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Call to Action to All Stakeholders

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# Promoting Wellness in Older Adults with Mental Illnesses and Substance Use Disorders: Call to Action to All Stakeholders

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## INTRODUCTION

There are two faces of aging. One face, which reflects the common perception of aging, associates it with an increase in morbidity and mortality and a progressive decline in independence and autonomy. The other face, much less acknowledged despite growing evidence, associates aging with improved mental health including life satisfaction, happiness, and wisdom. It is important to consider both aspects to develop plans for promoting wellness and healthy aging among people with mental disorders including substance use disorders. This article summarizes the current information base, identifies gaps in knowledge, and presents recommendations for a research agenda in this arena.

Common disorders of aging include hypertension, heart disease, cancer, diabetes, Alzheimer disease and related dementias, and geriatric syndromes such as falls and incontinence. Four-fifths of adults over age 65 have at least one chronic disease and 77% have at least two. Moreover, these statistics do not reflect the high burden of mental illnesses and behavioral problems among persons with dementia. The prevalence of depressive disorders in older adults is expected to more than double by 2050,<sup>2</sup> and of major concern, substance use disorders—including alcohol use disorder—are also on the rise among older adults.<sup>3</sup> Data show that even as average lifespan among the baby boomers has increased over the past several decades, the average “healthspan,” which is the number of years morbidity free, has not.

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At the same time, however, many studies have shown that well-being and satisfaction with life improve in later life. What has been called the paradox of aging posits that as a person gets older physical health declines and mental health tends to improve.<sup>4</sup> Older adults who are physically, cognitively, and socially active have been found to have higher levels of emotional regulation, compassion, empathy, self-reflection, and experience-based social decision-making—the characteristics that constitute wisdom—than younger adults.<sup>5</sup> Studies have suggested neurophysiologic reasons for these improvements: recruitment of additional neuronal networks in performing an activity to compensate for age-associated loss of synapses and neurons and neuroplasticity as new synapses and new neurons in specific brain regions are formed. Even among people with mental disorders such as schizophrenia, subjective well-being and psychosocial functioning often increase with age. Jeste et al.<sup>6</sup> have promoted a positive psychiatry of aging that focuses on promotion of health and well-being and prevention of mental disorders through enhancement of positive psychosocial factors relevant to mental or physical illnesses. Enablers of improved health and longevity include resilience, optimism, and social engagement, with medium to large effect sizes in published empirical studies.

To achieve these benefits, there is a need for a shift away from hospital- and clinic-based treatments to interventions and support in the home and community. Involvement of community-based primary care and mental health sites, the aging network, mobile interventions, and a wider use of technology could facilitate the delivery of more efficient person-centered care to a broader segment of the population, including those in rural communities. Around the world there is a call for the establishment of age-friendly and dementia-friendly communities that would provide accessible housing, transportation, outdoor spaces, social engagement, and community support, along with educational, occupational, and leadership opportunities and health and wellness services and care.

With the aging of persons born between 1946 and 1964, the population of older adults in the United States will double from 2010 to 2030, putting additional strain on available mental health resources. Recognizing the need to build consensus around what needs to be done

Stein Institute for Research on Aging at the University of California San Diego convened top academic provider, and public policy experts in the field of geriatric mental health, patient advocacy organizations, and representatives from appropriate federal agencies to explore the essential mental and behavioral health concerns of older Americans, identify gaps, and propose solutions. The round table agenda and a list of panelists can be found in Appendix 1, along with a list of meeting attendees. Here, we present a summary of these discussions and recommendations for moving forward.

Because numerous topics were covered during the roundtable and time was limited, a few topics were considered to be “out of scope” for the days discussion. First, although more resources are always desirable, we did not discuss increased funding as a potential solution. However, it was okay to discuss how to reallocate resources and what priorities for funding should be in the future. Second, although workforce shortages and other challenges are immense, we did not have enough time to tackle them at the roundtable. Finally, because we were honored to be joined at the roundtable by a number of representatives from the federal government, we did not discuss national politics or related matters.

## DEMENTIA

Dementia is a major neurocognitive disorder, and at present there are no evidence-based interventions to prevent or significantly impact cognitive impairment. At the same time, neuropsychiatric symptoms (NPS) such as depression, agitation, apathy, psychosis, and sleep disorders are among the most common and distressing symptoms for people with dementia and their family caregivers. Although evidence-based psychosocial interventions have shown promise in managing these symptoms, unfortunately they are rarely used in everyday clinical practice. Among people with Alzheimer disease, depression is the earliest observable symptom in at least one-third of cases.<sup>8</sup> Additionally, milder symptoms of agitation may manifest early and increase in prevalence and severity with worsening dementia, often leading to an increase in family caregiver burden, greater morbidity, poorer quality of

and hearing loss, are often under-diagnosed and under-treated in older adults and may contribute to confusion, agitation, and anxiety, thus complicating and possibly exacerbating cognitive symptoms.<sup>10</sup> The use of multiple medications, including over-the-counter medications, which is common in older adults, may further adversely affect cognition.

Caring for older adults who present with a combination of medical, cognitive, and behavioral challenges requires substantial resources and presents difficulties with transitions of care as symptoms progress.<sup>11</sup> Challenging behaviors absent appropriate supports may also make it more difficult for certain individuals to access supported housing or home and community-based services and social supports. As a result, these individuals often end up living in institutional settings such as nursing homes.

Lack of stimulation and environmental cues in the nursing home environment may exacerbate cognitive and behavioral symptoms. Cognitive impairment also makes older people especially vulnerable to fraud, which may be perpetrated by family members or other close relatives and friends.<sup>12</sup>

### Progress in Improving Dementia Care

In recent years federal agencies and private institutions have adopted policies to improve the care and treatment of older individuals with dementia. One of the most promising models is offered by the U.S. Department of Veterans Affairs, which provides integrated care from primary care to subspecialties. The Department of Veterans Affairs has also implemented STAR-VA, patterned after Teri's STAR (Staff Training in Assisted living Residences) program. This program takes an interdisciplinary behavioral approach to manage challenging dementia-related behaviors.<sup>13</sup> Federal agencies are also working to reduce fraud through the Consumer Financial Protection Bureau's Office of Financial Protection for Older Americans and the Federal Trade Commission's "Pass It On" financial fraud campaign.

The Centers for Medicare & Medicaid Services (CMS) has embraced the concept of person-centered care and implemented novel ways to ensure that older adults receive appropriate services and supports. For example, in 2012 the CMS launched the National Partnership to

agency also developed new reimbursement codes to improve diagnosis of dementia and coordination of care; the CMS has mandated a 30-day medication review to reduce overmedication and flag prescriptions that may exacerbate NPS. More time is needed to evaluate the effectiveness of these new safeguards. Moving forward, the CMS has also established several internal "Affinity Groups" to address issues related to the care of older persons; these include groups targeted at dementia, nursing homes, and home and community-based services. Additionally, local communities such as Arlington, Virginia, offer a "Senior Adult Mental Health Program" that provides geriatric mental health services through interdisciplinary teams, including home-based services.

The National Institutes of Health (NIH) has also invested in research on programs designed to improve the care of people with dementia. In concert with the CMS, for example, in 2014 it funded the MIND (Maximizing INdependence) at Home program at Johns Hopkins University in Baltimore, Maryland.<sup>14</sup> The developers of the program estimate that providing coordinated care at home, delivered by trained nonclinical community workers under the supervision of a geriatrician, may delay or prevent nursing home admission and has the potential to offer better care at low cost. To accelerate clinical research and allow for comparability of data across studies and in the clinical setting, the NIH has also developed the NIH Toolbox ([www.NIHToolbox.org](http://www.NIHToolbox.org)), a set of well-validated and normed measures of behavioral and neurological function that are brief and have low subject burden. Validation of these measures is currently underway for people with mild cognitive impairment and early Alzheimer disease. Similar work is needed for other patient populations to be able to examine variability in risk architecture and response to preventive and treatment interventions.

### Gaps

Further progress in developing programs to manage NPS associated with dementia is stymied by a number of research, clinical, educational, and reimbursement gaps. The underlying mechanisms of NPS are complicated and poorly understood; hence, targeted therapies are difficult to implement.<sup>15</sup> A combination

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reserve are believed to play important roles. However, in the research arena insufficient longitudinal data have been collected on the emotional and behavioral aspects of dementia. There has also been insufficient study of comorbidities among persons with dementia and the impact those have on the development and management of NPS.<sup>16</sup> Similarly, there is a dearth of research on effectiveness of interventions including services and supports designed to improve the lives of people with dementia.

Clinicians and nursing home staff receive little formal education about caring for individuals with NPS and neurodegenerative disease. Likewise, there is poor understanding and recognition among clinicians, family caregivers, and the general public regarding mental health issues that individuals with dementia may have.<sup>17</sup> Clinicians may also not be aware that older individuals with dementia frequently become victims of fraud and abuse. Compounding this limited knowledge, some clinicians lack reliable tools to assess and manage the NPS in dementia patients. Some clinicians who perform community-based mental health and health outreach are well equipped to teach family caregivers and community volunteers how to work with people with NPS, but there is little support for these activities.

There are few programs that integrate physical and mental healthcare, and although there has been a trend toward reducing the use of antipsychotics, a lack of alternative U.S. Food and Drug Administration–approved pharmacologic treatments and a dearth of evidence-based yet practical nonpharmacologic therapies often result in inappropriate or inadequate treatment. Additionally, when alternative, nonpharmacologic treatments are available, they often are not reimbursable by public or private payers. Moreover, payment incentives for home, outpatient, and institutional settings are often not aligned with best practices for assisting people with dementia and their family caregivers.

There is a lack of data-driven information on which to base decisions regarding improvements to dementia care, such as when to use or reduce antipsychotic use, the best potential treatments for agitation in dementia, and the benefits and drawbacks associated with bifurcating treatment for psychosis and agitation. In addition, drug development for NPS is complicated

## Recommendations from Public Stakeholders

- To enable home-based care, train other professionals—such as pharmacists, occupational therapists, and social workers—to serve as educators for paid and unpaid caregivers about challenging behavioral issues such as wandering and NPS.
- Raise standards for early diagnosis and personalized management of residents with NPS in nursing homes, and improve staff training to meet those standards, especially via the use of behavioral interventions.
- Make dementia training certification and periodic recertification requirements for nursing home staff consistent across the country.
- Establish incentives in nursing homes to reduce staff turnover, provide career development pathways, and develop programs to prevent staff burnout.
- Develop and implement rigorous program evaluation systems that include both meaningful quality of care measures and cost effectiveness of new models of care for people with dementia.
- Work with groups—such as AARP and the Federal Trade Commission—to develop tools for improving financial literacy in older adults, including materials related to financial fraud, that could be distributed in healthcare provider offices and clinics.
- Assess the effectiveness of different models of improving the mental health of family caregivers. Partner with The Consumer Voice in these efforts because that is a key focus of their work (<http://theconsumervoice.org/>).
- Given the high prevalence of sleep disorders in people with dementia and the growing recognition of the critical contribution of sleep to cognitive fitness and brain health in older adults, encourage research on effectiveness of various interventions to improve the quality of sleep for older individuals, especially those with dementia.
- Prioritize research into understanding the pathophysiologic mechanisms underlying NPS in dementia for development of more targeted drug therapies.
- Embrace the use of technology to help people with dementia and their family caregivers to appropriately share control of their treatment in

- Develop innovative ways of applying technology for virtual care and telemedicine approaches for behavioral healthcare, including models that engage and support family caregivers, with the goal of improving the functional status of people with dementia.
- Adopt a lifespan approach to promote cognitive, physical and social activities, and a healthy lifestyle starting at a younger age that may reduce the risk of or delay the onset of dementia in later life.

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## DEPRESSION AND SUICIDE

Depression is a serious illness across all age groups, yet it is frequently under-recognized and under-treated in older individuals.<sup>19</sup> Many medical, social, and environmental factors unique to older people increase their risk of depression. These factors include high rates of cerebrovascular disease and other neurologic and neurodegenerative diseases, cognitive impairment, surgery, and hospitalization; as well as social and environmental factors such as retirement, financial limitations, loneliness, bereavement (particularly complicated or prolonged grief), and isolation. The biologic aging process may also increase the risk of depression in ways that are not well understood. Many older people have multiple chronic conditions, such as cardiovascular disease, diabetes, and arthritis, that further increase their risk of depression.<sup>20,21</sup> Depression, in turn, tends to complicate the treatment of these conditions, leading to poorer outcomes and increased mortality rates.<sup>22</sup> The fact that many blood pressure medications are central nervous system depressants adds to the mix.<sup>23</sup>

Older adults are also at a high risk of suicide, which is most often a consequence of the convergence of several risk factors, including depression, disability, social disconnection, and access to lethal means.<sup>24</sup> It is worth adding that suicide is not always linked to depression. Although the suicide rate of middle-aged Americans aged 45–54 has recently surpassed older age groups, people over 75 remain among the highest risk groups.<sup>25</sup> These numbers are expected to increase further as the population ages, particularly among baby boomers, who have historically high rates of suicide.<sup>24</sup>

increase the risk of suicide among older adults. Those who have previously attempted suicide are at a particularly high risk, as well as those with one or more terminal illnesses.

Pharmacologic treatments are effective in at least 60% of older adults with major depression<sup>26</sup> and frequently cause side effects that can lead to significant problems, such as falls. A combination of psychotherapy such as cognitive behavior therapy and antidepressants has been shown to ameliorate depression in older adults.<sup>27</sup> Nonpharmacologic treatments such as problem-solving therapy, increased physical activity, meditative interventions, and general wellness promotion, are also effective in many cases.<sup>28</sup> Yet the stigma of mental illness and suicide often prevents people from seeking the care they need. Marginalized subpopulations may face additional risk factors and barriers to getting help. For example, older gay men who experienced the HIV epidemic may experience survivor guilt and isolation as well as housing discrimination and access to only a small caregiver network.<sup>29</sup>

## Progress

Personalized therapy for depression represents a new frontier in managing depression. For example, brief nonpharmacologic therapies delivered in primary care settings have shown promise in treating depression and in preventing depression in older persons.<sup>31</sup>

Programs designed to enhance community-based social connection and increase access to mental health services for older adults, such as the STAR program mentioned earlier,<sup>13</sup> have also emerged. Specifically related to suicide prevention and Emergency Department Safety Assessment and Follow-up Evaluation, STAR has demonstrated effectiveness in identifying individuals at risk of suicide before discharge.<sup>13</sup> Increased public awareness and education, as well as partnerships with nontraditional organizations outside the healthcare system, have demonstrated feasibility and impact, such as the educational collaboration between the American Foundation for Suicide Prevention and the National Shooting Sports Foundation, which is rolling out suicide prevention education, including addressing lethal means during periods of risk, within the gun-owning community.<sup>33,34</sup>

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the Research Domains Criteria program, which led to the creation of a research framework that would lead to a better understanding of brain mechanisms underlying depression, as well as risk and causal factors.<sup>35</sup> In addition, the current director of the National Institute of Mental Health, Dr. Gordon, has prioritized the development of suicide prevention programs. In 2016, the 21st Century Cures Act for the first time authorized a grant program for adult suicide prevention efforts, and Congress provided funding for these grants in Fiscal Year 2017. The CMS also reports progress in creating payment codes that will enable reimbursement for services that may be helpful in behavioral health, such as codes for collaborative care, cognitive assessment, and advanced care planning. The CMS health risk assessment and annual wellness visit for Medicare beneficiaries includes screening for depression, questions on alcohol consumption, and detection of cognitive impairment (<https://www.medicareinteractive.org/get-answers/medicare-covered-services/preventive-care-services/annual-wellness-visit>). The American Foundation for Suicide Prevention ([www.AFSP.org](http://www.AFSP.org)) is the nation's leading philanthropic agency supporting research into suicide prevention, epidemiology, and neurobiology. The American Foundation for Suicide Prevention funds research into suicide across the life cycle and has played a major role in training generations of researchers in suicidology.

The Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Department of Health and Human Services, in addition to the newly authorized grants for adult suicide prevention offers many free materials to clinicians and the public online (<https://store.samhsa.gov>). And in 2017, the U.S. Department of Health and Human Services released a draft strategic plan for 2018–2022 that included a number of behavioral health objectives related to suicide and depression. At the time of the workshop, public comments were still being accepted regarding this plan.

### Gaps

Many older adults lack access to behavioral healthcare services. In primary healthcare and communal living settings, efforts to address older adults' mental

and staff about best practices. Evaluation of existing and emerging programs has also been inadequate. Current federal privacy laws inhibit the ability of some providers to access medical records and treatment history.

Despite increased attention from many stakeholders regarding depression and suicide risk in older adults, barriers and myths regarding suicide among older adults remain. No rapidly acting drugs have yet been approved for suicidal ideation, although ketamine is sometimes used off-label to treat depression. In treatment-resistant depression—pharmacotherapy augmentation strategies, including the use of atypical antipsychotic agents and lithium carbonate—may have particular value in reducing the intensity of suicidal ideation in depressed older adults.<sup>36</sup> Much less is known about preventing or treating suicidal ideation in older adults who do not have a depressive disorder.

Learning-based psychotherapies, such as problem-solving therapy, may usefully address cognitive risk factors for suicide in older depressed adults, especially those with executive dysfunction. Integration of community-based and clinical programs is imperative to optimally address suicide risk among older Americans.<sup>37</sup>

Physicians and other healthcare workers may fail to identify older adults at high risk of suicide.<sup>38</sup> Studies are needed on the use of suicide prevention programs for older adults seen in emergency departments who present with depression or suicidal ideation.

### Recommendations from Public Stakeholders

- Consider Healthcare System solutions that enhance depression, other mental health, and suicide outcomes, such as the integration of behavioral health in primary care, or even simplified treating depression screening as part of routine health maintenance at primary care visits.
- Consider suicide preventive models such as the Zero Suicide framework,<sup>39</sup> which identifies people at risk for suicide, closes gaps in care, trains staff, and improves access to evidence-based suicide risk-reducing treatment modalities.
- Embrace a public health approach that teaches basic scientific facts, risk factors, and warning signs for depression and suicide risk to all layers of

- increased competency to provide social support, connection, referral, and follow-up to prevent suicide and improve the detection of mental health needs.<sup>40</sup>
- Develop and test ways of implanting evidence-based practices to improve depression and prevent suicide and to train and educate laypeople and healthcare providers. For example, encourage broader dissemination of toolkits such as “Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities (SPARK Kit)” and models such as PEARLS for Older Adults (<http://www.pearlsprogram.org/>).
  - Align the confidentiality requirements of substance use disorder treatment records under 42 CFR Part 2 with the Health Insurance Portability and Accountability Act’s patient privacy and security protections so that behavioral health providers can review prior treatment plans and safely and effectively treat patients, while at the same time protecting patient’s right to participate in treatment decisions.
  - Bring to scale evidence-based depression management programs such as PEARLS (<http://www.pearlsprogram.org/>) and HealthyIDEAS (<http://careforelders.org/default.aspx?menugroup=healthyideas>) as well as chronic disease self-management programs that have been shown to reduce depression symptomatology.
  - Improve training and deployment of care; include training of people in community settings outside of normal healthcare settings (e.g., pharmacists, clergy, funeral home personnel, hospice workers, beauticians) to identify people at risk and to deliver brief interventions that reduce social isolation, encourage help seeking, and ensure safety.<sup>41</sup>
  - Develop and test new models for screening and intervention for older adults with suicidal ideation seen in various healthcare settings and in communities of faith.
  - Ensure adequate reimbursement for evidence-based models of suicide prevention programs in older adults.
- Prioritize the funding of research on preventive interventions for depression and suicide in older adults, including those that investigate cognitive and social risk and protective factors, via the use of evidence-based learning-focused interventions and medications that specifically reduce suicidal ideation.
  - Increase partnerships with organizations outside of healthcare systems, such as home-delivered Meals on Wheels and communities of faith, which serve to reduce social isolation and loneliness, and nonprofit organizations to improve community-based education and outreach.<sup>1</sup>
  - Improve public and family caregiver awareness regarding the increased risk of suicide that is associated with firearms access.
  - Develop and test/evaluate safe and effective treatments specifically for use in depressed older adults at risk of suicide.

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## SERIOUS MENTAL ILLNESSES AND SUBSTANCE USE DISORDERS

Older people with serious mental illnesses—including schizophrenia, schizoaffective disorder, and bipolar disorder—are among the most disenfranchised population groups with regard to healthcare and thus have not benefitted from the general population’s gain in longevity. For example, individuals with schizophrenia experience accelerated physical aging, resulting in an average lifespan that is 15–20 years shorter than unaffected people. A recent study suggests that the mortality gap for schizophrenia has increased by 37% since the 1970s.<sup>42</sup> Smoking, sedentary lifestyle, poor diet, and poor access to primary care combine to increase these individuals’ risk of heart disease, diabetes, and other chronic diseases.

In December 2017 SAMHSA’s Interdepartmental Serious Mental Illness Coordinating Committee released its first report to Congress, which found that individuals with serious mental illnesses are further burdened by social factors, including loss of independence and autonomy, sometimes resulting in a finding



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of incompetency (<https://store.samhsa.gov/product/PEP17-ISMICC-RTC>). Indeed, predictors of sustained remission in schizophrenia include social support and being or having been married as well as early initiation of treatment and greater cognitive and personality reserve.<sup>43</sup>

Alcohol and other substance use disorders, including a rise in opioid use disorder, have also increased in prevalence among older adults for a variety of reasons<sup>3</sup> yet are also under-recognized and under-treated. As people age their sensitivity to alcohol increases, and the effects of alcohol may be magnified by the concomitant use of other drugs or the presence of other illnesses, including psychiatric illnesses. The use of cannabis for either medical or recreational purposes is particularly high among younger older adults. Prescription drugs, including benzodiazepines and opioids, are used frequently by older persons. When prescription and nonprescription drugs are used in combination with each other and/or alcohol, they can be particularly dangerous. Unfortunately, opioid abuse and misuse, which was recently recognized by the federal government as a public health crisis, has not exempted older adults.

### Progress

Nonpharmacologic interventions such as cognitive behavioral social skill training and other cognitive- and functional-enhancing therapies have demonstrated effectiveness in older persons with schizophrenia.<sup>44</sup> Another important trend in the care of people with serious mental illnesses is supported decision-making, which offers an alternative to substituted decision-making or guardianship.<sup>43</sup> Supported decision-making has been used most commonly among people with developmental disabilities. It allows the person with the disability or mental illness to choose who will provide assistance with decision-making. That person may be a family member, clergy member, family caregiver, or friend; the important point is that the person gets to choose. The Department of Health and Human Services has funded a national resource center for alternatives to guardianship (<http://www.supporteddecisionmaking.org/>).

More research is clearly needed to identify effective management strategies for people with serious

on Schizophrenia and Depression, is the nation's top private funder of mental illness research, providing grants totaling nearly \$4 billion since 1987. The Brain & Behavior Research Foundation aims to augment federal research support by providing seed funding for young investigators as well as mid-career, independent, and senior investigators who may be pursuing new ideas outside of the mainstream or who are making a transition from another field of research.

Given the high prevalence of alcohol use disorders in the United States, the National Institute of Alcohol Abuse and Alcoholism, in collaboration with SAMHSA, recently launched an online treatment navigator (<https://alcoholtreatment.niaaa.nih.gov/>) to guide individuals through a step-by-step process for finding professionally led treatment. The navigator educates users about alcohol use disorder and treatment options for adults and provides instruction for finding qualified treatment providers and helps older people and others find appropriate alcohol treatment options.

### Gaps

There remain many unmet needs for older persons with serious mental illness including dementia and substance use disorders. These include inadequate treatment alternatives, a paucity of large population studies in diverse populations to document the extent of the problems, lack of healthcare providers trained in the care of older adults with mental disorders, and the lack of research relevant to the experienced lives of older persons who have them, as well as the needs of their family caregivers.<sup>45</sup> Such studies could provide essential information about the effects of marijuana and other substances in older populations and the impact of substance use interactions with other comorbid conditions and with the numerous medications that older adults typically are prescribed.

Adequate care for older persons with these disorders will, however, require attention to current shortcomings in terms of access to care. Although the health risk assessment tool associated with Medicare's Annual Wellness Visit may include questions related to substance use, follow-up care for such problems in older people remains limited. For older persons with serious mental illnesses, there remain substantial gaps with regard to the process of enabling these

**Recommendations from Public Stakeholders**

- Develop and test the effectiveness of broad, community-based interventions to identify and treat older persons with co-occurring serious mental illnesses and substance use disorders, including the Screening Brief Intervention and Referral to Treatment, which has been shown to be effective in older adults.<sup>46</sup>
- Develop and test models to ensure implementation of evidence-based treatment plans for serious mental illnesses that begin with psychosocial or behavioral interventions (such as cognitive behavior social skills training) along with U.S. Food and Drug Administration–approved medications as needed, before proceeding to more intensive treatments with a greater risk of adverse effects.
- Support research studies that would test models of reducing inappropriate prescribing and distribution of opioid misuse by physicians and pharmacists; for example, educating customers about the fact that patients may be sharing their prescribed pain medicines with others or others may steal it from them, practices that have contributed to the opioid epidemic. Similar studies are needed to test ways of educating patients about safe storage and disposal of medications to help prevent diversion and the risks and side effects of not taking opioids as prescribed.
- Develop and test methods to train frontline office staff and others who interact with older persons on a regular basis to offer simple interventions that could minimize risk factors that exacerbate mental illnesses and contribute to substance use disorders.
- Identify and develop multidisciplinary treatment algorithms for appropriate alternatives to opioids for pain, keeping in mind trade-offs unique to older adults, for example, that nonsteroidal anti-inflammatory drugs may have severe renal and gastrointestinal adverse effects.
- Develop and test rehabilitation programs to help older people with disorders such as schizophrenia to live well, for example, by manipulating their environment or adopting a more active lifestyle.
- Promote programs that offer integrated living environments and supported decision-making for

- Develop and test the utility of decision support tools for management of severe mental illnesses in older adults.
- Test ways of training clinicians to prescribe opioid analgesics appropriately to discourage dependency and prevent addiction.
- Promote the use of medication-assisted treatment for older adults with alcohol and opioid use disorders.
- Support development and testing of models for transitioning individuals from institutional settings to home and community-based care.

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**SUMMARY OF RECOMMENDATIONS AND NEXT STEPS TO IMPROVE OUTCOMES FOR OLDER POPULATIONS FROM PUBLIC STAKEHOLDERS**

Below we summarize recommendations for various conditions discussed above into a general list applicable to older adults with mental disorders including substance use disorders.

1. Provide person-centered care in home and community whenever possible and in most integrated settings whenever appropriate.
  - Make home the center of care.
  - Develop and use strategies (including new technologies) that support home-based care with an emphasis on wellness, prevention, and early intervention.
  - Support community-based mental health services that engage individuals, family caregivers, and other community members.
  - Implement (and for some settings, develop) evidence-based suicide prevention programs in community mental health settings, primary care, emergency departments, and other community-based entities, including places of worship.
  - Develop and test new ways of using technology to provide mental health services in rural areas; partner with technology companies to enable this.
  - Include faith-based and other community organizations in planning efforts.

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- appropriate, person-centered care, addressing outcomes that matter to individuals and their family caregivers.
- Leverage the Welcome to Medicare and Annual Wellness Visit benefits as well as existing programs in Area Agencies on Aging and senior centers to educate people about mental health services and identify those in need.
  - Expand programs and opportunities in Medicare that offer support to unpaid family caregivers.
  - Provide appropriate reimbursements for nonclinician-delivered care, including family caregivers and pharmacists.
  - Develop and test models for recognition and treatment of mental illnesses in older adults seen in emergency departments.
  - Develop evidence-based programs to train non-traditional providers such as clergy to recognize risk for suicide and refer that person to appropriate clinician or clinical service.
  - Embed provisions addressing mental health needs in long-term care initiatives.
  - Align incentives to reduce unnecessary and revolving-door hospitalizations for common medical issues such as congestive heart failure, including enhanced planning for postdischarge transitions and implementation of aftercare programs.
3. Develop and test programs to educate and train clinicians, paid and unpaid caregivers, and others in the community.
    - This should include staff in long-term care settings as well as clinicians, family members,<sup>47</sup> payers, and the general public.
    - Engage the gun-owning community in suicide prevention efforts.
  4. Identify and implement best practices for diagnosis and treatment.
    - Enable early but accurate diagnosis of NPS in persons with dementia (e.g., agitation, apathy, psychosis, etc.) and understand their etiology to develop targeted personalized interventions, services, and supports.
    - Identify and emphasize low-cost/high-impact interventions such as those that can be pro-
  - Support research to develop risk calculators for producing adverse outcomes including challenging behaviors such as wandering, screaming, and severe agitation, in people with dementia.
  - Support dissemination and implementation research to bridge science and service.
  - Develop policies and efforts to encourage inclusion of minority and other underserved older populations and persons with substance use disorders in clinical studies (similar to what was done in pediatrics), with due concern for the vulnerability of older people to adverse effects with certain interventions.
  - Improve infrastructure for conducting clinical trials (e.g., registries, observational studies and clinical trial networks) and use of electronic medical record systems for conducting “virtual clinical trials.”
  - Ensure that all programs are evaluated and found to be effective before implementation.
5. Coordinate efforts of all stakeholders: patients, family caregivers, governmental agencies, healthcare providers, academic institutions, pharmaceutical companies, medical technology companies, and advocacy organizations.
    - Convene all relevant agencies within U.S. Department of Health and Human Services to address the current lack of coordination in implementing evidence-based intervention strategies and avoid silo effects, with a focus on integrated care.
    - There should be more emphasis on research in these common problems faced by older people. Encourage academic institutions and professional organizations to embrace and work with other institutions and organizations to address issues that might otherwise fall between the cracks (e.g., sleep and stress).
    - Working with advocacy groups, involve end users, including patients and family caregivers as well as other relevant stakeholders, in priority setting and development of models to improve outcomes for older adults with mental disorders.



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**References**

1. National Council on Aging: Healthy Aging Fact Sheet: 2016. (online) Available at: <https://www.ncoa.org/wp-content/uploads/Healthy-Aging-Fact-Sheet-final-2018.pdf>. Accessed May 11, 2018
2. Heo M, Murpy CF, Fontaine KR, et al: Population projections of US adults with lifetime experience of depressive disorder by age and sex from year 2005 to 2050. *Int Geriatr Psychiatry* 2008; 23:1266–1270
3. Kuerbis A, Sacco P, Blazer DG, et al: Substance abuse among older adults. *Clin Geriatr Med* 2014; 30:629–654
4. Thomas ML, Kaufmann CN, Palmer BW, et al: Paradoxical trend for improvement in mental health with aging: a community-based study of 1,546 adults aged 21–100 years. *J Clin Psychiatry* 2016; 77:e1019–e1025
5. Bangen KJ, Meeks TW, Jeste DV: Defining and assessing wisdom: a review of the literature. *Am J Geriatr Psychiatry* 2013; 21:1254–1266
6. Jeste DV, Palmer BW: A call for a new positive psychiatry of ageing. *Br J Psychiatry* 2013; 202:81–83
7. Kane RL, Butler M, Fink HA, et al: Interventions to Prevent Age-Related Cognitive Decline, Mild Cognitive Impairment, and Clinical Alzheimer’s-Type Dementia. Comparative Effectiveness Review No. 188. Rockville, MD: Agency for Healthcare Research and Quality, 2017. (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-2015-00008-I.) AHRQ Publication No. 17-EHC008-EF
8. Masters MC, Morris JC, Roe CM: Noncognitive symptoms of early Alzheimer disease: a longitudinal analysis. *Neurology* 2015; 84:617–624
9. Jeste DV, Kaysen D, Kaysen D, et al: Diagnostic criteria for mild behavioral impairment. *Alzheimers Dement* 2016; 12:195–202
10. Davidson JG, Guthrie DM: Older adults with a combination of vision and hearing impairment experience higher rates of cognitive impairment, functional dependence, and worse outcomes across a set of quality indicators. *J Aging Health* 2017; doi:10.1177/0898264317723407
11. Ray CA, Ingram V, Cohen-Mansfield J: Systematic review of planned care transitions for persons with dementia. *Neurodegener Dis Manag* 2015; 5:317–331
12. National Committee for the Prevention of Elder Abuse, Center for Gerontology at Virginia Polytechnic Institute and State University, The MetLife Mature Market Institute. The MetLife Study of Elder Financial Abuse: crimes of occasion, desperation, and predation against America’s Elders. Available at: <https://www.giaging.org/resources/the-metlife-study-of-elder-financial-abuse-crimes-of-occasion-desperation-a>. 2011
13. Karel MJ, Teri L, McConnell E, et al: Effectiveness of expanded implementation of STAR-VA for managing dementia-related behavior among veterans. *Gerontologist* 2016; 56:126–134
14. Samus QM, Johnston D, Black BS, et al: A multidimensional home-based care coordination intervention for elders with memory disorders: the maximizing independence at home (MIND) pilot randomized trial. *Am J Geriatr Psychiatry* 2014; 22:398–414
15. Rosenberg PB, Nowrangi MA, Lyketsos CG: Neuropsychiatric symptoms in Alzheimer’s disease: what might be associated brain circuitry? *Mol Aspects Med* 2015; 43–44:25–37

## Promoting Wellness

17. Alzheimer's Association National Plan Care and Support Milestone Workgroup, Borson S, Boustani MA, et al: Report on milestones for care and support under the U.S. National Plan to Address Alzheimer's Disease. *Alzheimers Dement* 2016; 12:334-369
18. Yaffe K, Falvey CM, Hoang T: Connections between sleep and cognition in older adults. *Lancet Neurol* 2014; 13:1017-1028
19. Fiske A, Wetherell JL, Gatz M: Depression in older adults. *Annu Rev Clin Psychol* 2009; 5:363-389
20. Andreoulakis E, Hyphantis T, Kandyliis D, et al: Depression in diabetes mellitus: a comprehensive review. *Hippokratia* 2012; 16:205-214
21. Choi NG, Kim J, Marti CN, et al: Late-life depression and cardiovascular disease burden: examination of reciprocal relationship. *Am J Geriatr Psychiatry* 2014; 22:1522-1529
22. Gallo JJ, Morales KH, Bogner HR, et al: Long term effect of depression care management on mortality in older adults: follow-up of cluster randomized clinical trial in primary care. *BMJ* 2013; 346:f2570
23. Boal AH, Smith DJ, McCallum L, et al: Monotherapy with major antihypertensive drug classes and risk of hospital admissions for mood disorders. *Hypertension* 2016; 68:1132-1138
24. Conwell Y, Van Orden K, Caine ED: Suicide in older adults. *Psychiatr Clin North Am* 2011; 34:451-468
25. Curtin SC, Warner M, Hedegaard H: Increase in suicide in the United States, 1999-2014. *NCHS Data Brief* 2016; 241:1-8
26. Schneider LS: Treatment of depression in late life. *Dialogues Clin Neurosci* 1999; 1:113-124
27. Palazzolo J: Cognitive-behavioral therapy for depression and anxiety in the elderly. *Ann Depress Anxiety* 2015; 2:1-4
28. Farah WH, Alsawas M, Mainou M, et al: Non-pharmacological treatment of depression: a systematic review and evidence map. *Evid Based Med* 2016; 21:214-221
29. Cahill S, Valadez R: Growing older with HIV/AIDS: new public health challenges. *Am J Public Health* 2013; 103:e7-e15
30. McNaughton JL: Brief interventions for depression in primary care: a systematic review. *Can Fam Physician* 2009; 55:789-796
31. Cole MG: Brief interventions to prevent depression in older subjects: a systematic review of feasibility and effectiveness. *Am J Geriatr Psychiatry* 2008; 16:435-443
32. Boudreaux ED, Miller I, Goldstein AB, et al: The Emergency Department Safety Assessment and Follow-up Evaluation (ED-SAFE): method and design considerations. *Contemp Clin Trials* 2013; 36:14-24
33. Vriniotis M, Barber C, Frank E, New Hampshire Firearm Safety, et al: A suicide prevention campaign for firearm dealers in New Hampshire. *Suicide Life Threat Behav* 2015; 45:157-163
34. Pane LM: Gun industry, suicide prevention forge unlikely alliance: 2017. Las Vegas, AP. Available at: <https://www.seattletimes.com/nation-world/gun-industry-suicide-prevention-forge-unlikely-alliance/>. Last accessed May 11, 2018
35. Patrick CJ, Hajcak G: RDoC: translating promise into progress. *Psychophysiology* 2016; 53:415-424
36. Lenze EJ, Mulsant BH, Blumberger DM, et al: Efficacy, safety, and tolerability of augmentation pharmacotherapy with aripiprazole for treatment-resistant depression in late life: a randomized placebo-controlled trial. *Lancet* 2015; 386:2404-2412
37. U.S. Department of Health and Human Services Office of the Surgeon General and National Alliance for Suicide Prevention: National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington, DC: HHS, 2012
38. Arias SA, Boudreaux ED, Segal DL, et al: Disparities in treatment of older adults with suicide risk in the emergency department. *Am Geriatr Soc* 2017; 65:2272-2277
39. US Department of Health and Human Services (HHS) Office of the Surgeon General, National Action Alliance for Suicide Prevention: 2012 national strategy for suicide prevention, goals and objectives for action: 2012. (online) Available at: <https://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report-rev.pdf>
40. Moutier C: Tactics of the war on suicide. *Depress Anxiety* 2011; 31:961-963
41. Stanley B, Brown GK: Safety planning intervention: a brief intervention to mitigate suicide risk. *Cognitive Behav Pract* 2011; 19:250-264
42. Lee EE, Liu J, Tu X, et al: A widening longevity gap between people with schizophrenia and general population: a literature review and call for action. Special issue. *Schizophr Res* 2017, doi:10.1016/j.schres.2017.09.005
43. Jeste DV, Palmer BW, Saks ER: Why we need positive psychiatry for schizophrenia and other psychotic disorders. *Schizophr Bull* 2017; 43:227-229
44. Granholm E, Holden J, Link PC, et al: Randomized controlled trial of cognitive behavioral social skills training for older consumers with schizophrenia: defeatist performance attitudes and functional outcome. *Am J Geriatr Psychiatry* 2013; 21:251-262
45. National Alliance for Caregiving, Mental Health America, National Alliance on Mental Illness. On pins and needles: caregivers of older adults with mental illness. Available at: [http://www.caregiving.org/wp-content/uploads/2016/02/NAC\\_Mental\\_Illness\\_Study\\_2016\\_FINAL\\_WEB.pdf](http://www.caregiving.org/wp-content/uploads/2016/02/NAC_Mental_Illness_Study_2016_FINAL_WEB.pdf). 2016
46. Schonfeld L, King-Kallimanis BL, Duchene DM, et al: Screening and brief intervention for substance misuse among older adults: the Florida BRITE project. *Am J Public Health* 2010; 100:108-114
47. National Alliance for Caregiving: Circle of care: a guidebook for mental health caregivers: 2018. Available at: [http://www.caregiving.org/wp-content/uploads/2018/03/CircleOfCareReport\\_0318\\_FINAL.pdf](http://www.caregiving.org/wp-content/uploads/2018/03/CircleOfCareReport_0318_FINAL.pdf)