Depression, Anxiety, and Suicide Prevention

Funded by SAMHSA in collaboration with AoA
Introductions & Welcome
• Jennifer Solomon – Substance Abuse and Mental Health Administration
• Shannon Skowronski – Administration on Aging

Depression, Anxiety, and Suicide Prevention: Overview
• Steve Bartels, MD, MS – Dartmouth Medical School

State Actions to Implement EBPs
• Nancy Wilson, MA, MSW, LCSW – Baylor College of Medicine

Local Implementation of EBPs by an AAA
• Cheryl Evans-Pryor, MA-G – Aging Resources of Central Iowa
Webinar Series Targeting Aging Services Network Providers

- Depression, Anxiety, and Suicide Prevention
- Prescription Medication and Alcohol Misuse
- Reaching and Engaging Older Adults in Behavioral Health Services
- Sustainability and Financing Behavioral Heath Services
- Family Caregivers: As Clients and Partners in Behavioral Health Care
Depression, Anxiety, and Suicide Prevention: An Overview

Stephen J. Bartels, MD, MS
Director, Dartmouth Centers for Health and Aging
Professor of Psychiatry & Community and Family Medicine, Dartmouth Medical School
What We all Know Is Coming

13 percent of U.S. population age 65+; expected to increase up to 20 percent by 2030

83 million 'Baby Boomers' (born from 1946-1964) in U.S. Census 2000
  • Second wave 'Baby Boomers' (now aged 35-44) contains 45 million

www.census.gov
What You May Not Know: Projected Prevalence of Major Psychiatric Disorders by Age Group

Jeste, Alexopoulos, Bartels, et al., 1999
Prevalence of Late-Life Depression & Anxiety Disorders

Clinically significant depressive symptoms
- 15% community
- 25% primary care
- 25% medical inpatients
- 40% nursing home

Major depressive disorder
- 1-3% community
- 10% primary care
- 15% medical inpatients
- 15% nursing home

Anxiety disorders
- 3-12%
  - Specific phobias (SP) & Generalized Anxiety Disorder (GAD) are most prevalent
  - Social phobia, OCD, panic disorder (PD), and Post Traumatic Stress Disorder (PTSD) are less common
Risk Factors for Late Life Depression and Anxiety

Depression
- Medical Illness
- Self-report of poor health and disability
- Pain; Use of pain medication
- Cognitive Impairment
- Medications; Substance Abuse
- Prior Depressive Episode
- Financial difficulties
- Bereavement
- Isolation; dissatisfaction with social network
- Physiological changes associated with aging

Anxiety
- Presence of several chronic medical conditions
- Impaired subjective health
- Physical limitations in daily activities
- Stressful life events
- Being single, divorced, or separated
- Lower education
- Female gender
- Adverse events in childhood
- Neuroticism
IMPACT of Mental Illnesses: Worldwide Causes of Disability

As a Percentage of All Disabilities

- Mental Illnesses
- Alcohol and Drug Use Disorders
- Alzheimer’s Disease and Dementias
- Musculoskeletal Diseases
- Respiratory Diseases
- Cardiovascular Diseases
- Sense Organ Diseases
- Injuries (Disabling)
- Digestive Diseases
- Communicable Diseases
- Cancer (Malignant neoplasms)
- Diabetes
- Migraine
- All Other Causes of Disability
Suicide in Older Adults

- 65+: highest suicide rate of any age group
- 85+: 2X the national average (CDC 1999)
- Men>Women; Whites>African Americans
- Peak suicide rates:
  - Suicide rate goes up continuously for men
  - Peaks at midlife for women, then declines

- 20% older men saw PCP on day of suicide
- 40% older men saw PCP on week of suicide
- 70% older men saw PCP on month of suicide
Suicide Rates by Age, Race, and Gender, US - 2007
Risk Factors for Suicide among Older Adults

- Depression – major depression, other
- Prior suicide attempts
- Co-morbid general medical conditions
- Often with pain and role function decline
- Social dependency or isolation
- Family discord, losses
- Personality inflexibility, rigid coping
- Access to lethal means
Lethality of Late Life Suicide

- Older people are
  - More frail (more likely to die)
  - More isolated (less likely to be rescued)
  - More planful and determined

- Implying that:
  - Interventions must be aggressive
  - Primary and secondary prevention are key

Source: Van Orden & Conwell, March 2012 SAMHSA webinar
SCREENING
Points of Access

Community
- Vet Centers
- VSO
- Banks
- Utility companies
- Pharmacists
- Mail carriers

Health Care
- Primary
- Specialty
- Long-term
- Home

Social Services
- Senior centers
- Nutrition
- Transportation
- Peer support
- Outreach

Mental Health Services

Religion
- Churches
- Temples
Screening Tools for Older Adults

- Depression
  - PHQ-9 (Patient Health Questionnaire)
  - Geriatric Depression Scale

- Anxiety
  - GAD-7, from PRIME-MD

- Suicide
  - Question 9 from the PHQ-9
    - “Thoughts that you would be better off dead or of hurting yourself in some way.”
  - P4 Screener
<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>c. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>d. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>e. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>g. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>h. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>i. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
## GAD-7: Generalized Anxiety Disorder-7 Item Screen

*Over the last 2 weeks, how often have you been bothered by the following problems?*

*(Use “✓” to indicate your answer)*

<table>
<thead>
<tr>
<th>Item</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it is hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
SUICIDE: Following Up on a Positive Suicide Screen

- If any positive response, FOLLOW-UP
  - Determine passive vs. active ideation
  - “In the last 2 weeks, have you had any thoughts of hurting or killing yourself?”
  - If yes = active suicidal ideation, FOLLOW-UP further

- There are routinized screeners designed to be used to follow-up the PHQ-9 suicide item.
  - Option: P4 Screener for Assessing Suicide Risk
Figure 1. P4 Screener for Assessing Suicide Risk

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Items 1 and 2</th>
<th>Items 3 and 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Neither is shaded</td>
<td>Neither is shaded</td>
</tr>
<tr>
<td>Lower</td>
<td>At least 1 item is shaded</td>
<td>Neither is shaded</td>
</tr>
<tr>
<td>Higher</td>
<td>At least 1 item is shaded</td>
<td></td>
</tr>
</tbody>
</table>

Past suicide attempt
Suicide plan
Probability (perceived)
Preventive factors

EVIDENCE-BASED INTERVENTIONS
Outreach Programs (An example)

→ Psychogeriatric Assessment and Treatment in City Housing (PATCH) program.
  • Serving Older Persons in Baltimore Public Housing

→ 3 elements
  • Train indigenous building workers (i.e., managers, janitors,) to identify those at risk
  • Identification and referral to a psychiatric nurse
  • Psychiatric evaluation/treatment in the residents home

→ Effective in reducing psychiatric symptoms
  » Rabins, et al., 2000
The IMPACT Treatment Model

Collaborative care model includes:

- **Care manager: Depression Clinical Specialist**
  - Patient education
  - Symptom and Side effect tracking
  - Brief, structured psychotherapy: PST-PC

- **Consultation / weekly supervision meetings** with
  - Primary care physician
  - Team psychiatrist

- Stepped protocol in primary care using antidepressant medications and / or 6-8 sessions of psychotherapy (PST-PC)
Depression Care Management
Core Components

1. Active Screening to identify depressed patients
2. Patient education / self-management support
3. Outcome measurement (e.g., PHQ-9, Geriatric Depression Scale (GDS))
4. Evidence Based Treatment
   • Brief psychotherapy (e.g., PST, IPT)
   • Medication Treatment
5. Psychiatric consultation / caseload supervision
6. Stepped care
   • Increased intensity as needed
   • Specialty mental health referral when necessary
The IMPACT Study

N=1801 subjects >60 yrs with major depression or dysthymia
Randomized to -- collaborative care (depression care manager; n=906)
-- or care as usual (CAU; n=895)

Unutzer et al., JAGS 54:1150-6, 2006
Community-Integrated Home-Based Depression Treatment for the Elderly: PEARLS

- Conducted in the client’s home
- 8 sessions
  - 45-60 minutes each
- Each session incorporates:
  - Problem solving therapy (PST)
  - Social and physical activation
  - Pleasurable activity scheduling
  - PHQ-9 administered at each session
- Team approach, involving PEARLS counselors, supervising psychiatrists, and medical providers

www.pearlsprogram.org
PEARLS: Improvement in Depression
12 Month Results

HSCL: Hopkins Symptom Checklist; Ciechanowski, 2004 - JAMA
Healthy IDEAS

→ Embedded in case management programs
  • Uses existing staff with established relationships.
→ Conducted in the client’s home on a one-to-one basis by case managers over a 3-6 month period.
→ Four components:
  • Screening for depression & assessing severity
  • Educating about depression & effective treatment: including self-care & medication.
  • Referral, linkage & follow-up for older adults with untreated depression to health or mental health providers.
  • Behavioral Activation empowering older adults to manage their depressive symptoms by engaging in meaningful, positive activities.

To find more information on Healthy IDEAS visit: Care for Elders
# SAMHSA’S Treatment of Depression in Older Adults Evidence-based Practices KIT

## This KIT at a Glance

<table>
<thead>
<tr>
<th>Depression and Older Adults: Key Issues</th>
<th>Selecting EBPs for Treatment of Depression in Older Adults</th>
<th>EBP Implementation Guides</th>
</tr>
</thead>
<tbody>
<tr>
<td>for all stakeholders</td>
<td>for all stakeholders</td>
<td>for four specific stakeholder audiences</td>
</tr>
<tr>
<td>Key issues gives you an overview of important information about depression in older adults. Topics include the following:</td>
<td>Selecting Evidence-Based Practices provides information about a range of EBPs for treating depression in older adults and information about how to select EBPs. Topics include the following:</td>
<td>The EBP Implementation Guides provide information for the four major groups of stakeholders about their roles in implementation.</td>
</tr>
<tr>
<td>- Demographic trends</td>
<td>- What are the EBPs?</td>
<td>- Older Adult, Family, and Caregiver Guide on Depression</td>
</tr>
<tr>
<td>- What is depression in older adults?</td>
<td>- Deciding to move forward with EBP implementation</td>
<td>- Depression in older adults</td>
</tr>
<tr>
<td>- Definitions</td>
<td>- Factors to consider in selecting an EBP</td>
<td>- How to recognize depression</td>
</tr>
<tr>
<td>- Risk factors</td>
<td>- Type of depression</td>
<td>- How to access treatment</td>
</tr>
<tr>
<td>- Prevalence</td>
<td>- Outcomes</td>
<td>- How to make informed choices</td>
</tr>
<tr>
<td>- Impact</td>
<td>- Fit with organization</td>
<td>- How to work with practitioners</td>
</tr>
<tr>
<td>- Cost</td>
<td>- Training and implementation resources</td>
<td>- Resources for older adults and their families</td>
</tr>
<tr>
<td>Why implementation of EBPs is important</td>
<td>- Characteristics of your population of older adults</td>
<td>- Practitioners’ Guide for Working with Older Adults with Depression</td>
</tr>
<tr>
<td>- Reduce depression symptoms</td>
<td>- EBP categories</td>
<td>- Why you should care about EBPs</td>
</tr>
<tr>
<td>- Improve functioning</td>
<td>- Psychotherapy interventions</td>
<td>- Working with older adults</td>
</tr>
<tr>
<td>- Improve health outcomes</td>
<td>- Antidepressant medications</td>
<td>- Screening, assessing, and diagnosing depression</td>
</tr>
<tr>
<td>- Access to effective care</td>
<td>- Outreach services</td>
<td>- Selecting a treatment</td>
</tr>
<tr>
<td></td>
<td>- Collaborative and integrated mental and physical health care</td>
<td>- Delivering evidence-based care</td>
</tr>
<tr>
<td></td>
<td>- Case Briefs: EBP implementation strategies</td>
<td>- Evaluating care</td>
</tr>
</tbody>
</table>

## The Treatment of Depression in Older Adults

**Selecting Evidence-Based Practices**

For Treatment of Depression in Older Adults

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**Found at:** [SAMHSA's Treatment of Depression in Older Adults Evidence-based Practices KIT](https://www.samhsa.gov)
Evidence-based Prevention and Early Intervention: Anxiety

Anxiety

- Psychotherapy
  - Relaxation training, CBT, supportive therapy, and cognitive therapy
- Pharmacotherapy
- Service-delivery models (i.e., Peaceful Living)

Protocols should address the specific issues and/or limitations that may be present among older adults.

Wolitzky-Taylor, KB; Castriotta, N; Lenze, EJ; Stanley, MA; Craske, MG. (2010). Anxiety Disorders in Older Adults: A Comprehensive Review. Depression and Anxiety, 27: 190-211.
Evidence-based Prevention and Early Intervention: Suicide

OPTIMAL SUICIDE PREVENTION =

Indicated + Selective + Universal

“MULTI-LAYERED SUICIDE PREVENTION”
## Universal, Selective, and Indicated Suicide Prevention in Older Adults

<table>
<thead>
<tr>
<th>Universal Prevention</th>
<th>Selective/Indicated Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening for depression, and suicidal ideation</td>
<td>Outreach Gatekeeper PEARLS and PST Integrated care of mental health problems in a community-based setting</td>
</tr>
<tr>
<td>- PHQ-9, GDS</td>
<td>PEARLS and PST Integrated care of mental health problems in a community-based setting</td>
</tr>
<tr>
<td>- Suicide Risk Screening</td>
<td></td>
</tr>
<tr>
<td>Harm risk reduction</td>
<td></td>
</tr>
<tr>
<td>- Public education reducing access to fire-arms for at-risk seniors</td>
<td></td>
</tr>
<tr>
<td>- Alcohol and medication misuse</td>
<td></td>
</tr>
<tr>
<td><strong>Multi-Layered Suicide Prevention</strong></td>
<td>Telephone-based support (TeleHelp TeleCheck)</td>
</tr>
<tr>
<td>- Mental health education workshops</td>
<td></td>
</tr>
<tr>
<td>- Annual, voluntary depression screening</td>
<td></td>
</tr>
<tr>
<td>- Referral for treatment</td>
<td></td>
</tr>
<tr>
<td>- Psychiatric consultation</td>
<td></td>
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</tbody>
</table>
Suicide Prevention Resource Center

The nation’s first and only federally funded suicide prevention resource center

- Advances the goals and objectives of the National Strategy for Suicide Prevention
- Staffing and Coordination for the National Action Alliance for Suicide Prevention
- “Charting the Future of Suicide Prevention”
- Prevention Support for GLS grantees
- Best Practices Registry for Suicide Prevention
- Primary Care Toolkit
- Training Institute
- Partners with American Association of Suicidology, American Foundation for Suicide Prevention, Suicide Prevention Action Network

Link to Suicide Prevention Resource Center
Suicide Prevention Resource Center
Promoting Mental Health and Preventing Suicide: A Toolkit for Senior Living Communities

Found at: [Promoting Mental Health and Prevention Suicide: A Toolkit for Senior Living Communities](www.samhsa.gov)
National Suicide Prevention Lifeline
1-800-273-TALK

- Answered over 700,000 calls in 2011
- More than 3 million total
- 152 local crisis centers
- In response to evaluation findings, created the Crisis Center Follow-up Grants
- Developed risk assessment standards and guidelines for callers at imminent risk
Suicide Assessment Five-step Evaluation Triage

1. Identify risk factors
   Note those that can be modified to reduce risk

2. Identify protective factors
   Note those that can be enhanced

3. Conduct suicide inquiry
   Suicidal thoughts, plans, behaviors, and intent

4. Determine risk level/intervention
   Determine risk. Choose appropriate intervention to address and reduce risk

5. Document
   Assessment of risk, rationale, intervention, and follow-up

Available at: Safe-T
Examples of Vital State Support for EBPs:
Eyewitness Reports from Depression Care Management

Nancy L. Wilson
Baylor College of Medicine
Houston Center of Excellence in Health Services Research-
Michael E. DeBakey Veterans Affairs Medical Center

Healthy IDEAS Program Director
Key Steps in Program Implementation

- Identifying Resources
- Building the Right Team
- Installing the Program
- Training and Coaching
- Evaluation for Continuous Quality Improvement and Monitoring Fidelity
Steps for Implementation

1. Readiness Assessment: Need, Motivation, Capacity
2. Leadership Team & Partnership Development
3. Staff Selection
4. Program Installation
5. Pre-Service and In-Service Training
6. Consultation and Coaching
7. Program Evaluation
Implementation Process: Activities and Resources

Agencies or Community Partnerships need:

- Dedicated program leadership: Champion, Supervisors
- Mental/behavioral health expertise for training/coaching
- Effective linkage & communication systems with treatment providers
- Practitioners with capacity/ability to incorporate components into their existing case management routine with older adults/caregivers
- System for collecting and monitoring depression and other relevant outcome data
States have helped play **active roles in exposing key stakeholders to EBP approaches**

- Hearing information from peers
- Use existing forums to present models with thoughts about how to advance

States have **organized cross-agency, intrastate calls and webinars to allow technical assistance for implementation activities**
Partnerships at the Top

States have *cultivated partnerships that flow downstream:* Ohio, Missouri, Oklahoma, NC

- Support training of workforce in mental health and aging: regional trainings for staff
  - Program models
  - Suicide Risk Assessment and Response

- Create connections which have mutual benefits for aging and behavioral health networks
  - AAAs and ADRCs: link all ages, disabilities to services
  - Suicide Hotlines, Crisis Team support for aging services
In support of implementation and pursuit of sustainability.....

States have **modified assessment tools and reporting systems to substitute valid screening/outcome tools**
- Depression/Alcohol/Substance Use Tools

States have **determined how to reimburse program functions within existing funding mechanisms**
- Billable units for Medicaid, state programs
- Title III-D funds-AoA
- Mental health funding of training, coaching
For Further Information

→ Depression Care Management through PEARLS and Washington State 1915-C Medicaid Waiver
  
  - **PEARLS Program Website**
  - For more information on the Washington Medicaid (1915-c Waiver) review the following: [NASHP Webinar](#)

→ Texas Behavioral Health Pilot
  
  - Upcoming Article: Spring 2012 *Generations: Stoner & Gold*
  - [Details on Money Follows the Person Program Support](#)
Mobilized Help with Data

States have **mobilized linkages to evaluation expertise within state or affiliated academic partners**

- Track outcomes of value and interest to support delivery and for funders
- Track process to measure fidelity
- Create efficient summary tools for data
Further Potential Assistance

➔ Reproduction of materials for client or staff education and training

➔ Linkage to other initiatives focusing on chronic health issues or at-risk populations
  • CDSMP provided via Peer MH Specialists
  • Attention to Depression through Diabetes Initiatives
Contact Information

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Houston Center of Excellence in Health Services Research
Huffington Center on Aging

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E-mail: nwilson@bcm.edu
Healthy IDEAS & PEARLS Implementation Strategies

Cheryl Evans-Pryor, M.A.-G
Aging Resources of Central Iowa Area Agency on Aging
www.agingresources.com
Cheryl.pryor@agingresources.com
Mission of AAA

- Advocacy and service coordination through Federal, state, and local support to persons 60+ years of age and their families. Our goal is to encourage individual choice in the care planning process to remain safe and independent in their community.

- Mental Health services are provided by collaborative partners to address, behavioral, emotional, & psychological issues

- My role is to provide consultation with partners regarding barriers to implementation, outcomes reporting, training & coordination (Certified in both Healthy IDEAS and PEARLS).
Implementation of EBPs: Healthy IDEAS

Training:
- 2010 = Case Manager (CM)/ Clinical Consultant/ Team Leaders.
- Completed our Pilot in Feb. 2011.

CM provide in-home services at the clients home, or assisted living
- Local MHC /Partner provides the Clinical Consultant to our team and training with fee for service agreement

CM clients are frail & home-bound.
- Initial screening occurs at the 90 day visit which allows them to build rapport prior to addressing emotional issues & mood.

Healthy IDEAS clients (to date):
- Screened positive (6+ on GDS) = 101
- Completed program = 52
Implementation of EBPs:

**PEARLS:** Program to Encourage Active Rewarding Lives for Seniors

- Adopted in 2009
  - Intent to train CMHC-Senior Outreach Counseling (SOC) program staff. Their team leader decided to go to Univ. of Washington-(HPRC) Seattle, for personal training
- 2010
  - Team started screening established clients and new referrals
- Serve ages 60+
  - In-home service (Independent living, housing complex, or assisted living facility. No long-term care facilities)
  - Psychiatric consultation with CMHC Psychiatrist (Model fidelity)
- SOC team works with multiple community providers
  - AAA, independent for-profit case management agencies, home health, govt. agencies, hospitals - inpatient and outpatient, police and various public services.
Implementation of EBPs: PEARLS (Continued)

→ Majority of their cases have Major Depression (MDD) which precludes them from meeting criteria for inclusion

→ PEARLS clients:
  • Screened and enrolled to date = 25
  • Completed program = 10

→ Team integrated the screening process into admission packet.
  • Makes it easier to identify symptoms of Minor Depression & Dysthymia up front

→ Rapport and Motivational Interviewing Skills (staff) are necessary to encourage benefits of feeling better and problem-solving.
Outcomes:

PEARLS

- Symptom reduction
- Improved PHQ-9 Scores
- Referrals to specialists: neurology

- Problem-solving skill set
  - Can be applied universally and fosters a sense of control, confidence, relief, and empowerment

- Pleasant events:
  - Request assistance from family, friends, to engage in more outings or spend time together, etc...
Outcomes:
Healthy IDEAS

→ Healthy IDEAS clients:
  • 101 scored 6+ on GDS screening
  • 52 successfully completed program.

→ Outcomes
  • GDS score reduction
  • Increased activity at home:
    – Task oriented, pleasurable experiences, new interests or revisit old hobby/activity of pleasure
    – Pain levels decreased
  • Confidence levels increased to cope with depression
  • “Feel better” in general
Elements of Successful Implementation (Both Models)

- Collaborative relationships
- Leadership:
  - Global understanding of how embedding into existing program is a natural fit and works
- Systematic approach:
  - Incorporate into assessment/routine
- Models are Time-Sensitive
  - Short-term interventions for staff to implement, cost-effective
  - Clients attain program skills and decide if they want to utilize knowledge acquired
- Universal understanding that not all clients want to discuss emotions/issues
  - Due to limited energy, lack of buy-in that counselors can help them emotionally, etc...
  - Helps those who are willing to participate.
Challenges to Overcome (Both Models)

- Embracing readiness to change ourselves.
  - Another new process to learn and implement with competing demands

- Time elements:
  - Training and service delivery

- Funding:
  - Securing funds to allocate staff time to coordinate the program.
  - During assessment & program implementation there may be different sources of funding and varied documentation to track.
  - Braided funding is essential initially to allow for flexible implementation.
Buy-in from management and Board of Directors, shared global understanding of unmet mental health needs of older adults (OA) we serve.

Partners define their own contributions = dialogue + periodic follow-up.

Global view of what optimal Mental Health services and benefits would look like for OA and community.

Committed to being solution focused.

Sense of accomplishment propels us forward.
Essential Leadership (Cont.)

➔ Become risk takers, be creative in addressing program needs

➔ Consistent message:
  • We are in it together, will solve problems as they arise, not giving up on interventions we adopt.
  • Programs are much bigger than all of us (altruistic)

➔ Recognize and take ownership of the necessity to stay on course
  • Better service provision overall

CELEBRATE SUCCESSES: Clients & Staff
Funding Strategies

BRAIDED FUNDING

➔ My Role:
   • Funded by State Aging Service Program Funds, Iowa Geriatric Education Center-Health Resources and Services Administration (HRSA) grant (education), Foundational applications for grant funds

➔ Healthy IDEAS$
   • State Elderly Waiver Funds (Medicaid)

➔ PEARLS
   • Assessments-County Funding (contract rate)
   • Sessions-EW or County Funding (contract rate)
Value and Importance of EBP Models: Older Adults

- **Engagement:**
  - Self-permission to engage with peers/family/community/self

- **Sense of HOPE for improvement**

- **Confidence building:**
  - Ability to care for self despite self-doubt or status changes/disability

- **Skill acquisition:**
  - Problem-solving, behavioral activation

- **Task oriented:**
  - Small, manageable steps, eliminates paralysis of being overwhelmed.
Value and Importance of EBP Models: Older Adults (Cont.)

- Teaches clients how to talk to Primary Care Provider (PCP), specialists, to ask for assistance, identify depressive symptoms, fosters increased treatment compliance

- Validates OA values /concerns

- Encourages natural relationships with peers:
  - Senior Center, Church, Out to Eat, Movies, Dances, Talk on phone, Walking in mall or exercises programs, etc...
Value and Importance of EBP Models: Families

- Improved communication & interaction with OA
- Helps families recognize the valuable contributions OA make to self & family
- Deters co-dependency & negative behavior
- Provides a tool to encourage progress / set boundaries
- Gain insight into dynamics of change and how OA navigate it
- Recognize generational differences in a new context.
Questions and Answers