IMPROVING CLIENT MENTAL HEALTH TO POSITIVELY IMPACT ABUSE RESOLUTION

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Agenda

- Brief review of mental health and depression in later life
- Screening in non-mental health settings
- Depression among abuse victims
- Project to implement screening in NYC with abuse victims
- A new intervention and outcomes
- Questions and comments

As the older adults population increases…

- Abuse victim numbers will increase
- Mental health needs will grow
- Older adults often receive fragmented services
- Increasing need for integrated services
  - And services that address the complex needs

Current mental health needs of older adults

- Approximately 15% of adults aged 60 and over suffer from a mental disorder (WHO data)
- The most common neuropsychiatric disorders in this age group are dementia and depression.
- Prompt recognition and treatment of mental disorders in older adults is essential for their health and quality of life.

DSM V Criteria: Major Depression

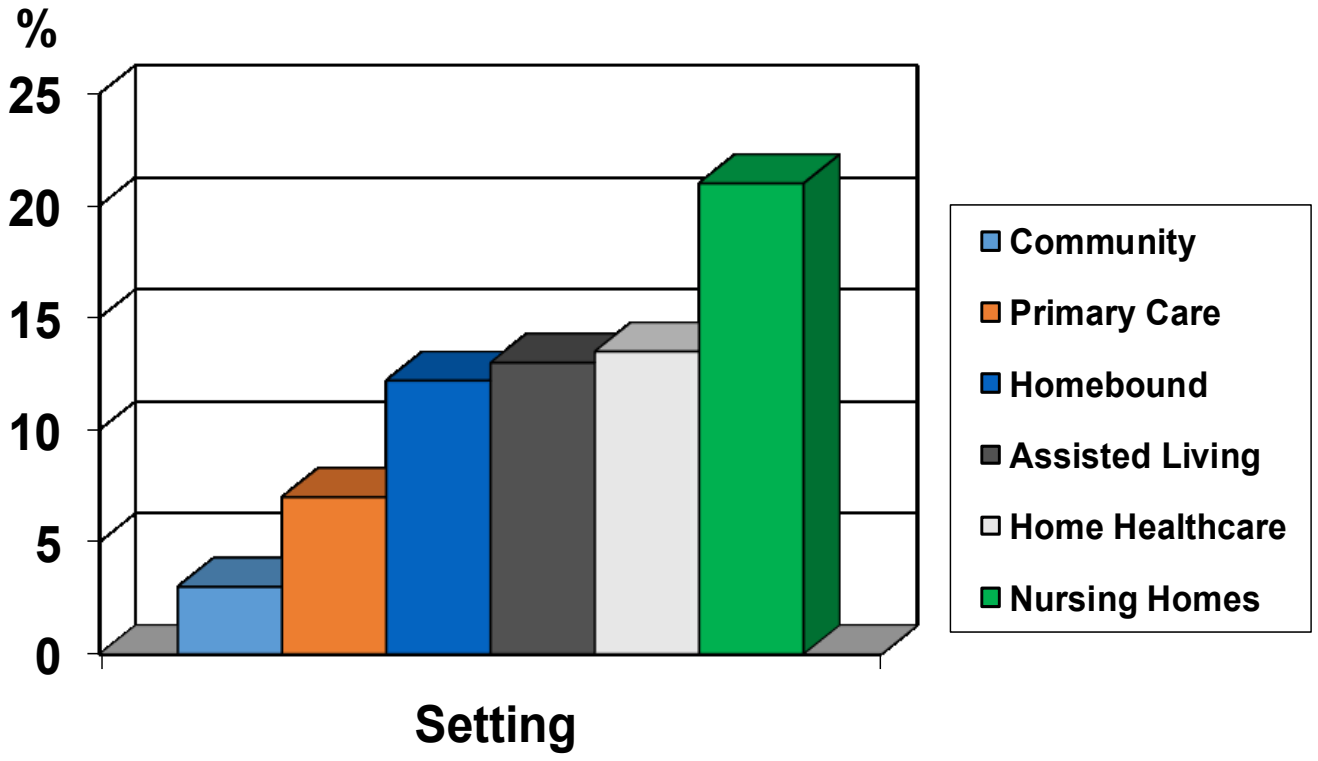
- Depressed mood
- Marked diminished interest or pleasure (anhedonia)
- Sleep disturbance (trouble falling asleep, waking up or sleeping too much)
- Appetite or weight disturbance (markedly increased or decreased appetite, weight, or both) when not dieting
- Persistent fatigue or loss of energy
- Diminished ability to concentrate or indecisiveness
- Feelings of worthlessness or excessive or inappropriate guilt
- Psychomotor retardation or agitation (or a change in mental and physical speed perceived by others)
- Recurrent thoughts of death or suicide (not just fear of dying)

MDD criteria: 1 of the 2 core symptoms and at least 5 of these 9 symptoms nearly every day for at least 2 weeks. The patient must also experience functional impairment related to these depressive symptoms.

Background: Depression

- Depression is common among older adults with disability and medical burden
  - Leads to disability, suicide and non-suicide mortality
  - Associated with excess use of health care, and higher annual health care costs
- Often missed by the older person, family, staff in aging services
- Rarely treated adequately

Prevalence of Major Depression Diagnosis Among Older Adults



Background: Elder abuse

- **Recent prevalence data**
  - **141** out of every thousand older adults a victim of elder mistreatment (Under the Radar: New York State Elder Abuse Prevalence Study 2011).
  - For every 1 case of elder mistreatment reported to the authorities, 24 go unreported (Under the Radar: New York State Elder Abuse Prevalence Study 2011).
- **In a community sample of older adults living in Superstorm Sandy impacted areas in NYC (N=1378):**
  - 4.4% of older adults either reported a crime or abuse
  - An addition 3.1% requested information about elder abuse services

Background: Elder abuse and depression

- Abuse associated with depressive symptoms and worse mental health three years later (Mouton; WHI).
- Emotional abuse associated with poor mental health controlling for support, health and functioning (Begle 2010).
- Depressive symptoms associated with mortality among abuse victims (Dong et al., 2010)
- In a telephone survey of community adults (aged 60+), both financial exploitation and psychological mistreatment were associated with depressive symptoms (Beach, Schulz, Castle, & Rosen, 2010).
- Recently, a population-based study in China found that older adults who were mistreated had significantly higher rates of depressive symptoms (31.6% versus 6.8%) and suicidal ideation (16.4% versus 3.4%) than non-mistreated older adults (Wu et al., 2013)

Clinical interface of depression and implementing elder abuse services

- Depression makes everything harder to accomplish
- It can create hopelessness and helplessness that interfere with accessing and using services
- We ask victims to:
  - Develop and follow a safety plan
  - Obtain an order of protection
  - Find somewhere else to live
  - And many other difficult steps
- If we could treat the depression, could we improve the effectiveness of the elder abuse services?

DESIGNING A MENTAL HEALTH INTERVENTION FOR ELDER ABUSE SERVICES

PROTECT Project objectives

- The program is called **PROTECT** for **PR**oviding **O**ptions **T**o **E**lderly **C**lients **T**ogether
  - Program combines mental health training and intervention
- Community-academic partnership between DFTA (largest AAA) and Weill Cornell Medical College (academic)
- Test feasibility of integrating mental health into elder abuse services – Elderly Crime Victim Resource Center (ECVRC Director: Aurora Salamone)
  - Can staff detect mental health need (screening)?
  - Can an intervention be implemented within the agency?
- Ultimately, can an intervention in elder abuse services:
  - Decrease anxiety and depression (MH)?
  - Improve self-efficacy and implementation of EA recommendations (EA)?
- Program conducted by DFTA, all information/data is de-identified.

PROTECT is a community-based mental health intervention

- Begins with collaboration
  - What does mental health mean in this setting?
  - What are the goals and barriers of the service site?
  - Be clear about project goals.
- How can mental health be integrated within the "work flow" and "model of care"?

- Integration takes places with all levels of providers within the setting
- All mental health services need to include **detection** (screening), **referral** (hand off) and **treatment**

ECVRC: The service site

- New York State does not have mandatory reporting
- ECVRC service individuals with capacity to make decisions
  - split in NYC between APS (no capacity) and ECVRC
- NYC is service rich– in addition to ECVRC there are community programs in all 5 boroughs
- ECVRC provides a comprehensive array of services to persons aged 60 and over who are victims of crime and/or elder abuse
- Approximately 1,000 crime and elder abuse victims each year
- 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, emergency services and placement.

MENTAL HEALTH SCREENING

Begin with training on mental health screening

- PHQ-9 for depression and GAD-7 for anxiety
  - Both standardized routine screening tools to identify symptoms
  - Screening takes the bias and discrimination out of detection
- Training on measures
  - Cornell provided in person training
  - Follow-up supervision of the administration of the PHQ-9

  - Booster online training support for PHQ-9
    http://www.mentalhealthtrainingnetwork.org/

  - Mental health screening tools integrated into database
  - ECVRC Director tracked implementation with regular reports
  - Reviewed as a team

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the *last 2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns:		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) TOTAL:				

} Gateway symptoms

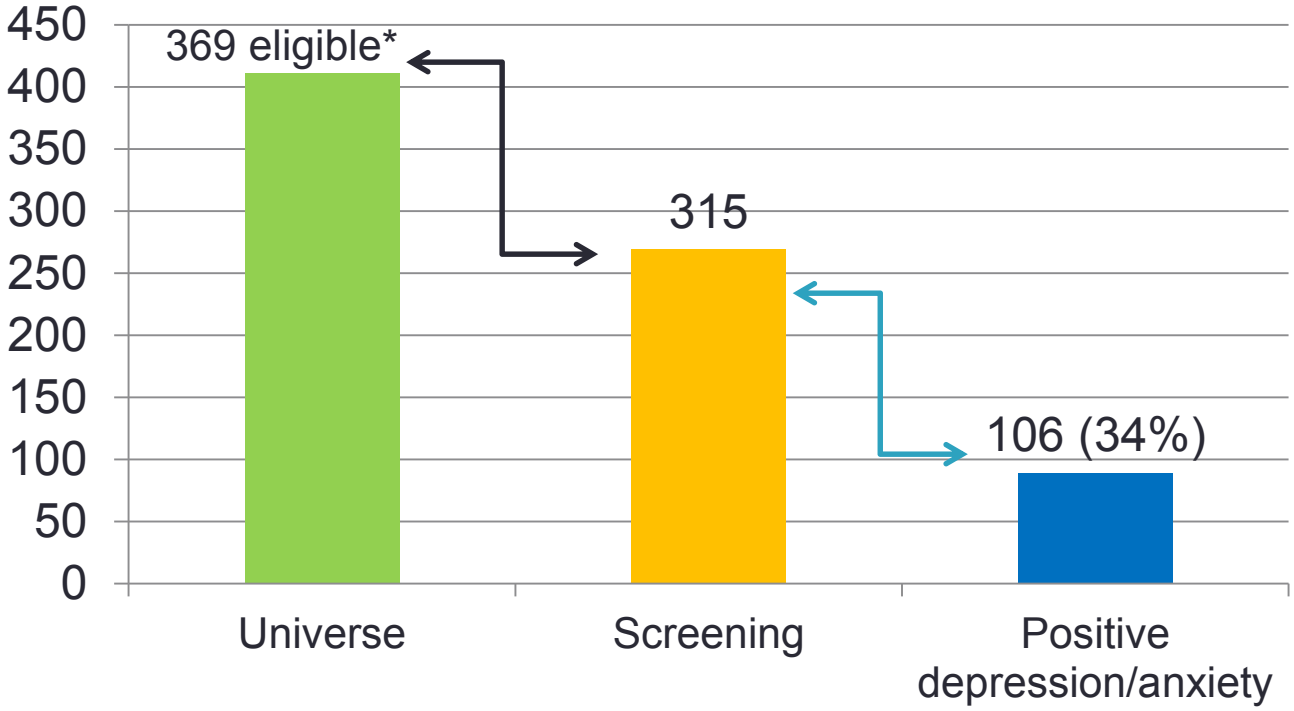
10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

Screening for depression

< 5	No Depression
5 - 9	Mild Depression
10-14	Moderate Depression
15-19	Moderately Severe Depression
20 +	Severe Depression

Mental Health Screening: GAD-7 and PHQ-9



*Many more calls are received per year

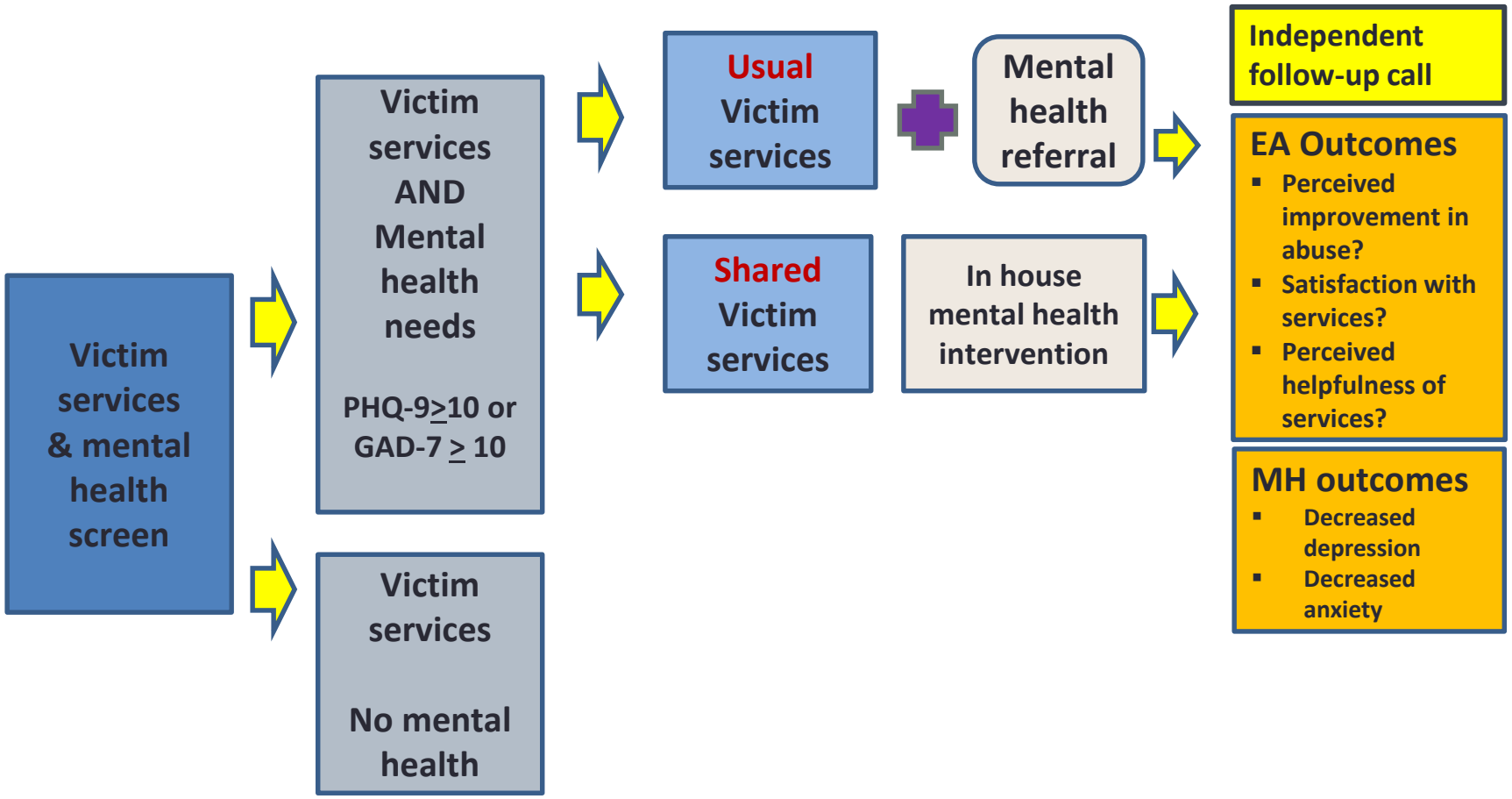
16.2% endorsed suicidal ideation on the PHQ-9 (item 9)

Clients who screen positive for mental health

- 16 (15%) refused any mental health support
- 21 were already in treatment or had a psychiatric illness other than depression or anxiety
- The remainder have become part of the service

PROGRAM DESIGN AND INTERVENTION

PROTECT program design



Problem Solving Treatment (PST) for Depression

- Brief, practical, time-limited
- Common sense
- Evidence-based
- Easily learned by therapist and client
- High client receptiveness and satisfaction

Problem Solving Treatment: Goals

- Increase understanding of link between current symptoms and problems
- Increase ability to clearly define current problems
- Teach a specific problem-solving procedure
- Solve problems and increase self-efficacy

PROTECT includes anxiety management techniques

- Symptom monitoring
- Deep breathing
- Visualization

PROTECT Intervention Format

- 8 sessions delivered weekly
- In-person (or if needed by telephone)
- Information and worksheets used to structure the sessions
- Begins with an evaluation
- PST session 1 lasts one hour
  - subsequent sessions last 45 minutes
- Delivered by a mental health social worker who was trained in EA
- She works very closely with EA staff

PST Premises and activities

- SYMPTOMS ARE DUE TO DEPRESSION

- ESTABLISH LINK BETWEEN PROBLEMS AND DEPRESSION
  - Unresolved Problems Worsen Depression
  - PST Strengthens Problem-Solving
  - Improved Problem-Solving Lifts Moods
  - Emphasize that Improvement Follows Action
- 7 STAGES OF PST
  - Defining and Breaking Down Problems
  - Establishing Realistic Goals
  - Generating Multiple Solution Alternatives
  - Implementing Decision-Making Guidelines
  - Choosing the Preferred Solution(s)
  - Implementing the Preferred Solution(s)
  - Evaluating the Outcomes

SAMPLE & RESULTS

PROTECT program participants

- Eligibility:
  - English speaking
  - Abuse victim
  - PHQ-9≥ 10 or GAD-7 ≥ 10
  - Exclude: crime victims, cognitive impairment, psychosis
- 106 clients eligible and referred
  - 16 refused (15%)
  - 69 randomized: 33 referral, 11 combined, 25 shared
  - Follow-up data on 45 to date
  - Fewer follow up interviews on referral clients (higher refusal rates)

Sample Characteristics (N=69)

	Total
Gender	
Female	91%
Mean age	71.5
Type of mistreatment	
Physical	26%
Psychological	87%
Financial	37%
Neglect	18%
Lives with abuser	81%
Relationship of abuser	
Adult child	49%
Spouse	7%
Other relative	23%
Other non-relative	20%

Mental health need

- All participants score a 10 or greater on the PHQ-9 or GAD-7
- Depression (PHQ-9) scores mean= 14.0 (SD=4.2)
  - Among the sample most (92%) have PHQ-9 scores $\geq$ 10
- Anxiety scores = 9.78 (SD=5.1)
  - Half (54%) have GAD-7 scores $\geq$10
- There were no differences between the two groups
- 33% (23/69) endorsed “thoughts that you would be better off dead, or of hurting yourself” several days or more in the past two weeks
  - Death ideation and suicidal ideation
- There were no differences in mental health symptoms by gender, age or type of abuse in this small sample.

PROTECT (Problem-Solving Therapy) participation

- 75% of clients who were recommended PROTECT attended all 8 sessions
- Half of the sessions were done in person and half over the telephone
- The average duration of follow up sessions was 45 minutes

Follow-up (N=45)

- Interview conducted by an independent DFTA staff member unaware of group participation
- Clients contacted by telephone
- Gift card incentive offered to encourage individuals who might not otherwise want to talk (due to dissatisfaction)
- Lower rates of follow-up among victims provided a routine referral

EA OUTCOMES: Perceived abuse status

Thinking back to when you first spoke to a DFTA worker, would you say the mistreatment you are experiencing now is the same, better or worse than previously?

	Referral (N = 14)	PROTECT (N = 31)
Same or worse	50.0%	32.3%
Better	50.0%	67.7%
Unknown	19 missing	5 missing

* Chi=1.29, df=1, p=0.21

EA OUTCOMES: Satisfaction with EA services (N=45)

Overall, how satisfied are you with the DFTA services you received?

Number of clients with follow-up (N=45)	Referral (n = 14)	PROTECT (n = 31)
Satisfied	**57.1%**	**87.1%**
Indifferent or Dissatisfied	42.9%	12.9%

Chi square = 10.32, df=2, p=.016

EA outcomes: EA service met their needs

To what extent have the services met your needs?

	Referral (n = 14)	PROTECT (n =31)
Most or all of my needs were met	35.7 %	**77.4 %**
A few of my needs were met	35.7%	19.4%
None of my needs were met	28.6%	3.2%
	64.3%	**22.6%**

Chi=9.24, df=2, p=.010

*Those clients whose needs were met were more likely to report an improvement in the abuse status.

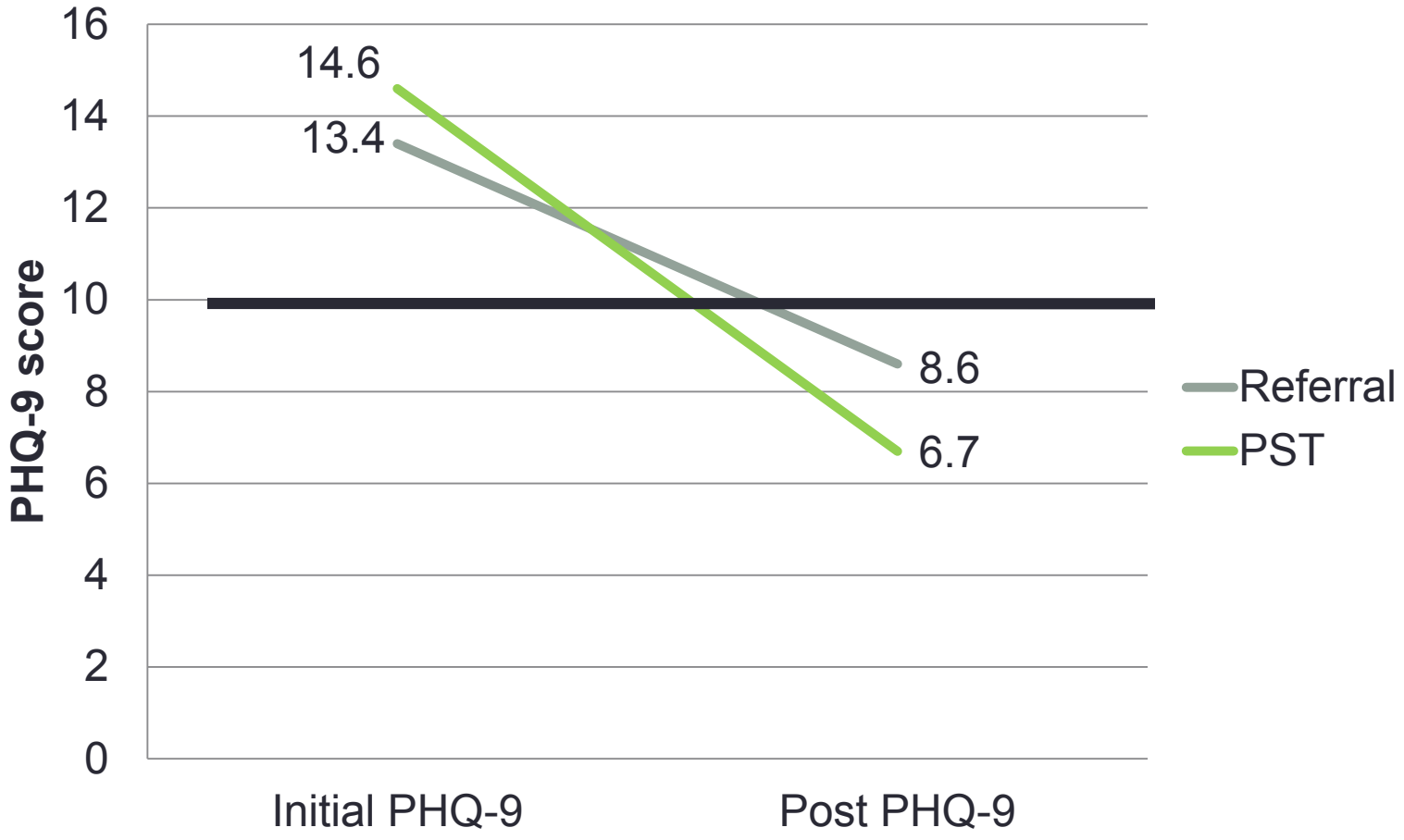
EA outcomes: Perceived self-efficacy (N=45)

Have the services helped you deal more effectively with your problems?

	Referral (n = 14)	PROTECT (n =31)
Yes, they helped a great deal	42.9%	**67.7%**
Yes, they helped somewhat	14.3%	25.8%
No, they did not help	**42.9%**	6.5%

Chi=8.76, df=2, p=.013

PHQ-9 by group over time



PROTECT clients had a 57% decrease as opposed to a 37% decrease in the Referral group, (t=1.77, df=44, p=.08)

Implementation Findings

- With strong training and follow-up, mental health screening was integrated into a high volume elder abuse service
- With co-location of a mental health person, clients could be referred and would participate in a psychotherapy concurrent with elder abuse services
- Mental health intervention and elder abuse resolution services complemented each other.
- Rates of mental health need are high in this population

Challenges / Benefits of Implementation

Challenges

- Takes time
  - Training
  - Ongoing support
  - Database must reflect new information collected
- Culture shift
  - Importance of screening vs. other work
  - Not make predetermined decisions about clients

Benefits

More victims having access to mental health services

Increased awareness of mental health

Improvement in database

Increased staff support

Elder Abuse outcomes

At follow-up, the intervention group reported:

- Higher satisfaction with services
- Felt more of their needs were met
- Believed that services helped them deal more effectively with their problems

Mental health outcomes

- We were able to help victims accept mental health treatment
- There was a decrease in depressive symptoms in both groups
  - But a greater decrease among those receiving PROTECT

Limitations

- Other factors that could affect outcomes
- Lower follow-up interview rates in referral group (the unhappy clients refuse follow up)
- Unable to assess criminal outcomes as well as perceived abuse

Next steps

- Currently implementing a large study to evaluate the impact of PROTECT
  - To conduct pre and post assessments
  - To determine who the intervention works best for
- Identify other characteristics that affect outcomes
  - Social isolation

- Document change in incidents of abuse
- Expand to other elder abuse services

THANK YOU!

Questions? Comments?