral health services for older adults

In addition, each AAA identified one or more additional services to provide beyond the core services. The Wabash Valley Region AAA partnered with Mental Health America to establish a warm line. Another AAA is seeking to expand its behavioral health workforce, while another is adopting a behavioral health assessment tool that could be used by AAA staff and volunteers to improve their ability to identify behavioral health issues among older adults.

Figure 10: Area Agency on Aging Grant—State of Indiana



In January 2024, as part of his 2024 Next Level Agenda, Governor Eric Holcomb announced that he was directing FSSA to work with all levels of government as well as with providers and other community organizations to create a multisector plan for aging (MPA).[46] DDARS included DMHA and a stakeholder group in the development process of the MPA through the Age Forward Together initiative. This plan does not target a specific age range, as it seeks to ensure that citizens in Indiana are able to access age-appropriate services throughout their lifespan. According to the interstate collaborative that provides support nationally in the development of MPAs, the plan will help "to create a coordinated system of high-quality care and support services that promote healthy aging, independent living, and social engagement, while also addressing issues related to healthcare, housing, transportation, and other social determinants of health."[47] DDARS and DMHA both plan to integrate behavioral health into the MPA.

DMHA defines older adults as those ages 55 and older but recognizes that understanding the needs of persons with SMI who are younger (as young as age 50) is important, since people with SMI die so much younger than the overall population. Similarly, expanding the opportunities for reaching older adults and supporting them in improving their health before they find themselves in crisis or die prematurely is an important part of an MPA. DMHA will work with DDARS to sketch out what aging-friendly communities in Indiana look like for all people, including individuals living with SMI.

DMHA's Older Persons Initiatives and Supported Employment Director indicated that a recent past challenge in Indiana was that older adults were not a targeted population within DMHA. This has changed with her appointment and the governor's increased focus on healthy aging. However, there remain ongoing challenges for older adults. As in other states, assisted living facilities or long-term care settings are not designed for caring for individuals with SMI or SUD. Similarly, inpatient and residential behavioral health settings are not designed for individuals who may need assistance with ADLs. A related issue is the lack of transitional services for persons who have SMI and need help with ADLs.

NEW YORK

Under Governor Kathy Hochul's administration, New York has launched several initiatives to ensure that mental health and aging services are aligned to support the well-being of older adults, including those experiencing mental health and substance use challenges. In 2022, Governor Hochul issued an executive order that required the New York State (NYS) Department of Health and NYS Office for the Aging to convene a council to advise the governor on the development of an NYS Master Plan for Aging (MPA). This MPA Council is comprised of representatives from many state agencies, including OMH. An important part of the process for creating the NYS MPA is listening sessions held throughout the state, to ensure that recommendations in the MPA are informed by community members and the lived experience of older adults and caregivers. The MPA is scheduled to be completed in January 2025.

In 2023, in planning for the governor's significant expansion in mental health funding, OMH conducted 40 community engagement feedback sessions with more than 1,700 individuals from across the state. Among the many recommendations that emerged from this process, two addressed older adults: (1) increase supportive housing for older adults and (2) encourage older adults with lived experience of mental health conditions to return to school to become service providers. OMH is currently exploring these recommendations.

THE NEW YORK STATE GERIATRIC MENTAL HEALTH ACT

Coordination of mental health care for older adults across state agencies is established legislatively in the state of New York.

The Interagency Geriatric Mental Health and Substance Use Disorder Planning Council has 19 members and four co-chairs: the commissioner of OMH, the director of the Office for the Aging (OFA), the commissioner of the Office of Addiction Services and Supports (OASAS), and the director of the Division of Veterans' Affairs. The council's 15 other members include 4 members appointed by the governor; 4 members appointed by the legislature; the adjutant general of the Division of Military and Naval Affairs; and representatives from the Department of Health, the Office for People With Developmental Disabilities, and the Office of Children and Family Services, as well as representatives from other agencies. The council meets to share innovative practices for meeting older adults' needs across service systems, discuss improvements in service provision for adults ages 55 and older with co-occurring cross-system needs, and coordinate care and policy responses to address these service gaps and improve access. One of the ways these gaps can be addressed is through the geriatric service demonstration grants.

Passed in 2005, the Geriatric Mental Health Act comprises three components:

1. An Interagency Geriatric Mental Health and Substance Use Disorder Planning Council
2. A geriatric service demonstration program
3. An annual report to the governor and the legislature on the activities and results of the council and demonstration program

New York is now in its fifth round of Geriatric Mental Health Act demonstration grants. OMH oversees these grants in partnership with OFA and OASAS. The first round began in 2007 and the latest round began in 2022. The grants are multiyear, although the length of the grants varies from round to round. The latest round, which runs from 2022 through 2027, targets the ongoing negative impact caused by the COVID-19 pandemic on older adult mental, behavioral, and physical well-being and is called the Partnership to Support Aging in Place in Communities Severely Impacted by COVID-19 (PSAP).[48] The state awarded $9 million over 5 years to six mental healthcare providers in New York City, Orange County (north of New York City), and Nassau County (on Long Island). All the projects aim to support older adults' aging in the places of their choice in their communities, whether they are living in privately owned homes or rented apartments, including subsidized OMH supportive housing or other designated housing specific to older adults. Project goals include identifying and engaging older adults at risk for hospitalization and/or losing community tenure; providing mobile outreach to older adults in their communities and homes; helping older adults and families navigate across care systems and access needed services; improving treatment of co-occurring conditions, including mental health conditions, substance use or SUD, and aging-related and chronic physical health issues; and making use of peer support to improve engagement, reduce social isolation and loneliness, and better identify the needs, goals and preferences of older adults.

NEW YORK STATE OMH'S TRIPLE PARTNERSHIP MODEL

The Geriatric Mental Health Act demonstration grants have been a source of innovative practices for improving care for older adults in New York since their inception in 2007. Starting with the fourth round of grants from 2017 to 2022, grantees have been tasked with establishing triple partnerships between

providers addressing mental health, substance use, and aging. The goal of this requirement is to decrease service siloes and improve understanding within each system of how the other systems work, as well as to deepen the relationships and referrals between systems. Since most services are generally organized in a single administrative domain, the partnerships also required projects to develop innovative program models that spanned mental health, substance use / SUD, and aging services in a local, defined service region. In the most recent round of grants, OMH has required the participation of peers, or individuals with lived experience, in all projects. In fact, peers are considered key to meeting one of the primary goals of the fifth round of grants, which is to engage older adults who have been overlooked or excluded by the system. To promote the engagement of individuals with lived experience of mental health or substance use challenges, OMH does not require that projects only engage Certified Mental Health Peer Specialists or Certified Recovery Peer Advocates; projects can also engage community members with lived experience of mental illness and/or substance use / SUD who are interested in exploring certification. In addition, PSAP requires projects to support individuals through person-centered use of technology, which may range from automated pill boxes to tablets and robotics that align with the preferences of older adults being served by the local triple partnerships.

PROMOTING MENTAL HEALTH AND SUBSTANCE USE EXPERTISE IN SUPPORT OF OLDER ADULTS

OMH's long-standing commitment to meeting the specific needs of older adults, as well as its role in administering the demonstration program grants and serving as co-chair of the council, has allowed it to develop deep expertise in the care system for older adults. In 2017, in recognition of its cross-system work to support older adults, New York was designated the first age-friendly state in the country, according to AARP's Network of Age-Friendly States and Communities.

OMH has also supported the creation of learning materials that promote cross-service system understanding of older New Yorkers' needs relating to mental health conditions and substance use / SUD. The Mother Cabrini Foundation, one of the largest health-focused foundations in the country, funded the Home Care Association of New York State to produce "Addressing Healthcare Disparities Through Home Care," a free series of live recorded learning videos and supporting materials for homecare agencies; community-based aging, long-term care, and behavioral healthcare providers; and insurance companies working with people receiving home- and community-based services for multiple co-occurring conditions. These materials include a mental health training section that shares concrete examples of integrated, collaborative care approaches and information on the foundation of mental illness care provided by experts from NYS OMH and the University of Rochester's Finger Lakes Geriatric Education Center.

Another example of New York's work to improve mental health care for older adults is the OMH-funded Skilled Nursing Facility Enhanced Supports Program (SNF-ESP). SNF-ESP includes three components: (1) regular teleECHO (Extension for Community Healthcare Outcomes) sessions, offering a live, interactive online platform for clinical and nonclinical staff at nursing homes, OMH psychiatric centers, and residences; (2) telepsychiatry and teletherapy for residents of skilled nursing facilities; and (3) consultation with psychiatric nurses with geriatric experience for nursing home staff and primary care physicians providing medical care to nursing home residents. This program is a new community care model that provides enhanced supports and subject matter expertise to nursing home staff, and now primary care providers, allowing them to meet the mental health needs of individuals living with SMI and receiving care in a skilled nursing facility. The program further ensures that individuals meeting the criteria for skilled nursing facility admission and discharged from an OMH state-operated psychiatric

center or residence receive high-quality mental health care and expert clinical support for mental health and substance use needs.

The teleECHO sessions offered in SNF-ESP, known as the geriatric ECHO mental health (GEMH) in long-term care initiative, is operated by the University of Rochester Medical Center (URMC), and the team includes a psychiatrist, a nurse practitioner, a pharmacist, a geriatrician, and a social worker. GEMH seeks to improve the skills and confidence of long-term care staff who are working with older adults with mental health conditions, substance use / SUD issues, and/or dementia. URMC is also the provider of telepsychiatry consultation with long-term care staff and teletherapy for residents of skilled nursing facilities that are a part of SNF-ESP.

NYS OMH also offers the Older Adult Assertive Community Treatment (ACT) program, an evidence-based model with a recovery-oriented, integrated approach that delivers treatment, rehabilitation, case management, and support services. Mobile, multidisciplinary ACT teams engage with older adults who are diagnosed with SMI and whose needs have not been well met by more traditional service delivery approaches. Older Adult ACT specifically addresses risk factors associated with aging, such as social isolation / loneliness, cognitive decline and impaired executive functioning, Alzheimer's disease and other related dementias, psychosis, and chronic medical conditions.

In addition, OMH is exploring a housing initiative that would provide building modifications and enhanced specialty staffing to address the medical needs of older adults aging in OMH housing. Combining OMH housing with aging-friendly design and services is a promising model that OMH is investigating to improve health access for individuals aging with SMI.

OREGON

In 2015, in response to the increasing number of older adults in Oregon and the higher than national average rates of substance use and suicide among people ages 65 and older, the Oregon Health Authority (OHA) launched the Older Adult Behavioral Health Initiative (OABHI).[49] The OABHI comprises 24 older adult behavioral health specialists who cover all 36 counties in the state. These individuals are the champions for older adult behavioral health within their assigned county or counties. The behavioral health specialists have three primary responsibilities: (1) to collaborate and coordinate, connecting agencies within the counties that serve older adults and have traditionally been siloed; (2) to consult on complex cases, helping to coordinate care for older adults with comorbidities and who require care from multiple agencies; and (3) to level up the workforce through free training and education on issues related to older adults.[50]

Behavioral health specialists are generally credentialed as qualified mental health professionals, holding a master's degree or higher. However, in rural areas where it has been difficult to recruit specialists, individuals credentialed as qualified mental health associates, holding a bachelor's-level credential, can serve as behavioral health specialists. Oversight of the OABHI is provided by an OABHI project director, a position within the Behavioral Health Division of the OHA. The OABHI fosters collaboration and coordination between, among other entities, the Behavioral Health Division, community mental health centers, AAAs, and the Office of Aging and People with Disabilities, which is Oregon's SUA. These divisions and agencies have traditionally been siloed, resulting in fractured, sometimes duplicative services that have not been effective in meeting the needs of older adults with SMI. Funding for this initiative totals approximately $4 million, which comes from state general funds.

The behavioral health specialists coordinate between partners at different county and state agencies to increase access to behavioral health services for older adults. One way they do this is through multidisciplinary team complex care consultations that are available to anyone who serves older adults, regardless of insurance type. The goal of the multidisciplinary team is to offer community partners the opportunity to discuss complex cases that might otherwise "fall through the cracks." Behavioral health specialists also work to reduce barriers preventing providers from billing for older adult services, including by expanding the certifications that are allowed to bill Medicare. Ensuring that older adults with behavioral health issues can successfully remain in their homes is also a goal of the OABHI. Finally, behavioral health specialists have worked to grow the number of public guardians and provide support to family members willing to take on guardianship.

Another important role of the behavioral health specialists is to improve the workforce that serves older adults by providing training on behavioral health issues to staff across the continuum of care for older adults. This includes training the long-term care workforce on how to serve older adults with behavioral health conditions. Some of the training that behavioral health specialists have provided to staff in assisted living facilities, nursing homes, and adult foster homes includes behavioral intervention strategies, providing trauma-informed care, and identifying suicidality. Behavioral health specialists have also trained first responders and law enforcement on how to respond to behavioral health crises among older adults, including when the person in crisis has dementia. Ongoing training initiatives include a monthly Gerontology Education Hour and annual conferences on specific aspects of providing behavioral health services to older adults.

OABHI behavioral health specialists also engage community partners within each county in Oregon. Beyond the complex care coordination mentioned above, behavioral health specialists work to connect behavioral health systems with AAAs to overcome barriers jointly. These specialists build local alliances in order to identify gaps within local behavioral health care for older adults and brainstorm ways to bridge these gaps. These alliances have led to the development of solutions for specific issues, such as addressing hoarding and creating dementia-friendly communities.[51]

Finally, a further role of the behavioral health specialists is to work upstream on primary prevention, to improve the social determinants of health that influence mental health. One of the primary goals in this domain is to increase opportunities for social connection among older adults and thereby reduce loneliness. Behavioral health specialists have done this by organizing in-person and virtual meetups for older adults, allowing them to socialize, discuss issues they are experiencing, and share experiences and suggestions. Behavioral health specialists have also adapted a California-based hotline to Central Oregon, called the Senior Loneliness Line, which gives people someone to talk to and enables them to find out about other resources. Behavioral health specialists have set up the Oregon Senior Peer Outreach program, which connects isolated older adults living in rural areas with peer outreach specialists who are older adults with lived experience of mental illness. Similar to behavioral health specialists, these peer specialists are also empowered to design initiatives to address needs they identify among the older adults they serve.

Oregon is addressing suicide rates in older adults with the implementation of CALM training. CALM, which stands for "Counseling on Access to Lethal Means," is an evidence-based suicide prevention strategy aimed at reducing access to lethal means of suicide such as firearms and lethal medication.[52] CALM helps program participants identify individuals in need of lethal means counseling and can be used to educate providers, individuals served, and families about ways to reduce lethal means access.

The program offers strategies for initiating conversations about lethal means and helps individuals feel more comfortable and competent in using these strategies to help those in need. It provides resources on specific off-site and in-home methods of secure storage for firearms and dangerous medications, as well as strategies that can be used to develop specific plans to help reduce access to lethal means, with follow-up plans over time.[53] Oregon's 26 older adult behavioral health specialists are all trained in the CALM methodology, and these specialists, in turn, educate providers and families throughout Oregon about lethal means access reduction. This methodology aligns with the approaches highlighted in the National Strategy for Suicide Prevention, and particularly Goal 3 of Strategic Direction 1: Community-Based Suicide Prevention, which is "Reduce access to lethal means among people at risk of suicide."[54]

TENNESSEE

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) coordinates with many other agencies to fulfill its mission. It works closely with the state's Department of Disability and Aging and the Division of Long-Term Services and Supports at TennCare (Tennessee's Medicaid agency) to meet the needs of the growing number of older adults in Tennessee, as identified in the state's most recent State Plan on Aging (projected to increase from 1.66 to 1.93 million people 60-plus from 2021 to 2031). TDMHSAS operates several programs that serve older adults and seek to close gaps in access to care, such as the Behavioral Health Safety Net (BHSN) and the Older Adult Program (**Figure 11**). TDMHSAS also works closely with TennCare on its PASRR program as part of the CHOICES screening process for determining financial and medical eligibility for skilled nursing facility placement. Enrollees are evaluated to potentially receive specialized mental health services, either through home- and community-based services (at a lower level of care threshold), or while living long or short term in a skilled nursing facility. Only the Older Adult Program is exclusive to older adults, with eligibility limited to those ages 50 and older, whereas BHSN can serve anyone over the age of 3, and the CHOICES program serves adults ages 65 and older or adults ages 21 and older with a physical disability.

BHSN covers mental health services for individuals with low incomes (up to 138 percent of the federal poverty line) who are not eligible for Medicaid, have no other mental health insurance coverage, and have a primary qualifying mental health diagnosis. The program is not age limited, but it serves a large number of people over the age of 50, including some who do not qualify for Medicare. BHSN also is available to people on Medicare, although it covers only those services not covered by Medicare, such as case management, medication management, and peer support. In total, BHSN provided coverage to 32,390 adults in 2023.

BHSN covers a defined set of community mental health services:

- assessment and evaluation
- psychological testing
- individual and group therapy
- psychosocial rehabilitation
- peer support
- case management
- transportation
- psychiatric medication management and associated labs
- administration of long-acting injectables

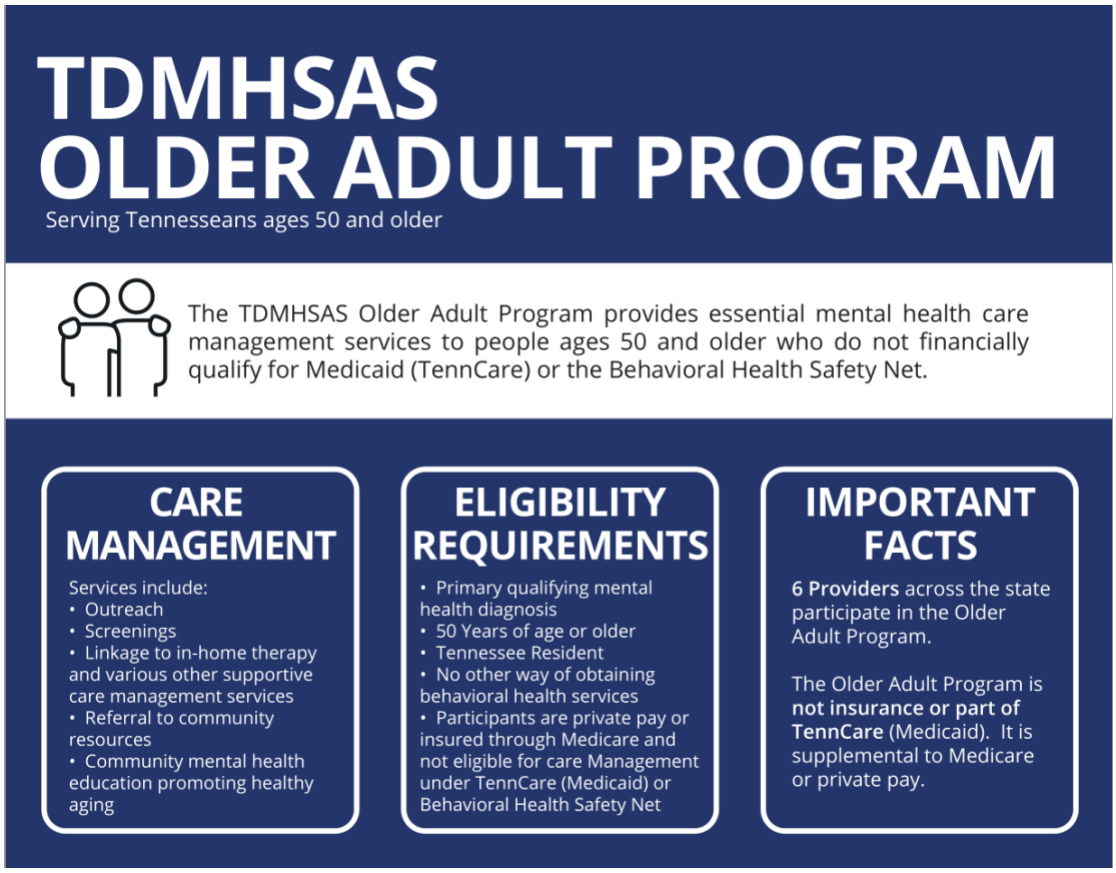
These services can be provided via telehealth when requested by the provider or when other options are not available.

The Older Adult Program works with six community mental healthcare providers who serve 53 counties in Tennessee. It provides mental healthcare management for older adults (defined as ages 50 and older) who are not eligible to receive these services from TennCare or BHSN. The population served includes individuals who self-pay or who have Medicare but are not eligible for TennCare or BHSN. In 2023, the Older Adult Program served 609 older adults. The Older Adult Program's care management includes the following services:

- screening and assessment
- referrals to appropriate care
- in-home therapy
- community outreach and supportive services
- older adult behavioral health education

The health education component has as an audience of both older adults and providers, covering topics such as healthy aging best practices, cognitive disease prevention, and older adult mental health concerns. According to an assistant director of the program, "recipients of this education may include but are not limited to local health councils, pharmacists, legal-aid organizations, senior centers, councils on aging, and faith-based communities, as well as clients, their families, and caregivers."[55]

Figure 11: TDMHSAS Older Adult Program—State of Tennessee



According to the TennCare website, the CHOICES program provides home- and community-based services to "assist individuals with daily living activities and allow people to work and be actively involved in their local community. If needed, CHOICES also provides care in a nursing facility as an alternative to home and community-based services."[56] To qualify to participate in CHOICES, an individual needs to receive Supplemental Security Income (SSI) payments or be eligible for Medicaid long-term services and supports. However, there are a limited number of spots available for individuals not receiving SSI. One way of entry into the CHOICES program is through a PASRR screening. If an individual's PASRR indicates a need to be served in the community with long-term supports, they can be enrolled in CHOICES if they are eligible.

Conclusion

State leaders should look to these examples to inform their own system improvements, because as the older adult population continues to grow, addressing their behavioral health needs will become an increasingly critical task for behavioral health and aging systems across the country. Older adults with SMI often age more quickly than other older adults, making it essential to extend behavioral health services to people younger than 65, ideally including those as young as 55 or even 50.

In order to ensure that resources are expended effectively, SMHAs should coordinate with SUAs to develop a policy framework that facilitates and encourages care coordination among providers of services for older adults. The SMHA should identify and empower a champion for older adults within the SMHA who will lead coordination with other state agencies and who will also work directly with behavioral healthcare providers to implement and troubleshoot care coordination with AAAs. Coordination of behavioral health and aging services at both the state and local levels should aim to enhance the capacity of assisted living facilities and long-term care settings to serve individuals with behavioral health needs and strive to improve the opportunities for older adults to live in integrated community settings with access to individualized supports and services. Similarly, the SMHA should ensure that behavioral health facilities are able to accept older adults with specific needs, such as those needing help with ADLs and those who have neurocognitive disorders.

Finally, SMHAs should ensure that they are addressing the needs of caregivers, as they are a critical factor in the ability of many older adults, including those with behavioral health conditions, to remain in the community.

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