

Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover



Building Relationships Between Mental Health and Aging Services

May 10, 2017



Disclaimer

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Building Relationships Between State Mental Health Authorities and Agencies on Aging/Aging Services

Kimberly Williams
President, MHA-NYC
**Chair, National Coalition on Mental Health
and Aging**



National Coalition on Mental Health and Aging

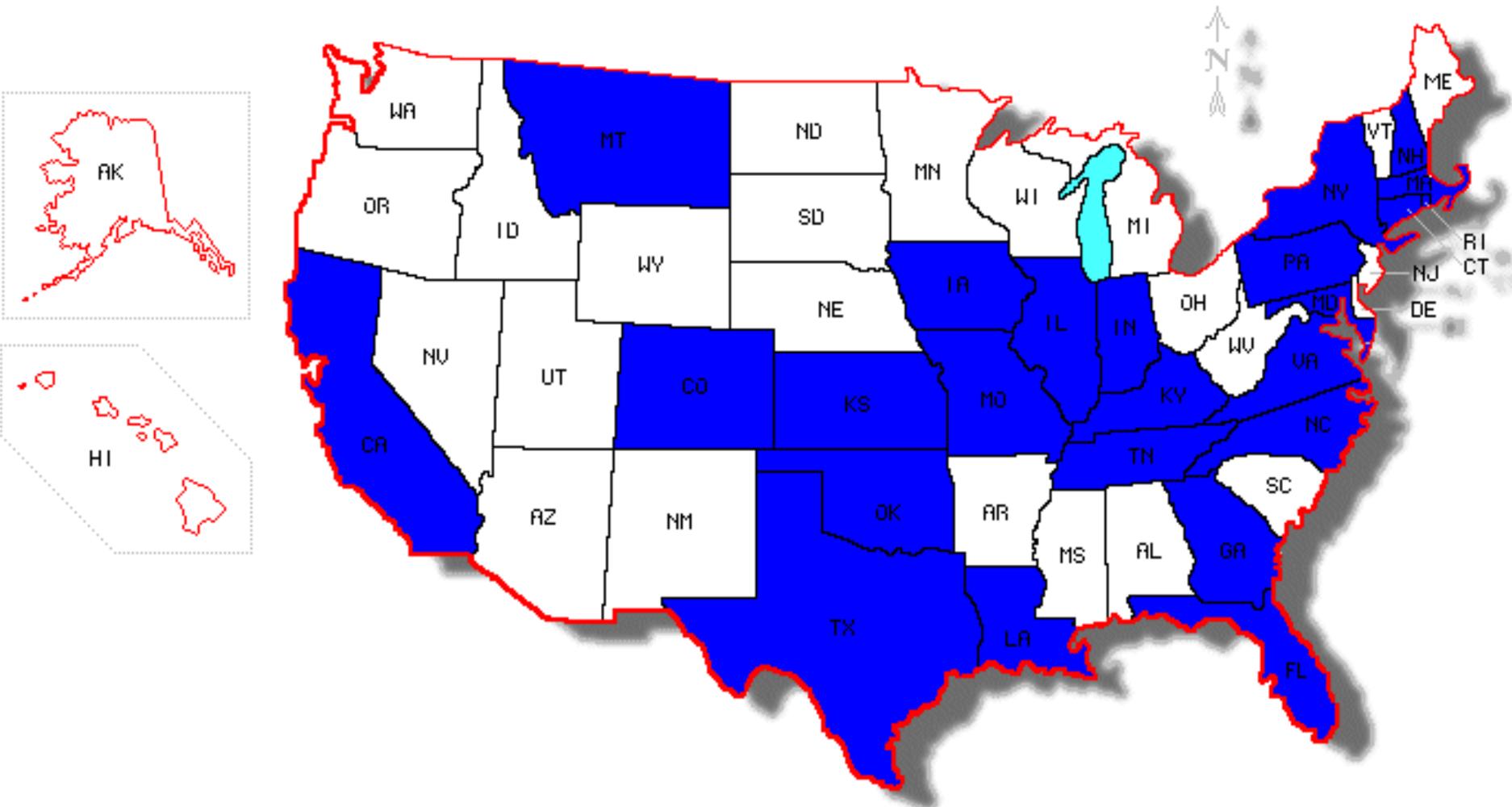
- **Established in 1991**
- **Over 80 diverse national organizations and state and local coalition members**
- **Goal: Work collaboratively towards improving the availability and quality of mental health preventive and treatment services to older Americans and their families.**
- **Key Functions:**
 - Go-to-resource on mental health and aging issues
 - Networking
 - Education
 - Policy analysis and recommendations
 - Public speaking
 - Technical assistance

State and Local Mental Health and Aging Coalitions

- **Partnership between interested organizations and individuals to improve and increase mental health and substance abuse care for older adults**
- **Members include public and private aging, mental health, substance abuse and health care systems, representatives from consumer, family and caregiver organizations, advocacy groups, professional organizations, higher education, the faith community, and other interested agencies and organizations**
- **Scope of Activities:**
 - *Networking*
 - *Education*
 - *Training*
 - *Resource Coordination*
 - *System Planning*
 - *Policy Analysis*
 - *Advocacy*



State Mental Health and Aging Coalitions Across the Country





State Mental Health and Aging Coalition: Development and Action in New York

Geriatric Mental Health Alliance of New York

- **Established in January 2004**
- **Over 3000 Members - Diverse constituency**
- **Policy and Advocacy**
 - *Advocate for improvements in public policy*
 - *Policy analysis and recommendations*
 - *Briefing material and consensus papers*
- **GMH Training and Technical Assistance**
 - Lectures
 - Webinars
 - Co-sponsor conferences
 - Speakers' bureau
 - Training
 - Technical assistance

Creation of the Alliance

- **Literature review**
- **Interviews**
- **Briefing Book**
- **Discussion Groups**
- **Issues Paper**
- **Creation of a website**
- **Sign On (No Charge; no work required)**
- **Established “workgroup”**
- **Dissemination of information via e-mail**

Constituency Building

- **Diverse**
- **Individual members rather than organizations**
- **Recruitment at every opportunity**
- **Working groups**



Initial Short-Term Goals

- Get geriatric mental health on the radar screen of NYS' s executive and legislative branches
- Lay the groundwork for long-term change
- Stimulate interest in local governments
- Build interest among providers, trade associations, advocates, etc.

Strategies

- **Consciousness raising with**
 - *government,*
 - *providers,*
 - *trade associations, and*
 - *advocates*
- **Focus on local and state, emphasizing state; Little federal**
- **Target executive and legislative branches**

State Advocacy: Executive Branch

- **Meetings with leadership**
 - *Office of Mental Health (OMH)*
 - *Office for the Aging (OFA)*
 - *Governor's Office*

⇒ **Geriatric mental health made a priority**

State Advocacy: Legislative Branch

- **Leadership Only**
- **Bicameral/Bipartisan**
- **Initially Sought Hearings and Study**
- **Legislators wanted to move faster**
- **Proposed Geriatric Mental Health Act**
- **Legislators Moved It**

Passing the Geriatric Mental Health Act

- **Support of committee chairs + other leaders**
- **Same bill in both houses**
- **Support from 110 organizations**
- **Bicameral/bipartisan press conference**
- **Lobbying legislative leaders and Gov.**
- **Gov. proposes compromise; we accept**
- **Passage of Act in both houses**
- **Gov. signs**
- **Gov. puts \$2 million in budget**

Geriatric Mental Health Act of New York

- **Interagency Geriatric Mental Health Planning Council**
- **Services demonstrations grants (\$2 million)**
 - *Integrating physical health and mental health*
 - *Community gatekeeper program*

Why It Passed

- **We worked hard**
- **Clear need**
- **Right issue at the right time**
- **Politically wise to say 'yes' to geriatric mh**
- **We avoided a high profile campaign**
 - *Didn't need it*
 - *Might have disrupted the tenuous, bi-partisan agreement*
- **Willingness to compromise**

What Happened?

Interagency Council

- **Expanded to include chemical dependency and veterans**
- **Chaired by four Commissioners: Mental Health, Aging, Substance Abuse and Veterans Affairs**
- **Other members include:**
 - *Adjutant General of the Division of Military and Naval Affairs*
 - *Rep from Office of People with Development Disabilities*
 - *Rep from Commission on the Quality of Care,*
 - *Rep from Department of Health*
 - *Rep from Department of Education*
 - *Rep from Office of Temporary and Disability Assistance*
 - *Rep from Office of Children and Family Services (which oversees adult protective services)*
 - *Eight individuals appointed by the Speaker, the Majority Leader, and the Governor.*
- **Meets quarterly**
- **Reports annually to the Governor and Legislature on plans and recommendations**

Service Demonstration Program Grants

Round 1 2007-2012

- Two program types funded:
 - Community gatekeeper
 - Integrated care
- 9 projects funded over 5 years
- Variations in program location
- Learning collaborative
- TA on sustainability
- All programs sustained beyond grant period

Round 2 2011-2014

- Integrate physical and behavioral health care projects in either:
 - behavioral health care settings (model 1) or
 - physical health care settings (model 2)
- 21 programs funded in two phases
- Many projects still operating beyond the grant period
- National Council for Community Behavioral Healthcare providing TA

Round 3 2014-2016

- Integrate physical and behavioral health care projects in either
 - behavioral health care settings (model 1) or
 - physical health care settings (model 2)
- 10 programs funded over 3 years
- National Council for Community Behavioral Healthcare providing TA

Round 4 2016-2021

- Triple partnership between mental health, health and aging services
- Technology
- Mobile outreach
- 8 programs funded over 5 year demonstrations
- National Council for Community Behavioral Healthcare providing TA

Building a Coalition: Starting Points

- **Put together a core group**
- **Plan and hold a first meeting**
- **Follow-up to the first meeting**
- **Next steps:**
 - Gather information and data
 - Develop mission and vision statements
 - Develop goals/plan
 - Design structure for the Coalition

Conclusion

- **Collaboration is paramount**
- **Persistence is key**
- **Geriatric behavioral health plans need to reflect the unique needs and challenges in your state or community**



Mental Health and Aging Service Partnerships

Jo Anne Sirey, Ph.D.

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Weill Cornell Medicine



Disclosure

- Funding from the National Institute of Mental Health, Fan Fox and Leslie R. Samuels Foundation and now NYC Department for the Aging
- Partnership between NYC Department for the Aging and Weill Cornell Medicine
- Researcher and clinician, originally trained as a community clinical psychologist

Background

- Tremendous mental health need expected with the aging population
 - *20.4 percent of adults aged 65 and older met criteria for a mental disorder, including dementia during the previous 12 months (Karel, Gatz & Smyer, 2012).*
- Aging services are serving older adults who require support – both those with and without mental health needs
- Combined services can improve health, mental health and independence
 - *Treating mental health conditions that affect physical health*
 - *Integrating aging support services for older adults with mental health needs*

Serving older adults

- Older adults underutilize mental health services, due to:
 - *inadequate insurance coverage; a shortage of trained geriatric mental health providers; lack of coordination among primary care, mental health and aging service providers; stigma surrounding mental health and its treatment; denial of problems; and access barriers (Bartels et al., 2004).*
- The primary care system is the de facto mental health system (Olfson, 2016).
- Older adults often prefer psychotherapy to psychiatric medications (Koh et al., 2010; Areán et al., 2002).
- Need alternatives to serve the mental health needs of older adults. In addition, should not offer mental health treatment when what is actually needed is aging support.

Partnership of aging and mental health

- Treatments and management strategies that work for younger adults generally work with older adults, if...
 - *if you can find them*
 - *get it to them or get them to it*
 - *get them to buy into it*
 - *and stay with it.*



Partnerships

- There are other partnerships that may bring together aging and mental health providers to build services that improve delivery of mental health to older adults.
 - *Dartmouth is collaborating with aging mental health services providers to develop strategies for delivering mental health services to people in rural communities*
 - *Partnerships funded by New York State*
 - *And others...*

Challenges

- Finding good partners
- Crossing silos and stepping out of usual care
- Finding financial incentives to initiate and sustain partnerships
- Doing the work to build a good partnership relationship

SAMHSA anticipates the need

- Guidelines and calls for integration
- Trainings and webinars to teach aging services

My agenda today:

- More general ideas about building a partnership
- Talk specifically about projects where collaborations were built and their outcomes



Building a partnership

Finding partners

- In academic life, mental health researchers' partnerships are built to implement deployment models for evidence-based practice
- In practice life, mental health providers may want to expand their practice
- Partners can be:
 - *Local - Westchester County Department of Aging*
 - *Have similar interests – aging conferences (n4a, ASA)*
 - *Networks – DFTA through Westchester County colleague*

Getting to know you

- Identify the need for each partner
- Building partnerships from the ground up
 - *Identify mutual goals and resources*
 - *Identify skills and limitations*
- Both groups are used to doing what they do
- Aging service providers see older adults with needs and refer them to services -- used to collaboration
 - *Unaware and may have biases about mental health*
- Mental health providers have expertise
 - *Not community oriented, unaware of aging services, may have stereotypes about aging*

Building a partnership

- Come to the table for discussion
 - *What is the interest of each?*
 - *Goals of each?*
 - *Realities of each?*
- Can shared goals be developed?
- Shared goals > collaborative partnership
- Who is going to pay for the work?

Building a partnership

- Involving administrators, front line staff, supervisors
- Involve champions and skeptics
- Describe the process of checking in
- Go out to the sites, see what the site is like, have them come to you
- Describe how you imagine it will work

Two partnered projects

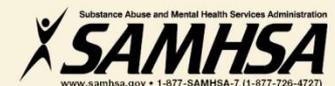
Cornell as mental health researchers and providers has built partnerships with non mental health partners (e.g., primary care, aging services, rehabilitation).

Two recent projects - different scales

- SMART-MH – external funding
- PROTECT – pilot project that becomes sustainable



Weill Cornell Medicine



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Sandy Mobilization, Assessment, Referral and Treatment for Mental Health: **SMART-MH**

Jo Anne Sirey, Ph.D.

Weill Cornell Medicine

Jacquelin Berman, Ph.D.

New York City Dept for the Aging

Funded by NY State SSBG grant



Overview

- A service delivery project applied for by the two partners collaboratively and funded by a large New York State Block Grant (1.3 million)
 - *Partners include New York City Department for the Aging, Aging in New York Fund (503c) & Hunter College*
- Objectives of project:
 1. *to identify the current mental health and social service needs of NYC older adults living in areas impacted by Superstorm Sandy*
 2. *Test a mental health service delivery model*

Partnership goals

- *Department for the Aging* : bring systematic identification of needs and evidence-based services to hard-to-reach communities (e.g. geographically isolated, monolingual Chinese, Russian, Spanish)
- *Weill Cornell* : test innovative service delivery model, psychotherapy in a new setting and with diverse populations (hard to engage populations and geographically limited services)

Hurricane Sandy impact

October 29, 2012

- Battery Park wave surge topped 13.88 feet with a 32.5 foot wave recorded; 19 Billion dollars in damages estimated, most uncovered
- Older adults appear more reluctant to seek assistance or support following a disaster (Wacker & Roberto, 2014)
- 57% of the 44 deaths in NYC were older adults (Goldman et al., 2014)
- Older adults had the lowest rate of face-to-face communication both during and after the hurricane (Goldman et al., 2014)
- Some older adults were unable to leave their high-rise apartments, or lost access to community services due to flooding or flood impact
- A number of older adult low income houses on the coast



SMART-MH design



- Interdisciplinary team approach with community partners
- Outreach activities at senior centers, community centers, NYCHA housing and faith-based organizations
- Brief needs assessment (mental health, functioning, storm impact, need for services)
- Offered ENGAGE (brief psychotherapy) to adults with significant depression (PHQ-9) or anxiety (GAD-7) in Chinese, Russian, Spanish or English
- Data entered electronic through DFTA; analysis done with de-identified dataset



Results



Reach

- Able to assess large numbers of older adults in impacted communities
- Over 2800 older adults assessed in all 5 boroughs
- Over 600 community partners contacted
- Outreach activities (talks, tabling, groups, advice) varied site by site, tailored to the specific needs and culture of each center
- Report on:
 - *Needs among subsample of 1549*
 - *151 older adults received psychotherapy*



Sample summarized (N=1549)



- Assessment language: 56% in English
33% Chinese, 6% Spanish, 5% Russian
- 75% female
- 11% Hispanic
- Mean age is 75
- 45% on food stamps and 46% have Medicaid
- 25% need help getting around & 27% need help shopping
 - 34% rely on assistive devices (*cane, walker, or wheelchair*)
- 43% report health status as fair to poor
- 9.6% had prior mental health treatment



Mental Health needs

Anxiety

- 25% experienced flashbacks ‘often/all the time’
- 24% worried about another storm often/all the time
- 5.7% avoided anxious situations often/all the time
- 28.5% had significant anxiety symptoms (GAD-7 \geq 10)

Depression

- 6% of the total sample endorsed suicidal ideation
- 14.7% had significant depressive symptoms on the PHQ-9
 - *Of those with depression, 26% endorsed suicidal ideation*
- Younger older adults (age 60-74) had higher rates than older older adults (75+)
17.5% versus 11.3%

Need is higher in this population than comparable populations

Delivery of ENGAGE psychotherapy

- 151 patients who had a baseline PHQ-9 or GAD-7 >10 or endorsed any suicidal ideation
 - *28.5% endorsed SI with 8.6% endorsing ideation every day*
- Therapy offered in English, Russian, Spanish, Chinese
- Therapy offered in whatever private space available to maximize accessibility to older adults
- 74.2% engaged in 6 sessions
- The average decrease was 7.5 points on the PHQ-9
- Suicide risk decreased from 28.5% to 8.7%
- Clinical staff became part of the setting

Project summary

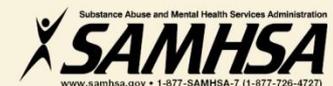


- Partnership is built around a target vulnerable population
- It takes advantage of available funding
- The model using outreach, assessment and delivering direct service was effective
 - *Able to reach individuals who did not access care*
- Needs were significant and could be identified and served in aging service settings
- A brief psychotherapy could be offered to diverse older adults in senior centers with meaningful clinical outcomes
- This model was used as a template for NYC Dept. for the Aging Thrive NYC initiative
 - *to locate mental health services in senior centers*
 - *service billing to promote sustainability*

Providing Options To Elderly Clients Together (PROTECT)

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NYC Department for the Aging



ECVRC: The service site

- The ECVRC is a direct service program that works with elder abuse victims with capacity to break the pattern of domestic violence, including financial, physical, and emotional abuse
- Funded by the Older Americans Act and NY State Victims Services
- Provides a comprehensive array of services to persons aged 60 and over who are victims of crime and/or elder abuse
- Services include: case management, assistance with an order of protection, eviction of abuser, mental health warrant, security device installation, referrals to DA and NYPD, advocacy, and additional emergency services and placement
- Approximately 1,000 crime and elder abuse victims each year

Partnership goals

- Victims refused services, ECVRC thought victims were depressed but unable to be sure. Goal to identify and service mental health needs better.
 - And if these needs were addressed, could they improve the uptake of elder mistreatment services?
- Weill Cornell: Can psychotherapy be integrated into an acute service to improve both mental health and aging service outcomes? Target high risk populations
- Funded by Fan Fox and Leslie R. Samuels Foundation

Using strategies from other settings to improve mental health care

- Bring systematic screening
- Victims with mental health issues are referred to programs in community with unclear engagement rates
- Lessons learned from primary care:
 - *Improve detection of need*
 - *Set up seamless referral strategies*
 - *Provide evidence-based mental health care for common disorders*

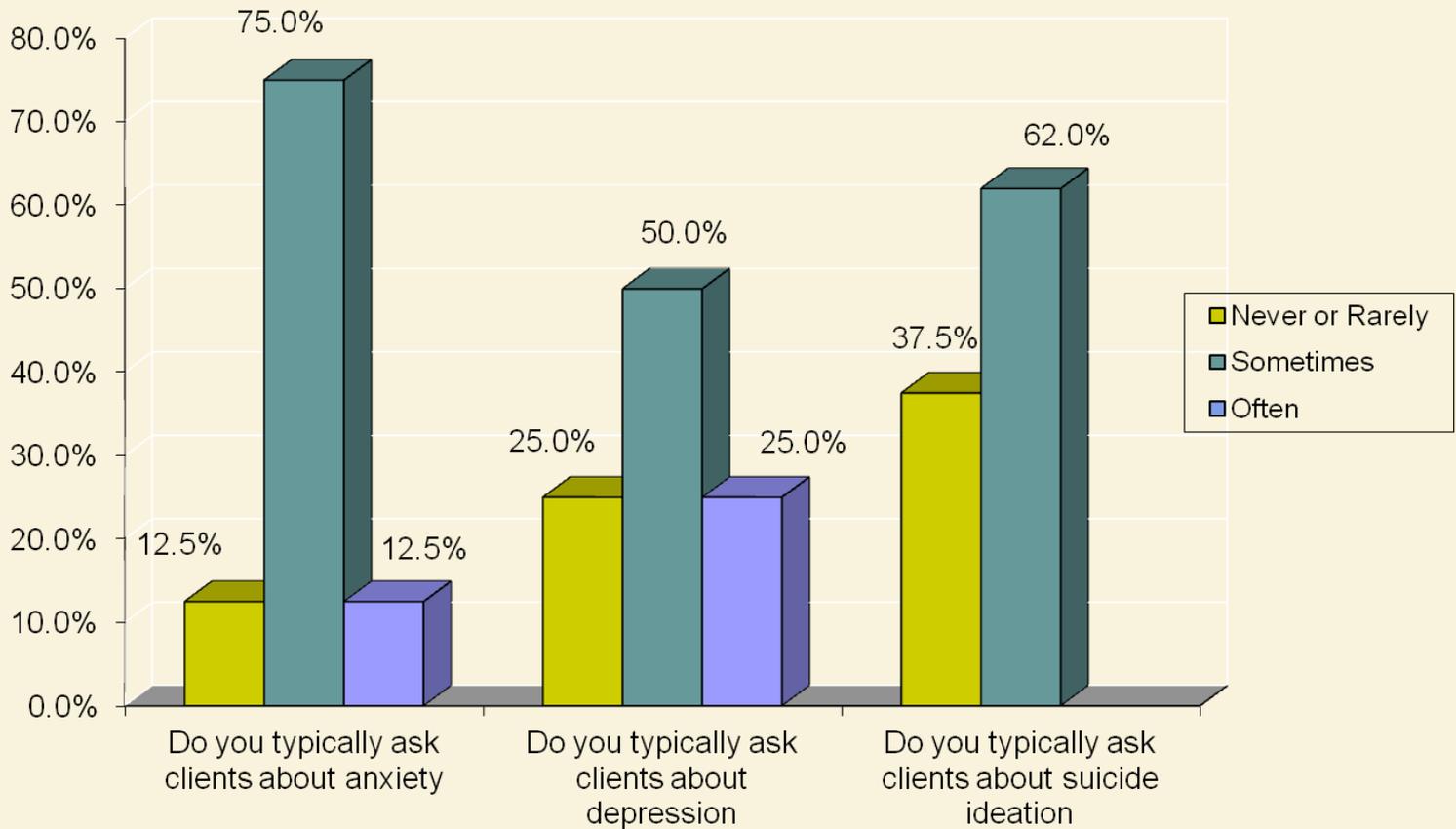
The PROTECT program

- A program to integrate mental health detection, referral, and treatment into abuse services for older adults
- Developed in collaboration between DFTA and Cornell
- **The PROTECT program includes:**
 1. Training and implementing screening procedures for depression (PHQ-9) and anxiety (GAD-7)
 2. Making an effective referral using a tested engagement strategy (Open Door, Sirey et al, 2013 and 2016)
 3. Offering an evidence-based psychotherapy (8 weekly sessions) concurrent with mistreatment service
 4. Tracking outcomes to see if it works

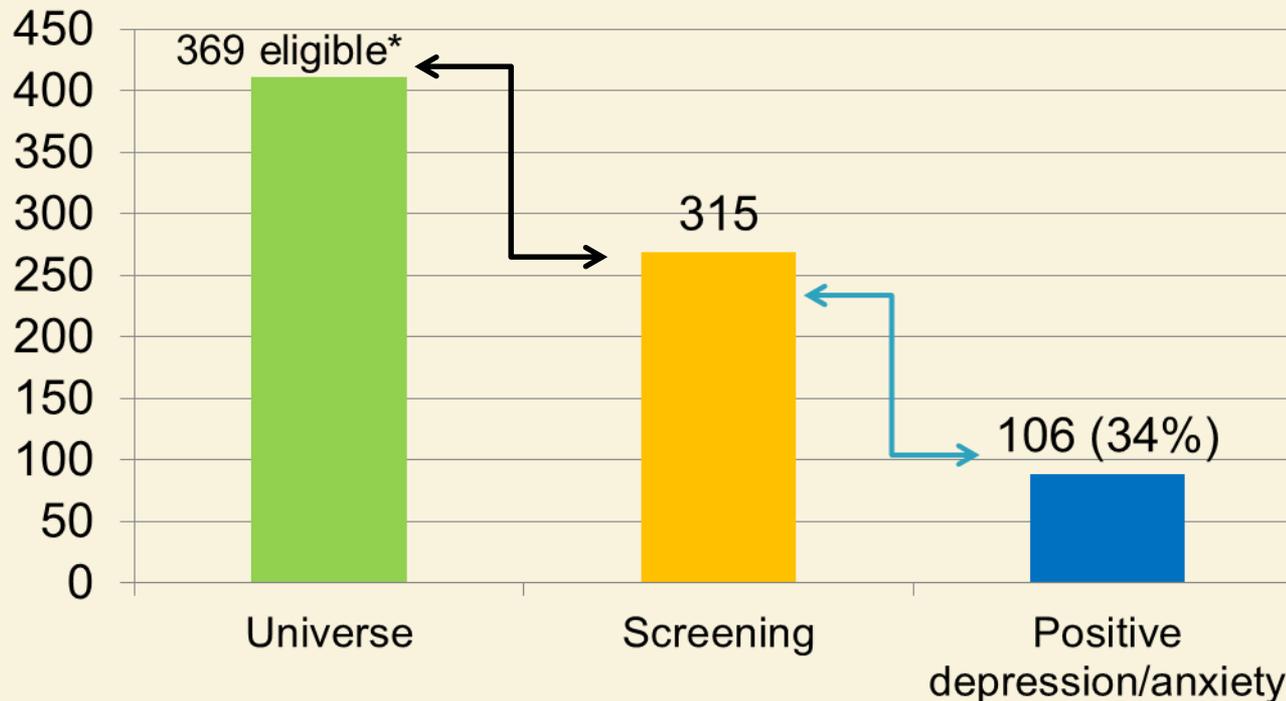
Implementation

- Making the case to the staff
- Weill Cornell becomes a resource
- Work on building screening into everyday practice (first two contacts)
- Training on screening and ongoing supervision
- Inspire them to be innovative
- Combined intervention could affect both mental health and elder abuse outcomes (12 weeks later)
- Weekly meetings (in-person/telephone)

Staff Pre-training Mental Health Practice



Screening: GAD-7 and PHQ-9



*Many more calls are received per year
16.2% endorsed suicidal ideation on the PHQ-9 (item 9)

Summary of first project (N=69)

- 32% screened positive for mental health needs
- 69 clients not in treatment and referred (15% refusal)
- PROTECT clients reported 57% (7.9 point) decrease in PHQ-9 score at follow-up compared to 37% (4.8 point) decrease in control referral group, $p = .08$
- 68% of PROTECT group reported better abuse status at follow-up compared to 50% of Referral group, $p = .21$ (ns)
- PROTECT clients felt that most or all needs were met, more effective at problem-solving, and higher rates of satisfaction
- Demonstrated feasibility but small N, not fully independent ratings, poor measures of abuse. Second pilot to document outcomes

Sirey et al., J of Abuse and Neglect 2015a and 2015 b

Pilot 2: Depression outcomes & mediator

Depression	Baseline	8 weeks	12 weeks
Hamilton score	21.2 (7.2)	13.5 (7.3)	16.7 (8.9)
Potential Mediator			
Behavioral Activation (BA)	81.4 (24)	94.0 (23.2)	91.4 (25.9)

By 12 weeks:

- Depression decreased by average of 21% (4.5 pts – 3 pts is significant)
- BA increased by average of 18% - no existing guidelines for what counts as meaningful change, but generally aim for > 15%

Pilot 2: Elder Mistreatment outcomes (N=30)

Percentage with no new abuse incidents during 12 weeks after baseline

Thinking back to when you first joined this program, has the mistreatment gotten better, worse, or stayed the same?

Financial	59.1
Verbal	50.0
Physical	80.0



Better	Same
64.7	35.3
63.6	36.4
76.9	23.1

No clients reported worsening of abuse since joining PROTECT

PROTECT Project Summary

- The pilot data support the feasibility, acceptability and impact of program
- With pilot data, it was possible to argue that the service was useful.
- Sustained with NYC Department for Aging funding
- Pilot data used by Weill Cornell to test a simplified version with funding from NIMH to improve dissemination

Limitations to generalizability

- NYC is unique. It is resourced, but also tremendously diverse.
 - *Outer boroughs have fewer services and greater transportation challenges.*
- Two partners who value research (including training, standardization, sustainability) and have experience going after funding.
- Partners wanted to build something together. You cannot create partnerships where they are unwanted.

Lessons Learned: Attention to the process

- Involving front line staff and administrators is key
 - *Hearing both challenges and successes throughout*
- Challenges can include:
 - *staff with limitations, cultural malaise or resentment, funding limitations*
- Weekly meetings by phone (e.g. to track activities, identify early trouble spots)
- Formal meetings twice a year to present project updates and review the process

Lessons about Implementation

- Implementation is critical
 - *Identification of goals, resources, and limitations*
 - *Strive for organic fit within agencies*
- Mental health staff need to be embedded and to become a resource for the aging service staff
 - *Ongoing support and supervision is necessary for mental health staff– it keeps it fresh*
- Pay attention to moments when the two systems meet
 - *Hand-off from aging to mental health*
 - *How clinician ‘fits’ into aging service*
 - *Feedback to aging services*

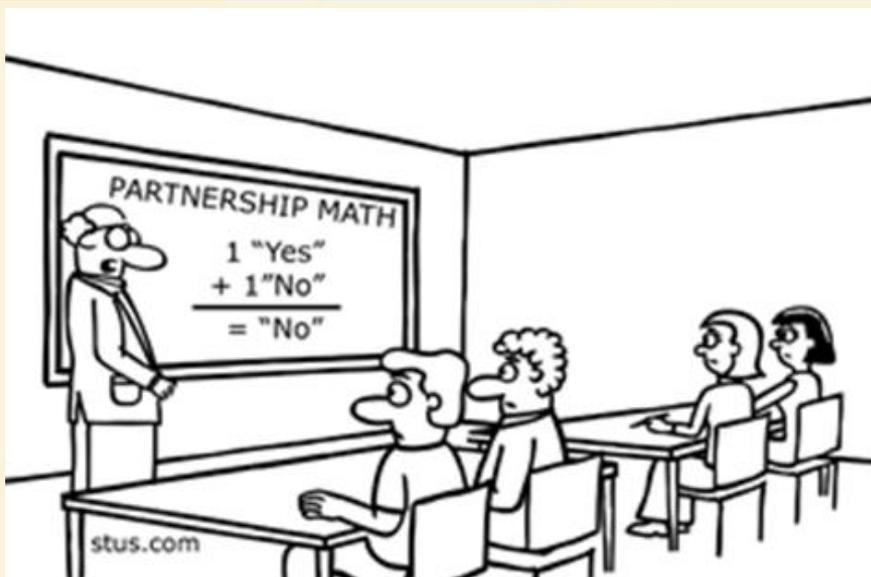
Key structural ingredients

- To evaluate outcomes there needs to be:
 - *a system of data management*
 - *a way to track participants*
 - *some method of evaluation*
- Use measurement based care to make decisions if partnerships interventions are effective
 - *The data on implementation can be reviewed by both partners (e.g., number screened, referred, contacted)*
 - *The response of participants demonstrates project impact*

Summary

- Partnerships between mental health and aging can serve the needs of older adults
- Partnerships can be large or small, they just need committed partners
- If there is an interest and an incentive (goal), the service can be tailored to support
- Mental health staff need to be embedded
- Building the partnership is important at the outset to weather the bumps along the way
- Some partnerships do not last indefinitely

Thank you



Note: A recording of this webinar and a pdf of the slides will be available within 10 days at

www.nasmhpd.org/webinars

Questions? Comments?

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