A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

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# Depression, Anxiety, and Suicide Prevention

Older Americans
Behavioral Health
Technical Assistance Center

Funded by SAMHSA
in collaboration with AoA

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

# Speakers

**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

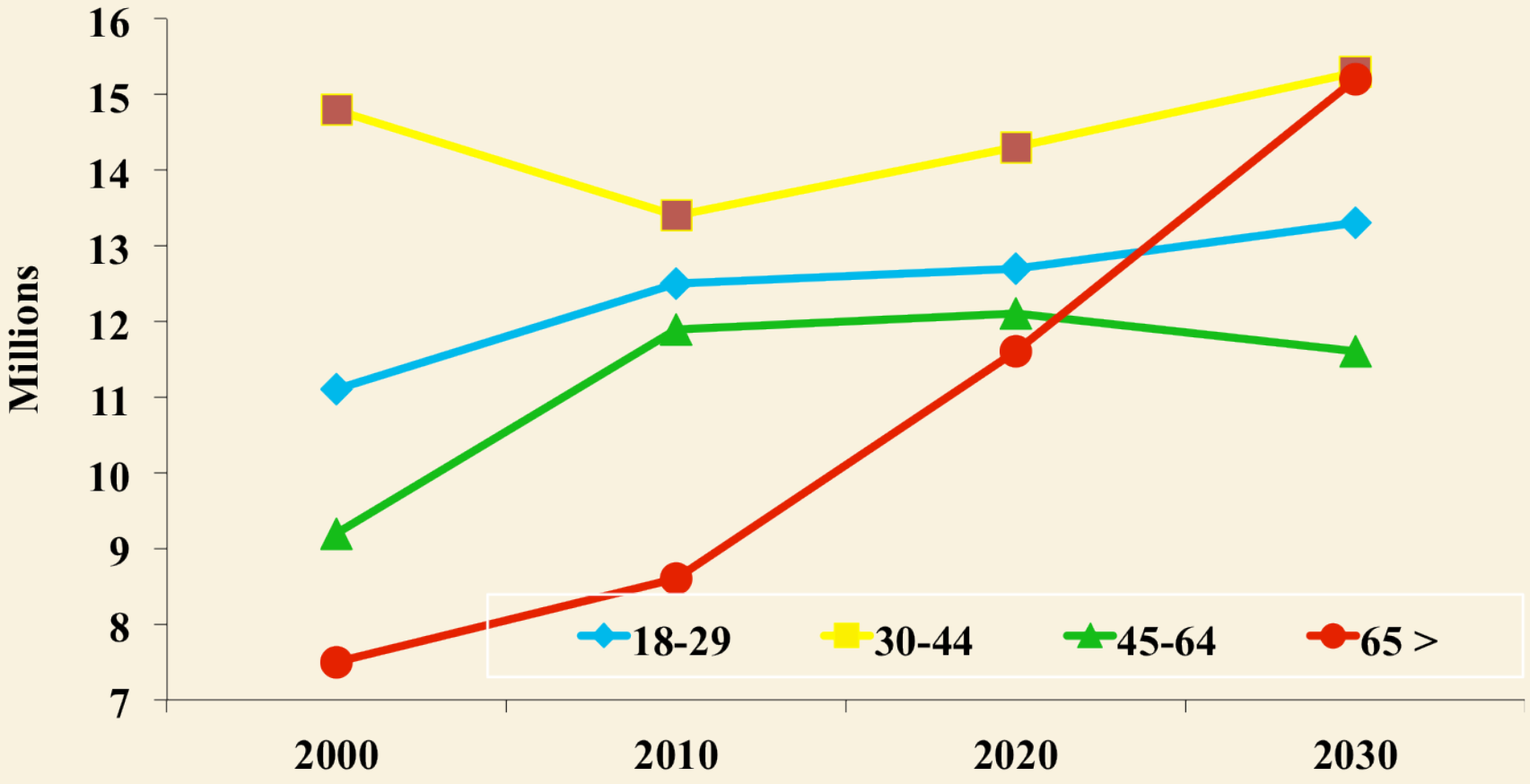
Professor of Psychiatry & Community and Family Medicine, Dartmouth Medical School

# 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

# What You May Not Know: Projected Prevalence of Major Psychiatric Disorders by Age Group




Jeste, Alexopoulus, 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

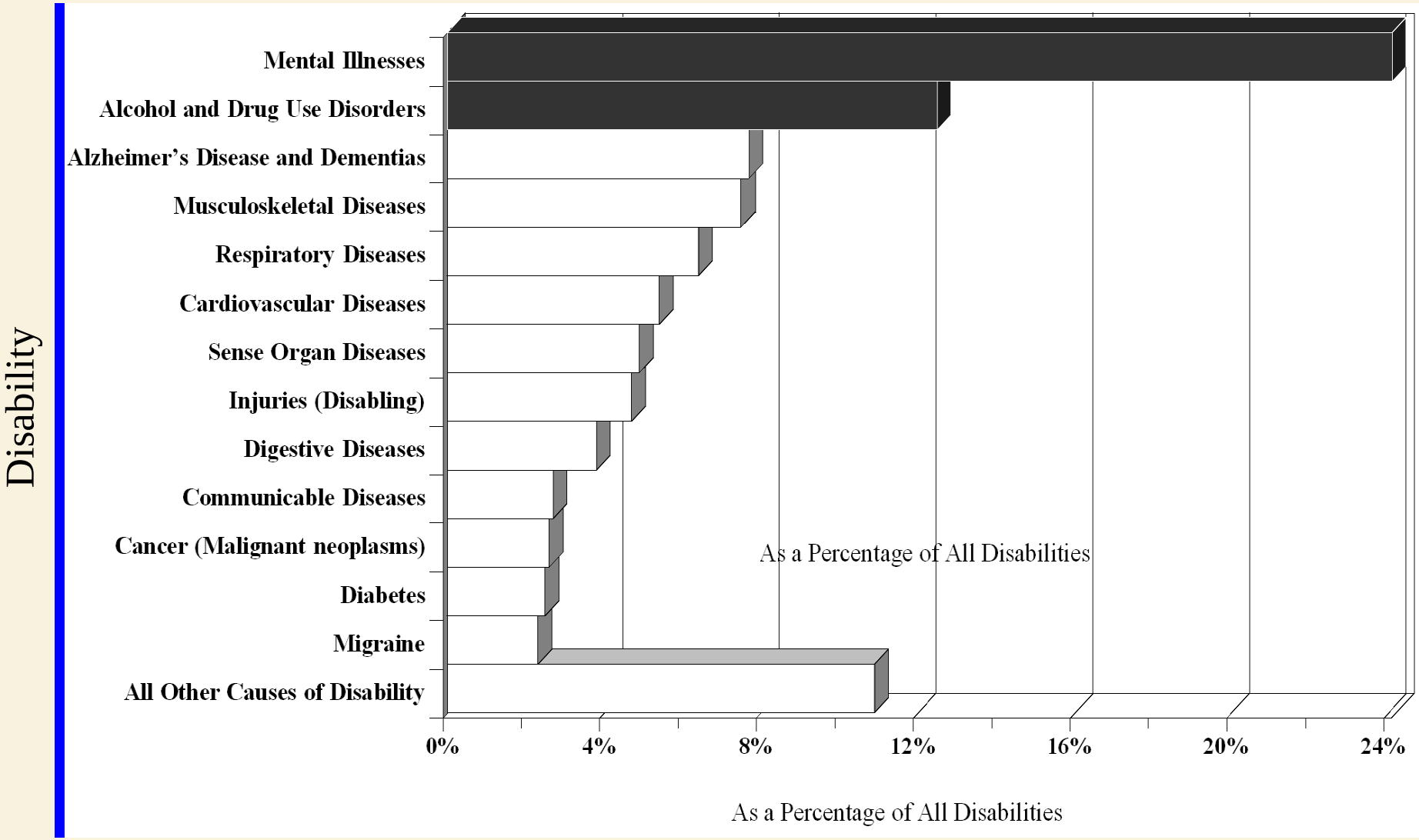
## Depression

- 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



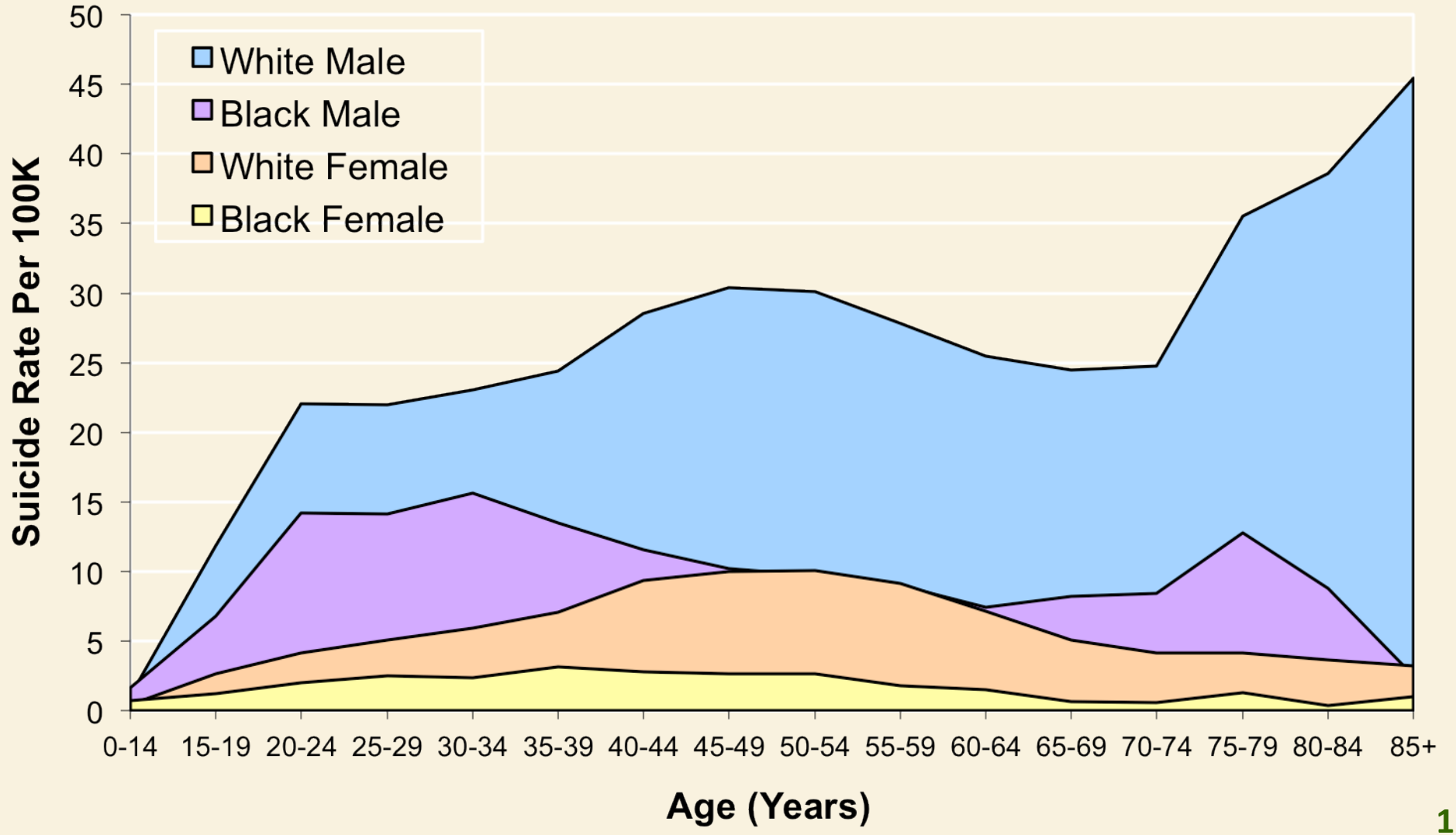
# Suicide in Older Adults

- 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

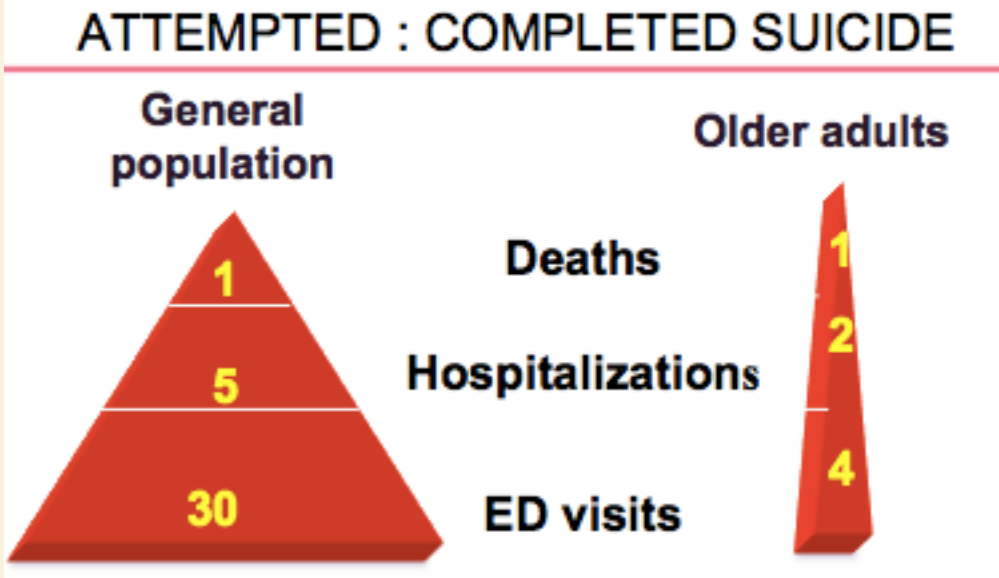


# Risk Factors for Suicide among Older Adults

- 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

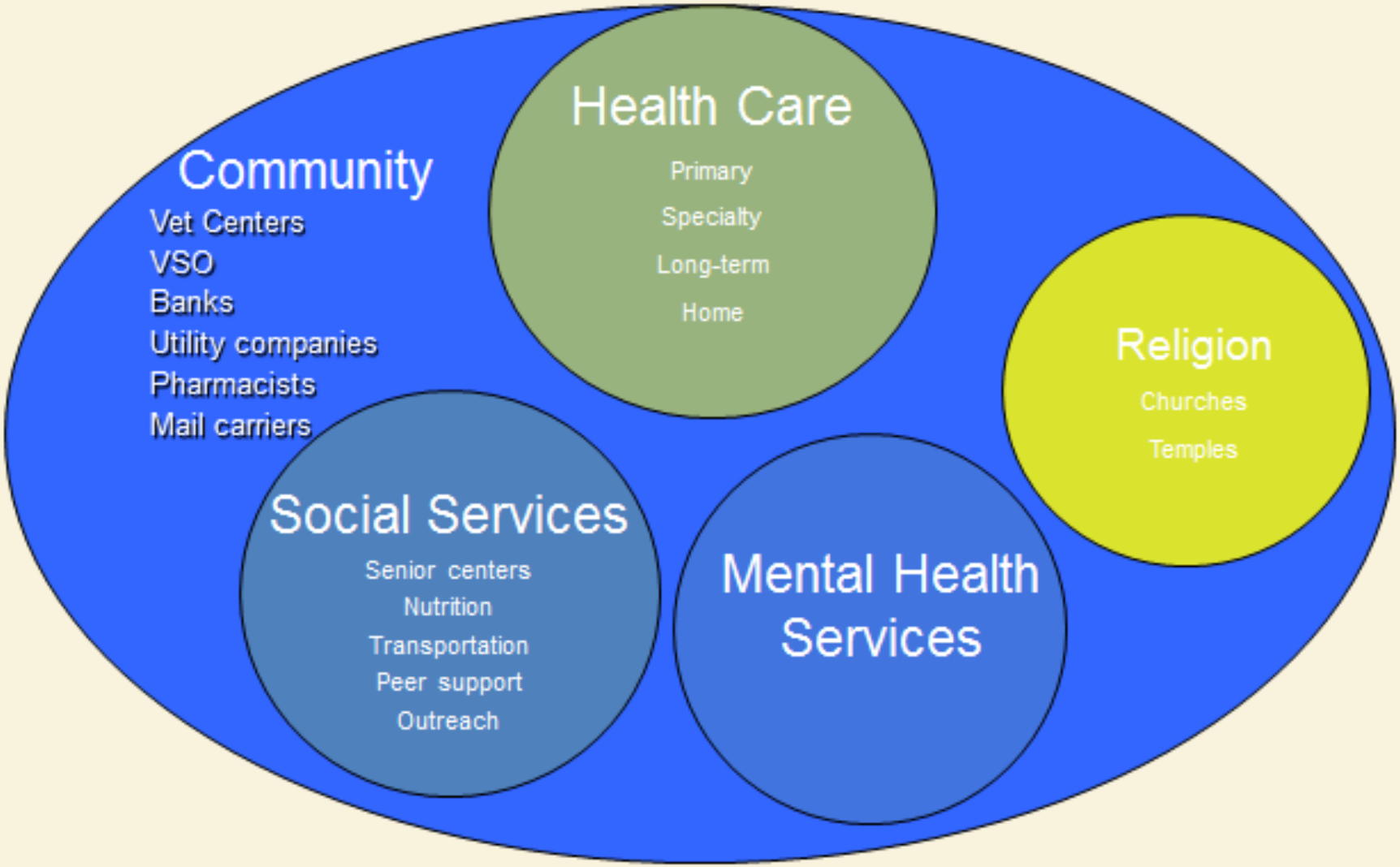



- ➔ Implying that:
  - Interventions must be aggressive
  - Primary and secondary prevention are key

*Source: Van Orden & Conwell, March 2012 SAMHSA webinar*

# SCREENING

# Points of Access



# 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

# Mood Scale (PHQ)

**Mood Scale (PHQ)**

***I am now going to ask you some questions regarding your emotional health.***

| In the past two weeks, how often have you been bothered by any of the following problems? | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| a. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| b. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| c. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| d. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| e. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| g. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 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 | 0 | 1 | 2 | 3 |
| i. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

# 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)* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

# 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*

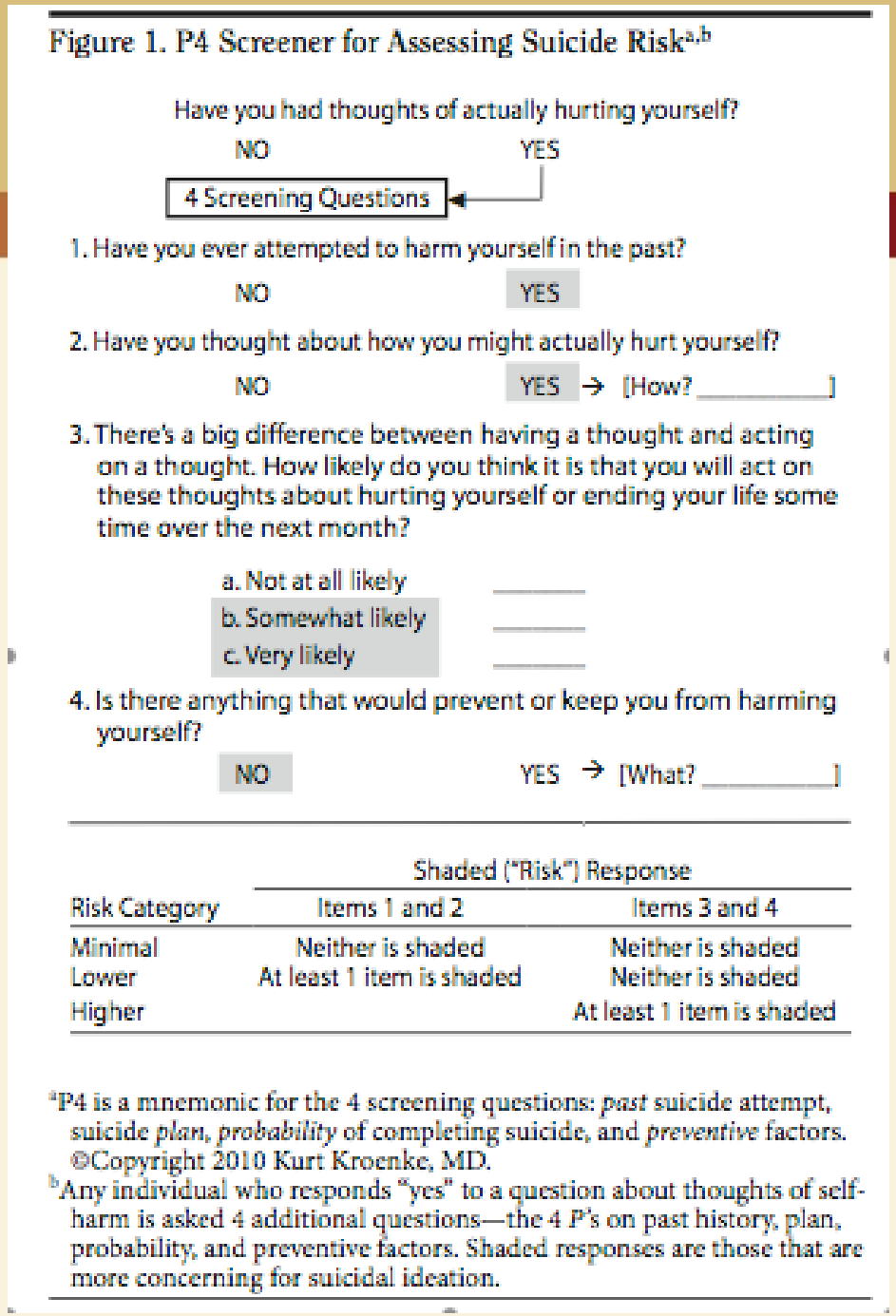


Figure 1. P4 Screener for Assessing Suicide Risk[a,b]

Have you had thoughts of actually hurting yourself?

NO YES

4 Screening Questions

1. Have you ever attempted to harm yourself in the past?

NO YES

2. Have you thought about how you might actually hurt yourself?

NO YES → [How? _____]

3. There's a big difference between having a thought and acting on a thought. How likely do you think it is that you will act on these thoughts about hurting yourself or ending your life some time over the next month?

a. Not at all likely _____
b. Somewhat likely _____
c. Very likely _____

4. Is there anything that would prevent or keep you from harming yourself?

NO YES → [What? _____]

| | Shaded ("Risk") Response | |
|---|---|---|
| Risk Category | Items 1 and 2 | Items 3 and 4 |
| Minimal | Neither is shaded | Neither is shaded |
| Lower | At least 1 item is shaded | Neither is shaded |
| Higher | | At least 1 item is shaded |

[a]P4 is a mnemonic for the 4 screening questions: *past* suicide attempt, suicide *plan*, *probability* of completing suicide, and *preventive* factors. ©Copyright 2010 Kurt Kroenke, MD.

[b]Any individual who responds "yes" to a question about thoughts of self-harm is asked 4 additional questions—the 4 *P*'s on past history, plan, probability, and preventive factors. Shaded responses are those that are more concerning for suicidal ideation.

# Past suicide attempt
# Suicide plan
# Probability (perceived)
# Preventive factors

Dube, P., Kurt, K., Bair, M. J., Theobald, D., & Williams, L. S. (2010). The p4 screener: evaluation of a brief measure for assessing potential suicide risk in 2 randomized effectiveness trials of primary care and oncology patients. Primary care companion to the Journal of clinical psychiatry, 12(6). doi: 10.4088/PCC.10m00978blu

# 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**

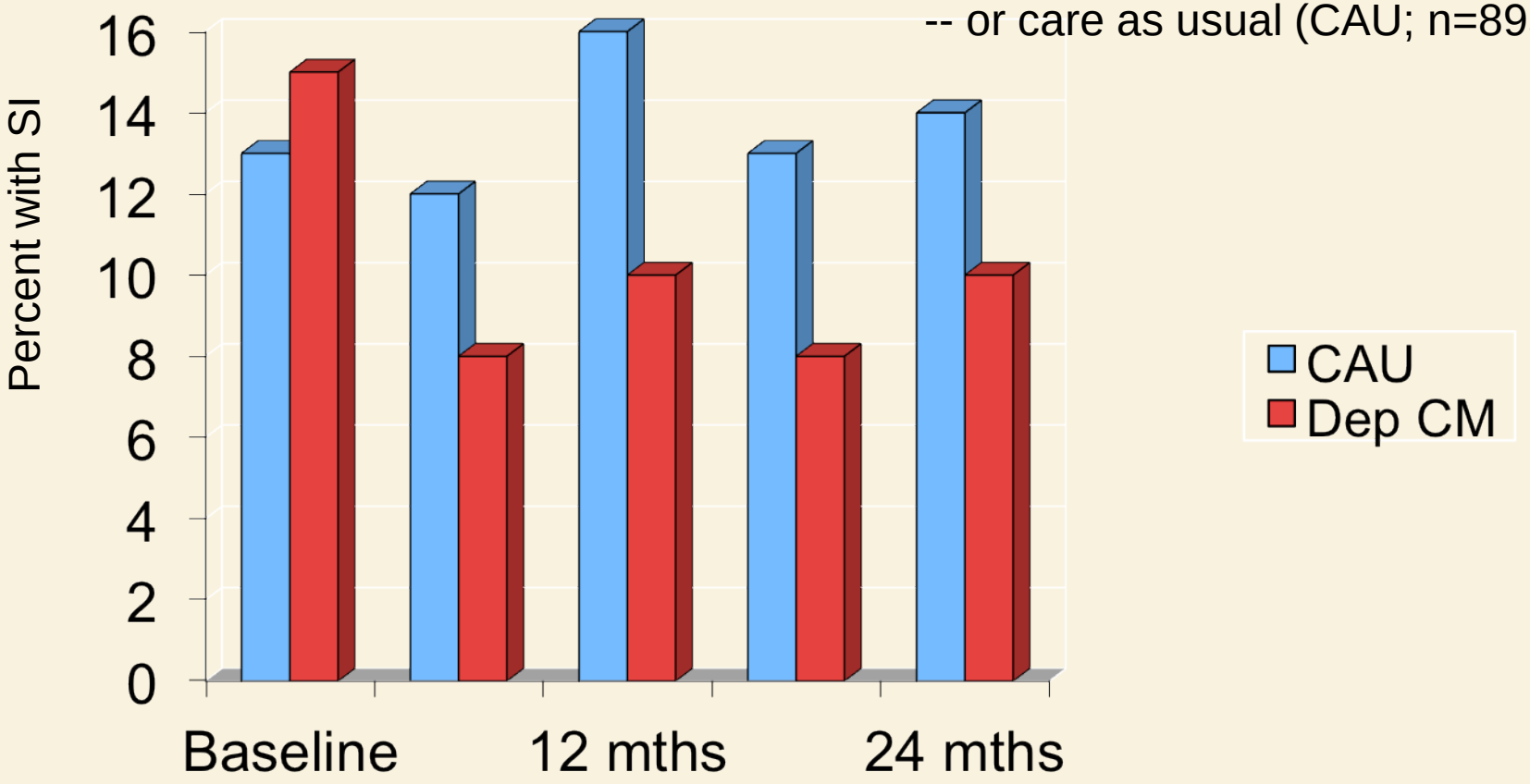
➔ **Stepped protocol in primary care using antidepressant medications and / or 6-8 sessions of psychotherapy (PST-PC)**

# 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)



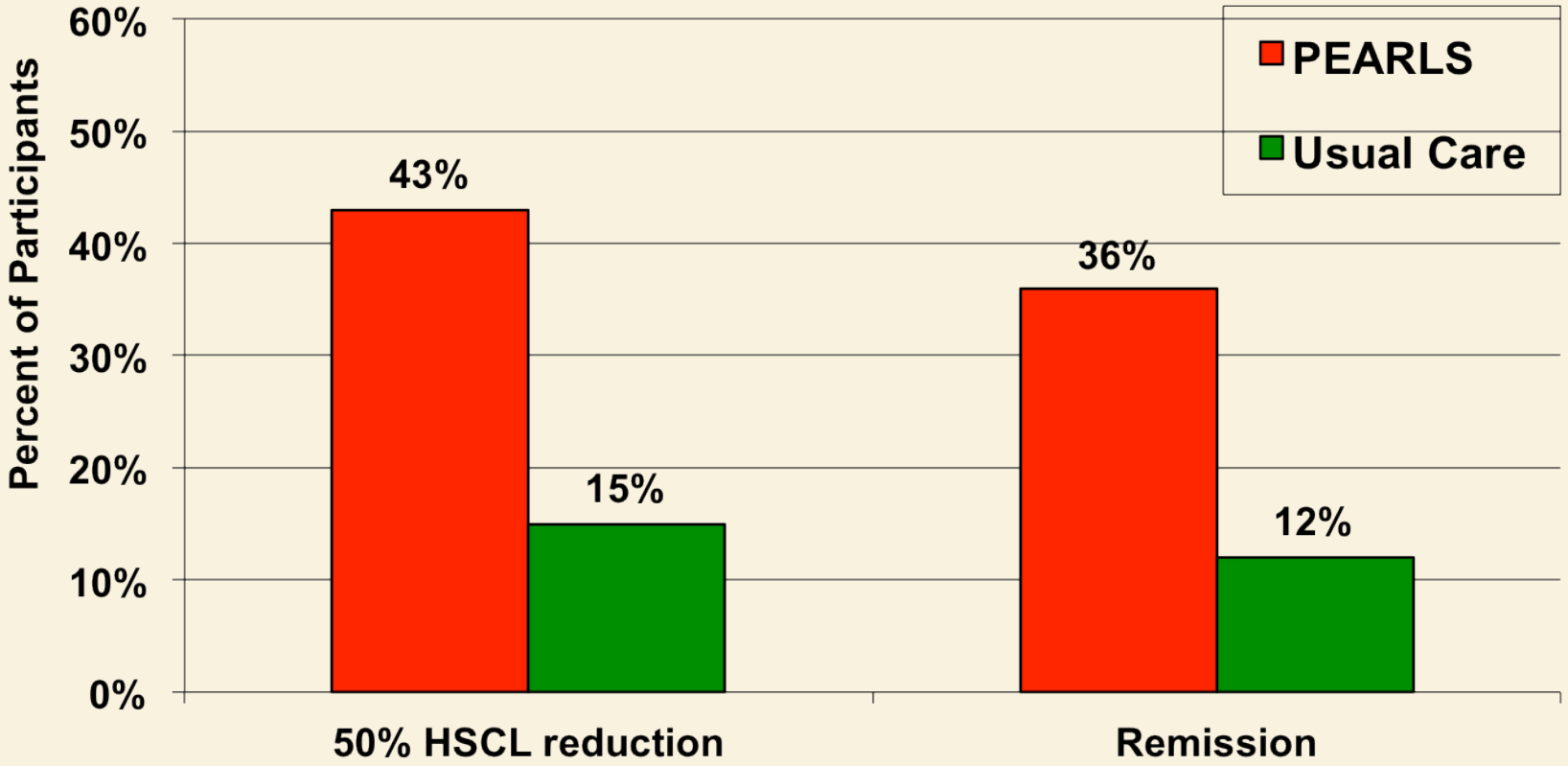

Unutzer et al., JAGS 54:1150-6, 2006

# 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



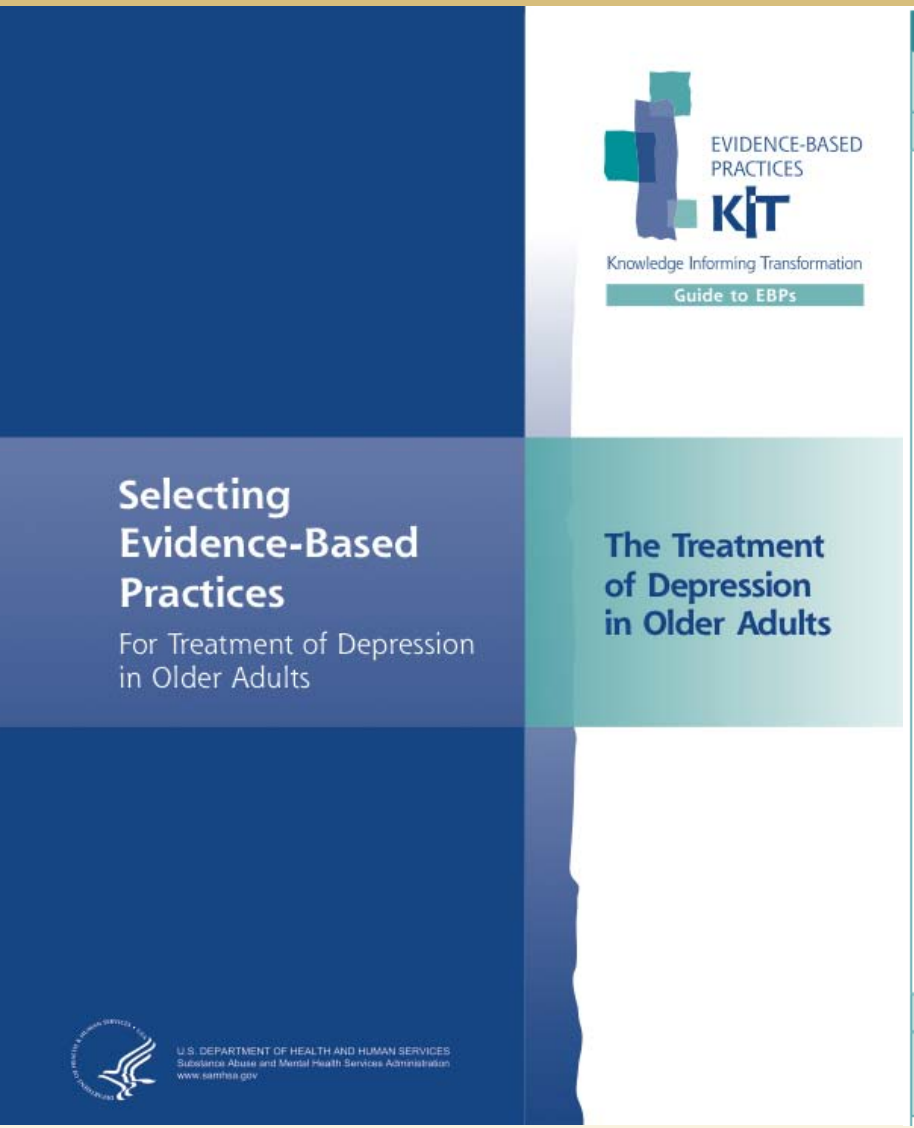

HSCL: Hopkins Symptom Checklist; Ciechanowski, 2004 - JAMA

# 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**

| Depression and Older Adults: Key Issues | Selecting EBPs for Treatment of Depression in Older Adults | EBP Implementation Guides |
|---|---|---|
| for all stakeholders | for all stakeholders | for four specific stakeholder audiences |
| *Key Issues* gives you an overview of important information about depression in older adults. Topics include the following:<br>■ **Demographic trends**<br>■ **What is depression in older adults?**<br>■ Definitions<br>■ Risk factors<br>■ Prevalence<br>■ Impact<br>■ Cost<br>■ **Why implementation of EBPs is important**<br>■ Reduce depression symptoms<br>■ Improve functioning<br>■ Improve health outcomes<br>■ Access to effective care | 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:<br>■ **What are the EBPs?**<br>■ **Deciding to move forward with EBP implementation**<br>■ **Factors to consider in selecting an EBP**<br>■ Type of depression<br>■ Outcomes<br>■ Fit with organization<br>■ Training and implementation resources<br>■ Characteristics of your population of older adults<br>■ **EBP categories**<br>■ Psychotherapy interventions<br>■ Antidepressant medications<br>■ Outreach services<br>■ Collaborative and integrated mental and physical health care<br>■ **Case Briefs: EBP implementation strategies** | The EBP Implementation Guides provide information for the four major groups of stakeholders about their roles in implementation.<br>■ ***Older Adult, Family, and Caregiver Guide on Depression***<br>■ Depression in older adults<br>■ How to recognize depression<br>■ How to access treatment<br>■ How to make informed choices<br>■ How to work with practitioners<br>■ Resources for older adults and their families<br>■ ***Practitioners' Guide for Working with Older Adults with Depression***<br>■ Why you should care about EBPs<br>■ Working with older adults<br>■ Screening, assessing, and diagnosing depression<br>■ Selecting a treatment<br>■ Delivering evidence-based care<br>■ Evaluating care<br>■ Implementing EBPs<br>■ ***Guide for Agency Administrators and Program Leaders***<br>■ Why you should care about EBPs<br>■ Leading the implementation<br>■ Building momentum for change<br>■ Making the change<br>■ Managing and sustaining change<br>■ ***Leadership Guide for Mental Health, Aging, and General Medical Health Authorities***<br>■ Why you should care about EBPs<br>■ Building momentum for change<br>■ Initiating implementation activities<br>■ Expanding and sustaining implementation |
| **The Evidence** | **Evaluating Your Program** | **Using Multimedia to Introduce Your EBP** |
| for all stakeholders | for practitioners, administrators, and members of the quality assurance team | for all stakeholders |

Found at: [SAMHSA's Treatment of Depression in Older Adults Evidence-based Practices KIT]

# 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

| Universal Prevention | Selective/Indicated Prevention | |
|---|---|---|
| **Screening for depression, and suicidal ideation**<br>**- PHQ-9, GDS**<br>**- Suicide Risk Screening**<br><br>**Harm risk reduction**<br>**-Public education reducing access to fire-arms for at-risk seniors**<br>**-Alcohol and medication misuse** | **Outreach**<br>**Gatekeeper**<br>**PATCH** | **PEARLS and PST**<br>**Integrated care of mental health problems in a community-based setting** |
| **Multi-Layered Suicide Prevention**<br>**-**Mental health education workshops<br>-Annual, voluntary depression screening<br>-referral for treatment<br>-psychiatric consultation | **Telephone-based support (TeleHelp TeleCheck)** | **PROSPECT/IPT and IMPACT/PST**<br>**Integrated care of mental health in primary health care settings** |

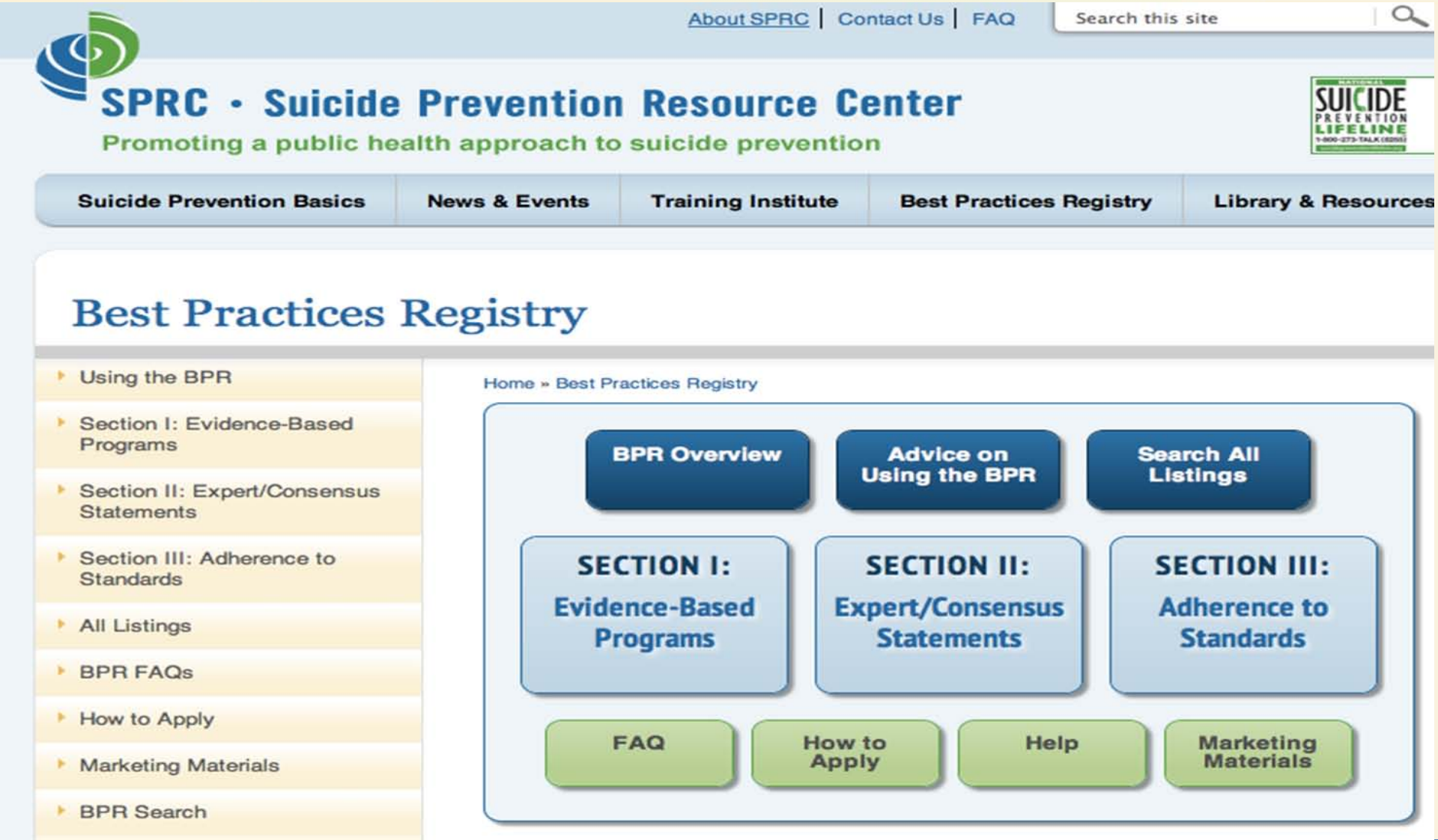
# Suicide Prevention Resource Center

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

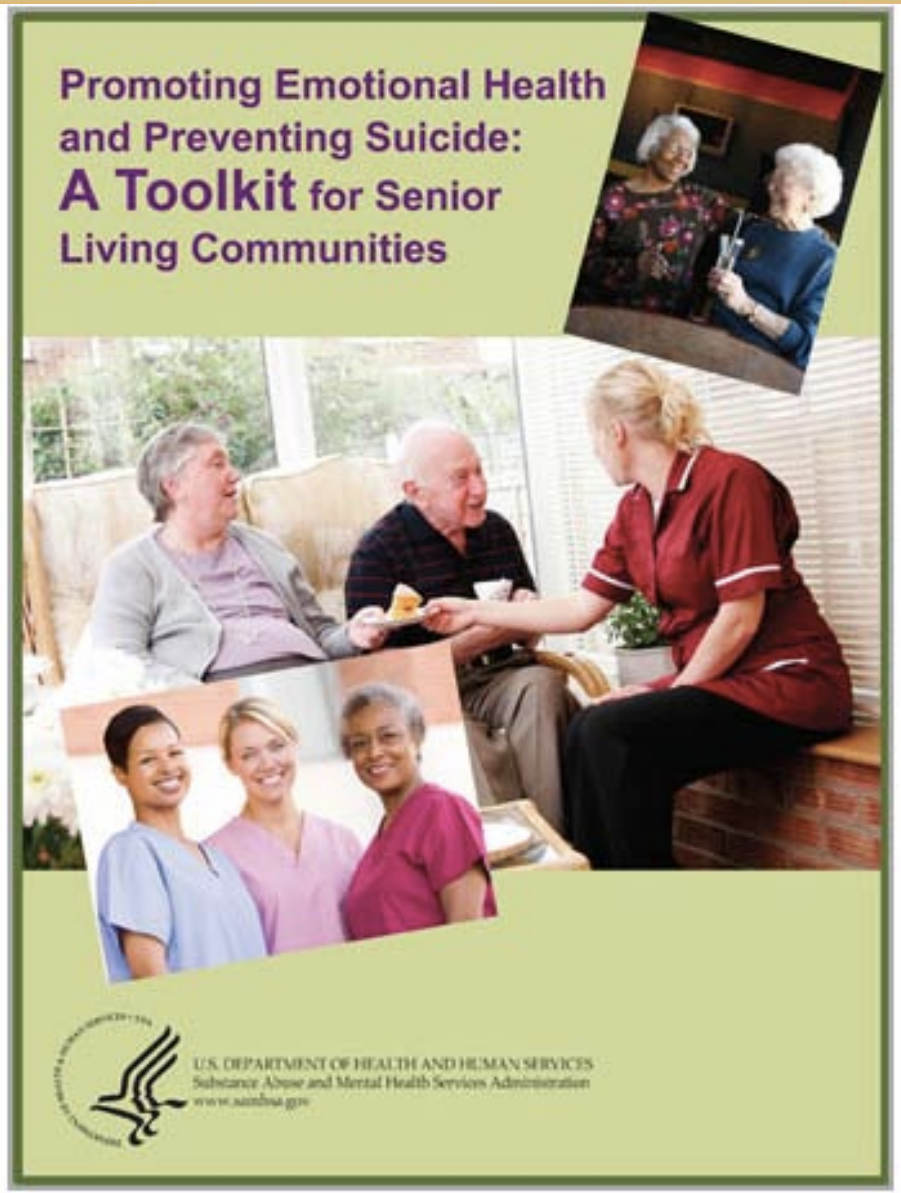

- Advances the goals and objectives of the National Strategy for Suicide Prevention
- Staffing and Coordination for the National Action Alliance for Suicide Prevention
- "Charting the Future of Suicide Prevention"
- Prevention Support for GLS grantees
- Best Practices Registry for Suicide Prevention
- 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



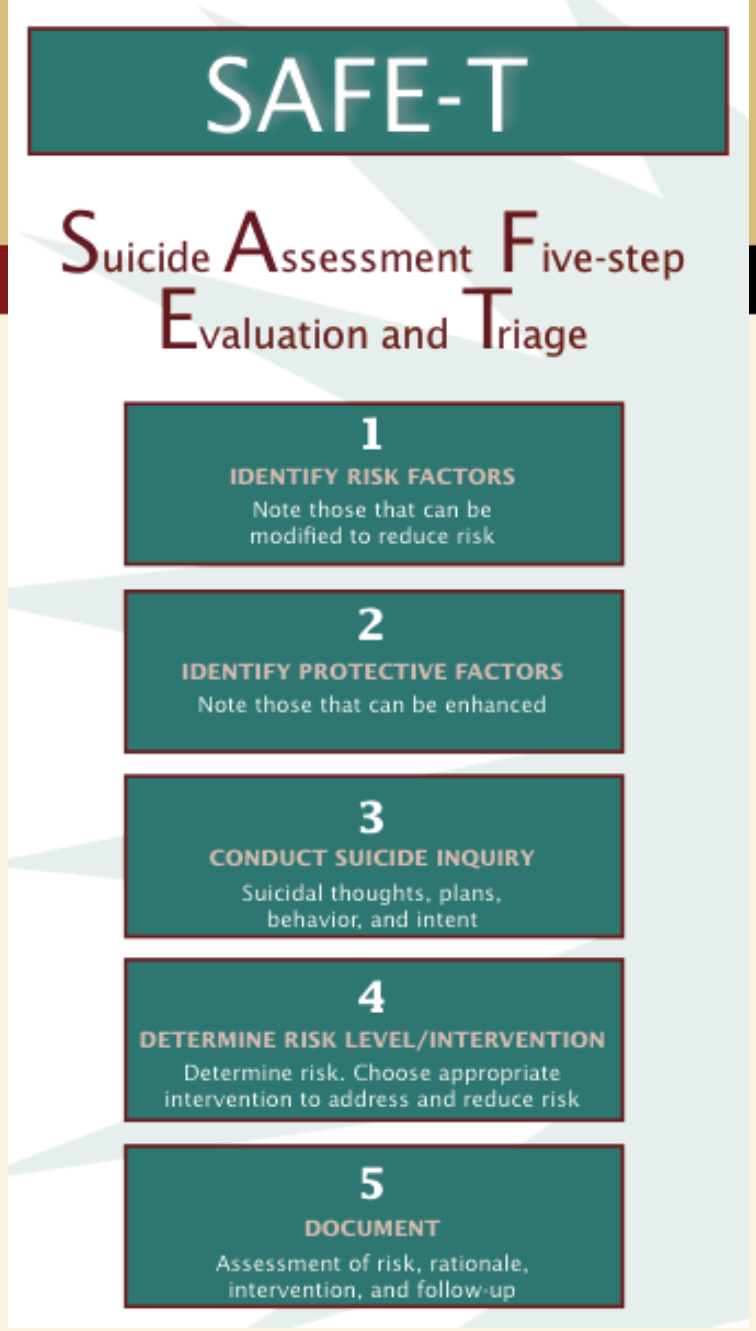

Found at: [Promoting Mental Health and Prevention Suicide: A Toolkit for Senior Living Communities]

# 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

# Created Awareness & Support

- ➔ 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 <u>cultivated partnerships that flow downstream:</u> 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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Huffington Center on Aging

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# 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

AGING RESOURCES of Central Iowa
The Experts on Aging

# Mission of AAA

AGING RESOURCES of Central Iowa
The Experts on Aging

- 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.

# Essential Leadership

- 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

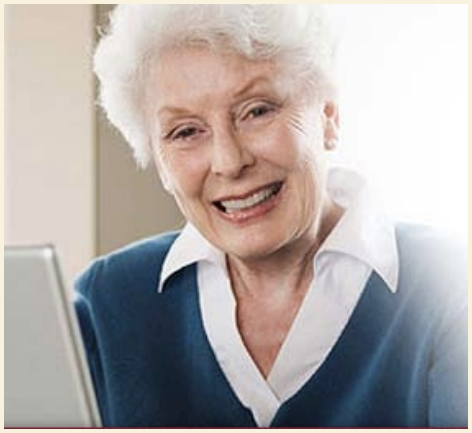
## BRAIDED FUNDING

- 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