OLDER AMERICANS BEHAVIORAL HEALTH TECHNICAL ASSISTANCE CENTER WEBINAR
TOPIC: DEPRESSION, ANXIETY, AND SUICIDE PREVENTION

KATIE WEIDER: Okay, everyone. We can get started. Jennifer?

JENNIFER SOLOMON: Welcome to SAMHSA's Older American's Technical Assistance Webinar Depression, Anxiety, Suicide Prevention in Older Adults. I'm Jennifer Solomon and I'm SAMHSA's Contracting Officer Technical Representative for SAMHSA's Older American Technical Assistance Center. I would like to thank you for participating today. This center supports a partnership between SAMHSA and The Administration on Aging to provide technical assistance to states and organizations as they implement behavioral health programs and services for older adults. Such as those focused on suicide, prescription drug abuse, alcohol abuse, and anxiety and depression. This initiative is focused on persons age 60 and older at risk for experiencing behavioral health problems. This initiative also provides technical assistance to five recipients of SAMHSA's grants to enhance older adult behavior health otherwise known as behavioral health program as well as the aging services network to implement and enhance provision of behavioral health programs and services. This center is going to provide 10 webinars. We are in the third webinar of 10, and 14 issues, along with five policy academy meetings, which will be serving all 10 HHS regions. We

also have another set of webinars that's part of the 10 that serves SAMHSA's behavioral health grantees, so, we are focusing on alcohol and medication misuse and abuse, suicide prevention and the behavioral health grantees are hearing the same information. I'd like to introduce Marian Scheinholtz from SAMHSA who is the project officer on the behavioral health grants. Marian? Marian doesn't appear to have audio at this point. Okay. Why don't I just go on. The purpose of these grants is to provide funding and focus technical assistance to a select group of grantees. These grantees are collaborating with the aging services provider’s area agencies on aging and disability research centers, and senior centers. The partnership represents a change in the CMHS grant program which had previously focused on mental health provider. In addition the goal of the grant program is to address two significant public health problems noted to the affect the quality of life of older adults and to prevent and address prescription drug and alcohol misuse and abuse and suicide prevention. And as I mentioned prior, there are currently five behavioral health grantees that includes Jewish family services of Los Angeles, the mental health association of south central Kansas, mantra's counseling center in Texas, Jefferson Center for mental health in Colorado, and Oakland family

services in Michigan. These programs follow the targeted capacity expansion growth program which has three cohorts of grantees for each three years, from 2002 to 2011. Overall, the 30 grantees address diverse mental health needs of older adults and in general made significant impact on decreasing symptoms of depression, anxiety, trauma, and other mental disorders while improving the functional ability of quality of life for older adults. I would like know introduce Shannon Skowronski from the administration office on aging who is a partner on this initiative and will further suction how AOA and SAMHSA are working together to improve behavioral services for older adults.

SHANNON SKOWRONSKI: Thanks so much, Jennifer. As Jennifer mentioned, my name is Shannon Skowronski, and I am the lead person for behavioral health at the Administration on Aging. I'd like to on behalf of Administrator Kathy Greenlee welcome you to this webinar. We're thrilled to be partnering with SAMHSA on this important initiative and looking forward to providing technical assistance opportunities and tools for the aging network over the coming months. As some of you may be aware, AOA recently became aware of part of a new agency within the department

of health and human services called the administration for community living or ACL. The goal of ACL is to increase access to community supports and participation while focusing attention and resources on the unique needs of older Americans and other persons with disabilities. ACL will support policies and programs focused on the unique needs of individual groups, including older adults who are at risk of behavioral health issues. The vision for the SAMHSA/AOA collaboration very much aligns with the goals of the ACL. So, this webinar series is really intended to provide an opportunity to learn about critical behavioral health conditions and problems affecting older adults, including depression, anxiety, suicide, and prescription drug use and misuse, as well as evidence-based prevention and treatment programs to address these problems. Today's webinar will describe the prevalence and impact of these issues in older adults, and will identify screening strategies and evidence-based treatments. And also actions that state and local agencies can use to implement effective treatments with a specific focus on the strategy that one area agency on aging has used in implementing healthy ideas and pearls. Other webinars that specifically target the aging network for this series will include prescription medication and alcohol abuse webinar which

will be in May, webinar on reaching and engaging older adults in September, one on sustainability and financing of behavioral health interventions which is scheduled for October of this year, and one on family caregivers as clients and partners in care which is scheduled for November. And be on the look-out for notices about registration for those webinars. The next webinar, as I mentioned, will focus on prescription medication misuse and abuse, and it will be on May 16th from 2:30 to 4 o'clock. and all who are registered for this webinar will receive upcoming webinar registration information. Again, I'd like to thank you for joining us, and I will turn things back over to Jennifer to introduce the presenters and sections for this webinar. Jennifer?

JENNIFER SOLOMON: Yes, thank you. Today's webinar is broken into three sections. Dr. Steve Bartels from the Dartmouth Medical School will provide an overview on the prevalent impact and best practices for depression anxiety and suicide prevention in older adults. Dr. Nancy Wilson from Baylor College of Medicine will provide examples of state actions to support the implementation of behavioral health interventions for older adults. And Ms. Cheryl Evans-Pryor from Aging Resources from central Iowa will provide

examples on how agencies have implemented the healthy ideas and pearls program for adults with depression. There will be a 15 to 30-minutes at the end of the webinar for questions. All questions must be typed into the comment box. This webinar will be recorded. [background noise] Slides will be provided to all who register. She dialed into the audio on the phone.

Now I would like to introduce Dr. Steve Bartels who will be our first speaker. Dr. Bartels is a co-scientific director on the technical assistance center. Dr. Bartels is a leading expert on older amore than 30 years experience in both behavioral health and primary care. He was a co-director on the first technical assistance center for adults and provided TA in the center from 2008 to 2011 cohort of SAMHSA's older American TCE grantees. Dr. Bartels is a professor of psychiatry and community and family medicine at dart smug medical school as well as protester of health policy at Dartmouth for health clinical practice. As a leader in the field on mental health and aging Dr. Bartels has extensive experience directing and supporting major research and associations. Since 2007 Dr. Bartels has served as a director of Dartmouth Center for Health on Aging where he leads the Dartmouth Center for

Aging research. The northern New England geriatric education center and Dartmouth Hitchcock Aging Resource Center. He has received many honors for his work and service which include--includes a term as president of the American Association of Geriatric Psychiatry and the founding chair of the Geriatric Mental Health Foundation. Steve? Dr. Bartels?

STEVE BARTELS: Great, I'm here. Thank you very much for that very kind introduction. And I'm really excited to be with all of you today to go over this topic and to have my colleagues who will be following up on the practical implementation. So, without further ado, what I would like to be doing is providing a bit of an overview before turning it over again for some more practical lessons around the implementation at the state and local level. If we could have the next slide, please.

So, this is what you know. You know for sure about the baby boomer so-called tsunami, silver tsunami that we're looking at. And this is, I think, something we're all familiar with in all of us when we give our talks attribute focus on older adults to this significant tsunami. The next slide, please.

What you may not know is that if you look at the projected prevalence of major psychiatric disorders by age group, the individuals who are over age 65 will meet or exceed those other groups that you can see in this table here by the year 2030. So, the take home here is that when you're talking to local agencies, particularly those that are mental health agencies, not necessarily agencies on aging who get this, but the local primary care and mental health providers, that this demographic imperative is going to substantially shift the way we think about providing mental health services so that all of us are going to need to be capable in that specific group of people who are age 65 and older. Next slide.

So, if you look at the prevalence of late life disorders and in specific depression and anxiety disorders, what you see in this slide here is that it varies substantially, particularly with respect to depression in where you look. So, even though the general prevalence in the community for disorder for depressive symptoms is around 15% or major depression as the syndrome of depression is 1 to 3%, you can see if you start moving into primary care or medical in-patient hospital stays or nursing homes, that the rates

dramatically sky rocket. So, again, the take home here is that if you are working with providers, particularly primary care providers or long-term care providers that it's important to be able to know that the rates are as high as one quarter of individuals in primary care have clinically significant depressive symptoms. So, one in four. In 40% within nursing homes. So, that's really quite prevalent if you look at treatment prevalence where the settings where people seek health care. Anxiety disorders we're not so sure about the distribution in different settings. But suffice it to say depending on how you define anxiety disorders; their rates can be as high as 12% in people over age 65. And it's very important to recognize that particularly in older adults that anxiety and depression frequently commingle so that it's not uncommon at all to see mixed symptoms of both depression and anxiety together in older adults. Next slide.

And, so, what are the risk factors for late-life depression and late-life anxiety disorders? Well, as I'm sure you can imagine medical illness and individuals who have significant medical co-morbidity in which they're on multiple medications is a major risk factor for late-life depression. Now, of interest, people who report poor

health and disability in the context of multiple [inaudible] are even more at risk. So, as you might imagine, you might have two people who have equal amounts of medical illness, both may have cancer. And if an individual feels they are in fact more disabled, that they have more pain, or they're more negative about their condition and feel that they're not socially—not supported, they're more likely to be depressed even next to that person who has the same exact medical disorder. So, having a co-morbid medical disorder by itself is not sufficient, but particularly having, again, complications, having poor social support, if you're bereaved, having been recently widowed, and having more of the burdens of aging that occur sometimes are associated with depression. Although you should know if you look at the overall rate of major depression, it actually is less in terms of prevalence in older adults and younger adults. So, the kind of stereotype that as you get older it's normal to be depressed simply isn't true. It's actually the case that the prevalence of major depression actually is less in older adults than younger adults, in part recognizing the resilience of older adults. And it also underscores this idea that depression is not normal, is not a normal part of aging. Anxiety, as you can see here, there are a number of

different things that can produce anxiety. So, certainly medical conditions, people particularly with cardiac conditions, arrhythmias, or people with breathing disorders, individuals with congestive obstructive pulmonary disease who have not much capacity or have limited ability to oxygenate and feel short of breath all the time, anxiety very high in this group. Certainly individuals who have stressful life events or being widowed or separated, and individuals who have had physical limitations and anxiety throughout life, often individuals who have been anxious throughout their life sometimes as they get older and supports strip away are more likely to have reemergence of significant anxiety symptoms in late life. Next slide.

I'm sure you know mental illnesses, regardless of age, are the biggest cause of disability. and, so, that I don't think it's—I'm sure it's preaching to the choir here that the consequences of psychiatric and mental health symptoms in older adults are profound. There's extensive literature on the fact that people, after heart attacks, are more likely to die if they're depressed or people have cancer are more likely also to have mortality, and a host of data on the intermingling of physical health and mental health

in older adults. Suffice it to say this is a major medical burden across all ages exceeding others. Next slide.

So, certainly one of the burdens is poor function ability and one of the outcomes of depression. Another is obviously suicide. I'm sure you know the highest rate of suicide at any age group are people over age 65 and individuals 85 and older have a suicide rate which is two times the national average. And what we know is that the greatest risk is among Caucasian, white males, older men, particularly those who are widowed, divorced, separated and who have——who engage in substance use disorders are cognitively impaired particularly. If you look at research that's been done, trying to reconstruct suicide after the fact, what's really remarkable here is that individuals who complete suicide, particularly older men who have successfully committed suicide, 70% saw their primary care doctor on the month of the suicide, 40% on the week of suicide, and 20% on the day of suicide. Now, what this means is that individuals who are particularly older men are coming into primary care physicians' offices in distress. It does not mean that they're saying, "I want to kill myself and I'm feeling like I want to end my life." But the contrary, when they've looked at these suicides,

usually these are non-specific, but significant distress and that this underscores the need to train primary care providers and other individuals who regularly touch the lives of older adults in routine screening. Next slide.

You can see here again this demographic of the suicide, the different rates of suicide, in the way that particularly climb especially for white males, but also go up for black males. Interestingly, older women seem to be more protected relative to middle age years in terms of suicide. Next slide.

So, what are the risk factors? Well, the risk factors include obviously having depression, major depression, but in the syndrome of depression the thing to look for is hopelessness, that most of the studies that have looked at individuals who commit serious suicide attempts, it's not just that they have depression, mainly low mood or difficulty with energy or some of the difficulties with sleep, but that that depression is marked by a sense of complete despair and hopelessness. And if you compound that with prior suicide attempts and individuals who are in chronic pain or socially isolated, you really start to pile up the risk factors substantially. And we also know that

access to lethal means, particularly guns for the men, dramatically increases suicide rate among older adults. Next slide.

So, what this slide shows you here is that in older adults compared to young adults, there are many fewer attempts for every completed suicide. So, in contrast to the general population where you could have, you know, 35 attempts for every completed death in individuals who are older, there are six attempts for every one death and four emergency room visits for every one death. So, you can see that individuals who are older who make attempts are much more likely to succeed. And perhaps that's due to the fact that individuals who are older are more vulnerable, more frail, more isolated, less likely to be rescued, and that they're more likely to be determined, and again particularly for men they're more likely to use firearms which is a much more lethal means than overdose in most instances. Next slide.

So, this all infers that we should be thinking carefully about how to systematically screen individuals. And part of this initiative that we're talking about promoting through SAMHSA and through the administration on aging is

thinking more broadly about where we should be doing screening. So, you can see here that although most screening in the past is focused on mental health services, it really makes sense to think much more broadly, thinking about where people——where older seek and receive a variety of services or seek help. Social services, clearly, thinking about senior centers or transportation services, or peer support services that might be touching individuals who are despairing and on the brink of suicide or being depressed or significantly anxious. Thinking about the array of community providers that can be so-called gate keepers, which we'll talk about in a few minutes, identifying people at risk. Primary care I think we've underscored already, very important. Very few older adults are likely to walk into a specialty mental health center saying, "I'm suicidal and I want mental health care." Much more likely to walk into a primary care office and say, "I'm not feeling well, I don't have any energy and I'm just feeling like giving up." Finally, many people seek their——some of their counseling or support services from faith-based sources. So, another important place for us to be training and supporting individuals. Next slide.

So, what are the screening tools? There are many, but we'd like to focus on several here. There is the phq-9. There is a component or from the same initial instrument which is called the prime MD that's derived for primary care. There is the general anxieties disorder, 7 question instrument. Some people use depression scale, and then there is also some suicide questions that really can be helpful, particularly suicide questions phq-9, the ninth question which is important and clear way of asking a direct question. And then there is a particular suicide screener. So, we'll go over these in time. One of the major things I want to underscore is there is absolutely no data that supports the asking an older person or anyone about whether they're thinking about suicide. We'll put the idea in their head and at the end we'll promote suicide [inaudible] totally unsupported. In screening, [inaudible] suicidal thoughts. You may potentially save a life. Next slide.

So, one of the major instruments that we frequently suggest people be familiar with is the phq-9, which is showed here. And this——the reason why this has been promoted is not necessarily that it's geriatric specific, but it is a brief and easy to use instrument that primary care physicians in particular understand and it's been promoted widely in

primary care. In fact, the phq-9, many of us who have been promoting this nationally, talk about it as the hemoglobin a1c of depression. The diabetes measure, it's as simple as doing——getting a blood sample for diabetes. It's just as simple as doing this sort of screen. So, often what we'll do is suggest to primary care physicians that they ask the first two questions here. Have you had little interest or pleasure in doing things? Or have you been feeling down, depressed or hopeless? That's the phq-2. And if anybody answers positively to either of those two questions, then we suggest primary care physicians complete the whole phq-9, the whole thing. It's kind of a stratified approach. You'll notice the last question on this, question I at the bottom, is the suicide question. So, you can see in a very compact way on this instrument, can help screen and actually it also helps track——there is a way of coding this that helps differentiate major depression versus minor depression which I won't go into, but it can be quite useful. The professional scale also quite useful. It doesn't have the same suicide question, isn't used as much in primary care but is a good alternative. Next slide.

So, in terms of screening for depression, this is the sister of the phq-9, it's the anxiety set of questions.

You can see they're rated exactly the same way in terms of the frequency. Not at all, several days, more than half of days, nearly every day. And there's a way of quantifying the presence of generalized anxiety disorder in older adults. We don't necessarily recommend that this be used in every instance of having a contact with an older adult. If we had to choose and you don't have much time, clearly screening for depression is really a great importance. And, again, those two questions I mentioned at a minimum to start is the place to go. Out if you have someone who has mixed anxiety questions, this is a good screen. Next slide.

So, what happens if you find that somebody positively states that they have some thoughts about suicide? It's suggested that if anyone has a positive response, what you want to do is you want to look at defining whether or not the individual actually has specific ideas of wanting to hurt or kill themselves. Not at all uncommon for older adults to have passive suicide ideation. As my grandmother used to say, "Steve, I'm ready for the bone yard. I could be dead tomorrow and I'd be fine. I've had a good life." That's you know, death ideation and is very normal. And then there are people who sometimes say, I think sometimes

about ending my life, but I'd never do it. So, it's important to ask those questions to specify. Are you specifically having thoughts of hurting or killing yourself? Not just passively dying. And then it——if you go to the next slide, there is an additional screener that sometimes used in high volume settings where people are seeing many individuals with suicide risk that actually goes through a number of——three, rather four specific questions which you can see. Bring you down kind of a decision path to rank individuals as being minimal, low, or high in terms of suicide risk. And, so, as you can see, if somebody——the question number 3, big difference between a thought of acting versus actually doing it, if it's likely or very likely, that's a great concern. Next slide.

So, what are some of the evidence-based interventions that exist? In addition to needing the screening, we need to be able to do something about the screen. And, so, there are outreach programs that exist in terms of helping to identify people in the community who are at risk for depression or anxiety or substance use disorders. One of these, a very interesting program, the patch program in inner city Baltimore had trained indigenous workers, managers and janitors to using what's called the gate

keeper model, training people who live in the community to identify older individuals at risk. And then referring to a psychiatric nurse and doing an evaluation, even beginning treatment in the individual's home or apartment. And that was effective in reducing psychiatric symptoms as a great example of an outreach program in a lower income indigent, inner city population. Next slide.

Now, one of the most common and widely spread models now that I'm sure you probably heard about is the impact model. And this is specifically for identifying the screening and treating individuals through brief interventions in primary health care settings. This model, which has also been called collaborative care, has a care manager, a depression clinical specialist. This could be anybody, a nurse, a social worker, a health worker who provides patient education, who does screening with the phq-9, and then tracks that over time and is trained in delivering brief problem solving therapy which is developed for primary care, so-called PSPPPC. And then it's also coupled with primary care physician consultation and involvement of a team psychiatrist if necessary. And individuals are given either medication or problem-solving therapy, and then monitored on a very regular basis. And if people aren't

getting better, then again treatment is changed. Next slide.

So, this shows——this is the depression care components which are in any kind of algorithmically derivative model which has been adapted in the community outside of primary care also. You'll see it's all about screening, helping people in self-management. Monitoring people over time with an instrument, giving a brief intervention and coupling that with medication treatment and doing step care. Next slide.

The impact study that looked at this, looking at the individuals who had depression care management versus care as usual, you can see that over time those individuals who had depression care management did a lot better and were much more likely to recover in terms of their depression compared to usual care. Next slide.

So, that's impact. Now, the whole idea of this collaborative model of screening and monitoring and delivering brief interventions has been also offered within community-based settings. And the pearls model is an example of a community integrated home-based depression treatment which looks like the impact model in many

respects except it's done in the patient's home or the client's home. Eight sessions, 45 minutes, 60 minutes each. After you screen the person originally and identify them as having depression, delivering problem-solving therapy, social activation, pleasurable activity scheduling, using a team approach. If you look at the next slide, what you'll see is that the results here are as good as and competitive with the impact program. So, here you'll see 50% reduction in depression and the pearls model compared to usual care. It's very important to note that, again, these components of step care in using a manualized intervention such as problem-solving therapy is the key, and then screening people downstream to make sure they're getting better. Simply doing supportive psychotherapy or general counseling is not good enough. You need to be following these algorithmically driven cognitively oriented therapies or use so-called behavioral activation strategies, and to monitor people over time. Next slide.

And, so, half the ideas, you'll hear a little more about later, is another evidence-based practice which, again, is focused on community-based interventions. It's embedded in case management programs and conducted in a client's home on a one-to-one basis over three to six months. Again,

this has similar components here. Screening is essential around depression and severity. This provides education, also provides referral and linkage to mental health providers which is a little different in the sense that if people need pharmacological treatment, that is provided outside or specialized care. But it has also a component that's similar to, again, one of the components in problem-solving therapy which is behavioral activation, empowering people to manage their symptoms, to engage in specific activities that are pleasurable or meaningful and taking one step at a time towards being more active and less passively depressed. Next slide.

So, we've put together, worked with SAMHSA in helping put together a treatment of depression tool kit. In essence, this is an implementation evident-based practice kit that you can obtain on the web. It is free. Your taxes paid for this. And this particular evidence-based practice kit helps you to select the specific evidence-based practice for depression in your agency or in your particular clinical setting. So, it will walk you through what are the different aspects of the different evidence-based practices, what are the competencies and capacities that you need to implement the evidence-based practice and where

you can learn about getting trained and implementing if you need it. So, I'd recommend this recently very nice product that SAMHSA has put together that the number of us contributed to over time, and that's available to you. Next slide.

So, if you look at anxiety, the important thing here is that you may start seeing that there are similarities. So, one of the major effective treatments for anxiety is, in fact, behaviorally oriented psychotherapy. So, cognitive behavioral therapy, supportive therapy, and to some extent problem-solving therapy is effective in anxiety. And also pharmacotherapy, usually consisting of antidepressant medications, not long-term treatment with benzodiazepine which is not indicated. And then providing certain supportive services delivery models. Once again, these are——should be protocol driven. The good news here is often many of the things that work for depression also worked for anxiety disorders and there's mixed anxiety and depression, cognitive behavioral therapy, and sometimes SSRIS as an antidepressant medication can be helpful. Next slide.

So, if we think about prevention and early intervention, you know, there are optimal focus is really to focus on

both individuals who are significant risk as indicated prevention, selective, those are people at increased risk people who are depressed, and universal, helping to train everybody in looking for and detecting and helping older adults who may be at risk in the greater population with respect to suicide prevention. Next slide.

So, if you think about these different areas, universal prevention is a population-based approach to prevention and selective an indicated is focusing on people with more risk. You can see in this table kind of the summary of what I've been talking about here. The universal prevention strategy is to implement screening in places where people seek and receive care, and often that should be at a minimum using the phq-2 to start those two questions and then maybe expanding to a larger array of questions if necessary, and then doing suicide risk screening. Harm risk reduction really important. Again, we know that particularly the highest rate of suicide is among older men and the major means is firearms. So, that's a really important target in term of thinking about risk reduction. Certainly alcohol and medication misuse dramatically places people at increased risk. And then thinking about a multi-layered suicide prevention with

workshops, volunteer depression screening in malls and neighborhoods and senior centers and long-term care, and referral for treatment and consultation if necessary. When people have actual specific risk factors like depression or significant risk, what we want to do is think about identifying those individuals through outreach, such as the gate keeper program or patch, providing telecheck or telehealth in terms of support. And then as you've heard, pearls problem solving therapy, PST or impact or healthy ideas, a number of these interventions are all useful in terms of thinking about risk. Next slide.

I also want to make you aware of the national suicide prevention resource center that is available that is federally funded and has a number of excellent resources. You should visit the website. Has not only various tools that can use or best practices, primary care tool kit and training institute, but also there are capacity to help answer your questions as they come up around various concerns that you might have or programs you're thinking about. Next slide.

And here, too, you can see on the web page various aspects of what they make available to you, evidence-based

programs, consensus statements standards, materials, and a number of things that are available to you that you should take advantage of. And there is also this specific tool kit that's been developed that you can see here on promoting mental health and prevention of suicide for senior living communities which I would commend to you is a very useful, very easy to read, and educational potential resource that you could share with some of your colleagues within the senior living commutes. Next slide.

Finally, national suicide prevention life line, there is a particular phone number that you can handout to individuals who you are serving or their family members that will provide crisis management 24 hours a day and provide assistance in getting help when that comes up. Next slide.

So, kind of in summary around the suicide assessment, there are——the focus is on identifying risk factors, thinking about protective factors, then conducting an inquiry around thoughts, plans and behaviors, determining the level of risk, how acute the risk is, and then choosing a specific intervention to address the severity of risk. And, again, you can find this as part of one of the tools at the

suicide prevention website and it's available as shown here. Next slide.

So, that's a quick tour as an overview and hopefully gives you an orientation to the issue of depression and anxiety prevention in terms of prevalence and risk factors and strategies. Now what we want to do after having done that broad swath in terms of an overview, what we want to do is start to drill down into specific examples. First, at the state level and then subsequently at a specific service provider level. So, it's my pleasure to introduce to you to provide some examples of support for evidence-based practices for depression and management with respect to the states is Nancy Wilson.

Nancy Wilson is a social worker who is specialized in gerontology and is well known as a national expert in geriatrics and particularly in social work in geriatrics. She's an associate professor in the department of medicine of geriatrics and assistant director of the Huffington Center on Aging at Baylor. She's an associate of the Baylor BA Houston center for health services research, very active researcher, particularly focusing on healthy ideas and a number of other areas that she's championed over the

years, and also works from the Texas consortium of geriatric education centers. At Baylor she's largely been devoted to developing and overseeing interdisciplinary education and community training programs in aging and participating in community-based research long term care and mental health. And economist recently has been the lighter of inter disciplinary academic team head of development of healthy ideas. So, it's my pleasure to introduce the next segment to you, a friend and colleague, Nancy Wilson. Nancy?

NANCY WILSON: Thanks, Steve. I am happy to follow you and always energized around the challenges that we all face. I think that we can all appreciate that community agencies, as Steve has indicated, reach at-risk populations and have very vital roles to play in addressing the disabling conditions of depression, depressive symptoms, anxiety, and obviously in addressing suicide risk reduction. And as we've heard, we have evidence-based practices and some models and we have very exciting and valuable tool kits to support our efforts to advance attention to these concerns. However, I'm sure you're all thinking, as we often do in our field, one more thing that I need to think about how I can do in this time of limited resources. And we certainly do face challenges in modifying practices and implementing

new program models that take new partnerships. I'm going to spend a little bit of time talking about some of the outstanding leadership that I've seen in states around the country that are stepping up to these challenges and figuring out how to work together. And I think those of us in aging services have been implementing evidence-based programs around a number of conditions and challenges that require partnerships. We always have to start with thinking about what our resources are, who needs to be on the team, what it is we feel prepared to do in our community and our specific agency, and how do we meld the professional resources needed for that. And obviously how do we track what we're doing as was emphasized by Dr. Bartels. We don't want to just begin asking questions and not take action and follow-up to see benefits. So, next slide, please.

I'd like to talk a little bit about the key challenges I think we face that are a little bit more unique than when we're perhaps addressing an issue that is——has been within the scope of either mental health services or within aging services, and that is we don't all share the same coffeepot or water cooler in the case of Texas, and we don't have an instant app for how we build these partnerships and how we

think about what we're able to tackle and where——what we're able to do in terms of introducing attention to these issues. And we know from work that's been done and it will be clearly described in the tool kit which I'd encourage you all to download on evidence-based practice depression, there are key steps to be successful in implementing evidence-based approaches that involve thinking about what skill sets we have and how do we meld the clinical behavioral health expertise to support our front line aging services staff, many of whom may not have had extensive training in addressing behavioral health issues or even having these conversations, being able to apply standardized screening tools may be a new change in skill sets. So, we have to think about how we incorporate these actions into our day-to-day work and how we build the relationships we need. And this is where I think states have very vital roles. Next slide, please.

I want to talk a little bit about how states have helped agencies have the right leadership and have helped them identify the necessary coaching and training expertise. All of us who are involved in day to day delivery learn in the doing. So, once we he learn a model, we have to be able to get some clarity implementing it with clients. How

do we set up these linkages and referral systems? Again, depression is a condition and anxiety; oftentimes we need further evaluation and attention as was talked about. We may need attention from pharmacotherapy. So, how do we have these systems in place? Because again, we're often working across silos of financing and delivery. So, what have states done to support this sort of implementation activity that's essential, even if we're just going to start paying attention to screening and suicide risk reduction or community education? We want to think about what are those systems in place to respond because, as was said, screening itself is not sufficient. We need to think about what supports are in place. So, next slide, please.

So, I'm happy to say that webinars like this and the type of partnership that I think that SAMHSA and AOA are illustrating to us by convening us all together is something that can be replicated and emulated at the state level. And by that I mean states have very vital roles to play in exposing their key stakeholders to evidence-based practices and approaches. So, how do we translate the information we've heard today to agency levels to help them think about how to take action? Hearing information from peers, as I've learned with adolescents, is oftentimes the

most valuable way to influence practice and behavior. Let them hear, as you're going to hear shortly, how an agency in their state has taken action towards implementing either if not full-blown depression care management model, has begun to pay attention to depression or anxiety in other approaches. And, so, thinking about what are those forums where states can take valuable time and say, talking about fall, let's see how we can address depression and suicide. One of the vital things we have going for us now are oftentimes technology platforms such as webinars and teleconferencing systems that allow us, although we may be at different addresses in the same community, be on the same phone call. And states have done very exciting things to bring together expertise from mental health and aging to support agencies as they do things like develop suicide risk protocols or think about how they're going to learn or continue to use their skills around a model that they may have been trained in. So, that's another vital opportunity to support the careful work that we need to do to modify our practices. Next slide, please.

So, oftentimes these partnerships may come from a local agency approaching a state partner to say, can you help facilitate access to the suicide support training that's

available through mental health? But many times states themselves have exercised this leadership and I want to commend to you just a few that I've seen where mental health and aging at the state level, not full-time dedicated people, pieces of individuals have come together and said, how can we bring our resources together to advance training and practice? And in Ohio they've made major progress in——across the single state agency for substance abuse as well as mental health as well as aging, to consolidate resources and do a lot of joint training, including giving mini grants to areas of agency aging that have adopted pearl ideas and gate keeper approaches you've heard about. Training work force is obviously a key issue. How can we do that jointly across agencies? And again, you have geriatric education centers or HRSA supported training going on in state institutions. North Carolina has used this. The state of Oklahoma was able to mobilize through the Oklahoma department of mental health their aging expertise to reach out to several agencies that were going to be implementing depression care management model. So, there are lots of opportunities to do this. And obviously through all our work going on with aging disability resource centers, we know there is also a lot that the aging services system can trade-off in supporting what's

going on with behavioral health delivery to older adults who need assistance. I think a key area where irk there is great hope is the crisis team suicide hotline linkage, making sure that we know as agencies——aging services begin to address these issues how they can be supported in this key issue. Next slide, please.

So, a key opportunity where states can do things that may not be cost——that may at least be cost neutral is to look at our mandated tools that we're requiring service providers to use and use some of these valid tools that we've heard about today to begin to look at the prevalence and to help individuals take action, but also help communities know the scope of the problem around depression, around alcohol use, around suicide so we know how to direct resources. So, many agencies most recently I've seen a version of the state of Florida have totally refined what they're doing, and this is valuable use of state policy expertise. Likewise, I think we're always eager to make sure we maximize all funding sources and how those can flow across silos. So, do we have opportunities for——within Medicaid, within state-financed programs to even using pieces of those funding to address these sorts of issues? And we heard recently new opportunities for title 3d. Again

perhaps we can support coaching expertise if we're not able to support all the front line adding staff. We've had agencies that allowed their community health centers to redirect resources that have been previously used to just work with individual clients to be the coaching support to an agency staff that's trying to adopt some of these evidence-based approaches of behavioral cognitive behavioral therapy or cognitive behavioral strategies, having that coaching support. Next slide, please.

So, other opportunities that I think we're all excited about that states have begun to think is how do we work within our existing Medicaid framework, realizing that, again, depression, anxiety, these are substance misuse and abuse, these are key disabling conditions that we see in our population of older adults receiving long-term care, particularly community long-term care community services. I commend to you looking at a webinar that talks about how the state of Washington has been able to modify its 1915 c waiver because they had valid data from using a valid depression screening tool in their program to look at a gap in service to persons with minor depressive disorders and have now been able to incorporate that into their 1915 c waiver. An upcoming publication will talk in more detail,

but there are also more resources available to talk about a pilot going on in the state of Texas and there are other pilots going on in this area as well through money follows the person. How do we address the population of older adults who may be able to live safe, independently in the community if their behavioral health needs are addressed, including substance misuse as well as depression treatment? So, these are programs to look into and other avenues to think about how do we use our state policy financing leadership and options within Medicaid systems. Next slide, please.

I want to also highlight the fact that terms to identify the scope of the problem, we could benefit from working with individuals whose attention is often on looking at issues around data, which may be academic institutions or it may be state evaluation teams, helping agencies look at whether or not as they begin to deliver services, are seeing improvements in rates of depressive symptoms or anxiety, but also helping to figure out what the scope of the problem is to help make the case with funders, whether that's public funders or private funders. So, think about making those requests at the local level or think at the

state level about how you can offer that expertise. Next slide, please.

Likewise, we oftentimes know that within many of these programs we need to offer education, which is not always done by verbally doing things, but have manuals, having materials available that are consumer ready, ready to be used. That's something that many states have said, we can't fund personnel, but we have a printing budget that we can support you around this area. We know that there's been very exciting work going on around other chronic health issues where we can get attention to depression incorporated with attention to co-morbid conditions such as those that Dr. Bartels talked about. I've personally seen diabetes initiatives where along with focusing on healthy behaviors related to diabetes, we were able to get attention to depression considerations, and then again there's been very exciting work going on with chronic disease self-management delivery through peer mental health specialists. Perhaps there are opportunities for peer training around other mental health models. Next slide, please.

So, I'm very privileged to talk to——to introduce to you now a local champion who I think exemplifies the best in leadership and advancing evidence-based practice, Cheryl Evans-Pryor. Cheryl is a gerontologist with over 25 years working in the field of aging and mental health. She is a very dedicated project manager for evident-based practice programs within the state of Iowa, specifically at the AAA known as the aging resources of central Iowa. I'm very proud to say she's a certified regional trainer in the healthy ideas model and has trained not only in her state, but in a neighboring state, and am also a local trainer for the pearls model. She has been responsible for leading the training implementation of both healthy ideas and pearls within her AAA region, and has focused very carefully around issues of adopting and implementing program——a program pilot to help look at what can be done to take things to scale. So, Cheryl, please tell us how it works at the local level.

CHERYL EVANS-PRYOR: Thank you, Nancy. What I'd like to offer you today, I'm here with my esteemed colleagues who have helped bring these evidence-based practices to fruition here in the state of Iowa. I'd like to offer some practice-based evidence that these program models do work

and from a practitioner perspective in regards to the implementation of the models.

The mission of our AAA or area agency on aging is to advocate or provide word nation through federal, state and local support to persons 60 and older. We certainly want to encourage individual choices and help folks remain safe and independent in the community. That's our primary mission. And we've done so by taking a proactive role regarding mental health services and working with collaborative partners to address the behavioral, emotional, and psychological issues that older adults do in fact face. And part of my role is to provide consultation with the partners regarding the barriers and the implementation issues, also regarding outcomes and then, of course, training and coordination of these models within our areas. An additional role that I have here at the agency is I do consultation with our case management staff who is implementing the healthy ideas model. So, that has, for co-location model that has worked very well for us also.

Regarding the implementation of—the next slide, please—of healthy ideas, we started our training for healthy ideas

and we were very fortunate to have Nancy Wilson be the national trainer to train us in 2010. And we also had a clinical consultant as well as the case management team and team leaders within our group. And we completed our pilot project in February of 2011. The case management staff provides the in-home services and coordination of service to clients in either their home or an assisted living facility. They do not coordinate services if that person then goes to long-term care. So, in working with our local mental health center who is our partner in our clinical consultant to our team, we have an agreement on a fee-for-service arrangement and agreement for upgraded training that we go through. Since most case management clients are frail and home bound, one of the strategies that we implemented is deciding to do the initial screening for healthy ideas at the 90-day visit instead of at the initial visit. And that allows the case managers to not only build the rapport with the older adult, but also to complete their service paperwork and implement and institute the brokering of services that they need for the older adults. And, so, we chose to take that 90-day approach which has worked quite well for us. To date, for healthy ideas we have screened a positive score of 6 or more on a geriatric depression score, 101 clients, and 52 of those folks have

successfully completed the program. The referrals are self-identified through enrollment assessment and screening. So, we meet the folks where they currently are and their identified needs, even though they may have a history of depression, but we meet them where they currently are screening in at through those instruments that we use.

In the pearls model we adopted that model in 2009 with the intent to train our partners which is senior outreach counseling staff through the local community mental health center. And then their team leader also decided to get trained specifically from the folks at the university of Washington health promotion research center. So, that person then would also be able to co-train with myself and in-house train the other staff in their inter disciplinary team that they have at the mental health center.

So, in 2010 when they started to conduct screenings for both clients that were new and referred clients, and their program serves folks that are 60 and older, they provide an in-home counseling service, which is unique in that they are able to go to where the person resides and conduct that counseling. So, as an outreach service through the mental

health center, it works very well and the psychiatric consultation then is provided by their psychiatrist at the mental health center, and that certainly helps with the fidelity to that particular model. And they have consultation every month, case consultation. They work with a host of providers in the community and get referrals from as well, not only the area agencies, but for-profit case managers, home health agencies, et cetera, and also work with various public service providers. Next, please.

The majority of their cases that they serve with mood disorders have major depression or major depressive disorder which does preclude them from meeting the criteria for inclusion in the pearls model, as that model is for minor depression and dysthymia. It is voluntary participation in the model and it is eight sessions over the course of 19 weeks. And they have screened and enrolled to date 25 clients and 10 of those folks have completed that program. There is an integration of the screening process and the screening can be quite lengthy in their admissions process. So, they've synthesized that information to make it easier to identify those symptoms of minor depression and dysthymia front. Algorhythmically they can decide which way to proceed. Both the trained

clinical consultant provides rapport and motivational skills to staff which are necessary [speaker not understood], and it helps encourage benefits of feeling better and problem solving. Next, please.

So, regarding the outcomes of the pearls model, there has been significant symptom reduction, improvement in their phq-9 scores, referrals to specialists such as neurology or psychiatry. The problem solving skill set that they acquire can be used universally. And also had helps them build their sense of confidence, which can be a major barrier for folks in dealing with depression. And it helps their coping skills and folks do gain a significant amount of insight into the connection between their mood and behavior.

Regarding pleasant events, they request assistance from their family and are more likely to ask to go out and do things together and participate in outings, and that is one of the key components to that model, is experiencing more pleasant events in their life. Next, please.

Regarding the outcomes for the healthy ideas model, we have 101 clients have scored a 6 or more which is a positive

score on the geriatric depression scale, and 52 of those clients have successfully completed the program. And in addition to the score reduction, we've had increased—increased activities at home. People are experiencing revisiting old hobbies or experiencing new things or new interests that they might want to try. Talk about their pain levels have decreased. They certainly have gained some confidence in their ability to cope with depression and report that they in general just feel better after having participated in the program. Next, please.

When we talk about the elements of implementation and how it has been successful, for both of these models it's very important that I think the number one thing that's been successful for us is we've established these collaborative relationships. Instead of focusing on our own silos of expertise, we have really all come to the table and been willing to be collaborative partners. And that's been one of the things that's very exciting about these models, is working with your colleagues in a different capacity. It certainly has taken leadership and having a good understanding of—that it works, and that it's beneficial to embed these programs into your existing programs that you serve with older adults. Having a systematic approach and

embedding it into your practice, these models are time sensitive and they are short-term interventions and they're cost-effective. And it's more in line with the brief treatment model that is very commonly utilized in the mental health world. There is a universal understanding, of course, that not all clients want to discuss their emotional issues or trust someone to do that with. And they may have, for other reasons as well, might just be that they don't have the energy or they might not have the buy-in that this person can help them emotionally. They may be skeptical. They may, in fact, sabotage your efforts and they may sabotage their own efforts. We also were willing to help those who are willing to participate. So, the folks that want to participate, we're going to proceed forward and help them as much as possible. Next slide, please.

We have had some challenges to overcome in both models as well. First of all, embracing the readiness to change, change can be quite scary for folks and it's another new process. When people have limited time, especially case management staff and clinicians in the field, seeing numerous clients in a day, so, embracing that readiness to change their selves was one of the biggest first steps that

we had to accomplish. There was some initial resistance to change, and certainly the time elements that are involved in the training and service delivery. In regarding funding, we had to make sure that we were able to secure adequate funding. And there may be different streams of funding for various parts of the training and/or the documentation pieces and figuring all of those out in trying to streamline the process. We use consistent forms in trying to reduce the variability to make it easier in a systematic approach for everyone to operate in the same way. And initially we utilize braided funding to be flexible. We felt we had to be flexible in order to make it all work. Next slide, please.

In addition to that, we have some essential leadership and we've been fortunate that with our executive director and board of directors as well as the management staff here that they have a global understanding of how we have the unmet needs of older adults regarding mental health that we want to take a proactive role in making sure that we address those issues and serve them in the best capacity possible. Some of our partners may have decide that their contributions, they're going to define their own contributions and set boundaries around what they're able

to do and not able to do. And also taking a more global picture of what kind of—what would it look like if we had optimal mental health services and what would that look like for the older adults in the community. And keeping those things in the forefront of our mind as we move forward. We have been very committed to being solution focused and not allowing these barriers to get in our way. And the sense of accomplishment that both the case management staff, the clinicians that are providing 9 service in the field, those types of accomplishments propel us forward.

We have also had to learn that we have to accept that stakeholders might not become change agents or early adopters, despite our encouragement. And have a realistic recognition of the barriers to implement the model, and also just the barriers that—for depression care services in general. We also have become risk takers and creative in addressing our program needs. We want to make sure that we have a consistent message, that we're all in it together, and that the problem is much bigger than all of us. And also recognizing that we are, in fact, helping deter suicides, and take ownership for the fact that we have to stay on course with this and provide better services

overall regarding mental health, and being proactive in our adoption and establishing leadership.

So, we are celebrating successes as the clients have and the staff has, both. We have——the next slide, please. Through our funding, we talk about braided funding. Part of my role, I'm funded through a geriatric education center, HRSA grant at the University of Iowa, and foundational grants, our healthy ideas model is sustained through state elderly waiver funds, Medicaid dollars. Pearls model is the assessments. Again, that's that braided piece. For county funding they have a contracted rate and then also for the sessions that the clinicians perform, they have the elderly waiver or county funding to utilize. Next, please.

So, when we talk about the importance and the value of these programs, I think for twofold, one is the older adults. We talked about engagement and it's the self-permission that they can make change, which is really important for the older adults. One of the senses of value is the hope for improvement, we are messengers of hope and confidence building which is very important for them to maintain their independence. And they get a lot of

secondary appreciation when they learn a new skill and acquire a new skill. So, the problem solving and behavioral activation has been very helpful. And its task oriented so it's broken down in a stepped approach and it stops folks from being sober while they can't make any moves forward. And it's motivational so, it also helps them stop their procrastination. Next, please.

It also teaches clients how to ask their primary care physician or specialist for assistance in identifying symptoms. And that's one of the greatest caveats, I think, of these programs, is that when you can have a client who is able to ask for help and articulate that themselves, they are then recognizing that connection between their mood and behavior and reaching out. When that occurs, then you're going to have better treatment compliance. It also validates the older adults' values and concerns and not necessarily the caregiver or the staff member. And it encourages those natural relationships with their peers. Next, please.

And finally, I want to talk about the value and importance to family as families report to the staff that they have improved communication and interactions. It helps them

recognize the contributions that the older adult can make, focusing on positive behavior and change versus negative. And it deters some of the co-dependency that exists and it encourages progress and it can set boundaries around it. In having the insight into dynamics of change and the stages of change and how to resolve the ambivalence that occurs when we're in a stage of change, gaining some of those insight into those dynamics are very important. And looking at how to recognize the generational differences in a new context, it takes courage to talk about and show emotion and some older adults are quite guarded about that. It can validate feelings and it allows families to be very supportive of the older adults who are participating in these models. So, that's what we would like to offer you today from a practitioner perspective.

KATHY CAMERON: Well, thank you, everyone. This is Kathy Cameron with JBS. And we don't have any questions that have been submitted, but I wondered if any of the speakers have questions of the other speakers or SAMSHA or AOA. If you have some questions you'd like to pose, or those participants on the webinar, you still have time to submit questions if you want to in the chat box. I don't know if someone is trying to ask or——[laughter]

Well, I think you were all incredibly comprehensive in your presentations with these——overview of the problems and the evidence-based programs, and then Nancy's review of state strategies for implementation and Cheryl's review of what's happening with her organization in Iowa and implementing two excellent evidence-based programs. Okay, we do have one question.

Is there only private pay as a means for community-based services for social programming?

So, this is a question about financing of these evidence-based programs and community-based settings. I guess either Nancy or Cheryl; would you like to discuss that question? And talk about the different funding strategies that are available?

NANCY WILSON: Certainly. So, Cheryl, I'll start off, and please feel free to chime in. I don't know what setting the caller represents, but it's been our observation that and from talking to my colleagues who run the TA center at pearls, that a variety of different funding, public and private, particularly nonprofit sources have been used.

So, for instance, close to home in my own community of Houston, we have social service providers who get support through their united way service delivery, and the united way here was particularly interested in the fact that they were looking carefully at outcomes and focusing on high risk. So, these are agencies doing case management delivery that are also part of the area agency on aging service delivery system.

As was talked about in the state of Washington, their area agency on aging case management providers have the option of getting reimbursed on a unit rate for delivering the pearls intervention that Cheryl described. And we have seen that oftentimes getting the program developed initially is supported by foundations which allow agencies the opportunity to explore some of these other public sources. Cheryl, do you want to add?

CHERYL EVANS-PRYOR: Well, as I spoke to earlier, that in our particular situation we do use the type of braided funding, but primarily for our case managers is through the elderly waiver funds. And, so, that's how that is primarily paid for. And then the pearls model is through county dollars that are allocated for mental health interventions, as well

as they can also utilize elderly waiver funds when they're seeing clients as well.

KATHY CAMERON: Okay, thank you. We do have another question.

How will mental health parity from Medicare impact Cheryl's most excellent programs in Iowa?

CHERYL EVANS-PRYOR: Well, I'm not sure how to answer that. [laughter] I think one of the things we recognize is that in order to get Medicare reimbursement, you have to be a, you know, certified Medicare provider which typically requires a certain level of licensure at this stage. And we have found that it doesn't always require front line providers of either pearls or healthy ideas to be licensed providers if they have adequate training support, consultative back up and supervision. So, one of the things I guess agencies will have an opportunity to look at is whether or not they want to have licensed behavioral staff. And we do have some community aging service providers around the country that already do bill for Medicare, but obviously we hope that the rate of reimbursement will increase substantially through parity.

KATHY CAMERON: Thank you.

NANCY WILSON: I'd like to piggyback on that as well and say the rate of reimbursement through Medicare currently for the community providers is quite substantially lower than other funding mechanisms. So, in addition to having to operate the program in a certified Medicare facility and get that facility authorized, it also is an issue of the reimbursement rate being substantially low. So, we hope that that will change. Thank you.

But I do want to underscore the Medicare wellness visit that many primary care settings are looking at. I think that these are important opportunities for avenues of discussion with community aging service providers to have with local health providers. How are they going to—if you screen for depression, you have to have something in place. So, maybe this is an opportunity for a partnership discussion.

CHERYL EVANS-PRYOR: Agreed.

KATHY CAMERON: Thank you both. A question came in about whether or not we'll get a copy of the PowerPoint presentations.

And everyone who registered for this webinar will receive both a copy of the PowerPoint presentations as well as a recording of this webinar that you can share with your colleagues in your organizations.

Well, that is it for questions.

We want to thank all the presenters for your excellent presentations about depression, anxiety, and suicide prevention programs. And we will be sending out information about the next webinar which will be in May on psycho active prescription drug misuse and abuse. So, thank you all for being part of this webinar. Have a good afternoon.

Thank you.