

The Sonoma County Older Adult Collaborative: Providing Depression Intervention to Seniors

MARTHA JACQUEZ

EXECUTIVE SUMMARY

Depression is the most prevalent mental health condition experienced by seniors. Depression affects the entire body, interferes with daily life routine, and reduces quality of life. Untreated, depression complicates other chronic conditions, such as stroke, heart disease, diabetes, Parkinson's, and more. Depression also interferes with participation and success in services and treatment plans. Disability, social isolation, loss, and other issues faced by seniors place them at risk for depression. While depression may carry a stigma among all age groups, the diagnosis presents a greater obstacle among seniors seeking treatment.

This case study explores an innovative program, the Sonoma County Older Adult Collaborative (OAC), which seeks to address depression in its senior population. The OAC utilizes the well-regarded Healthy IDEAS (**I**dentifying Depression,

Empowering Activities for Seniors) program to offer evidence-based, systematic, and community-centered intervention. The program offers depression screening, education and intervention to seniors throughout the County of Sonoma. The OAC offers a model that could be replicated on a smaller scale in Santa Clara County (SCC). As the senior population grows in SCC, meeting their mental health needs will require coordinated efforts between county departments and community based organizations. These partnerships would allow for more efficient use of limited financial and staff resources. SCC would offer depression screening to approximately 2,300 more seniors per year. This program presents the opportunity to reach a segment of the senior population that is often isolated and underserved and to help improve their quality of life.

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Background: Depression in the Senior Population

Depression is well recognized as the most prevalent mental health problem among seniors in the United States. Approximately seven million of the country's 39 million adults age 65 and older are affected by depression.¹ In Santa Clara County (SCC), depression represents 34% of all outpatient mental health diagnosis in seniors. While the risk for depression increases with age, it is not thought to be a part of the normal aging process. Instead, it is understood that loss, social isolation, financial hardship, chronic medical conditions, physical limitations, and medication side effects can all contribute to, and are associated, with depression. Despite its prevalence, health professionals, family members, and other service providers often ignore depression in seniors. Physicians are often the only professionals that see seniors; yet, statistics show that just 1 in 5 California seniors was asked about his or her emotional well-being by a physician in the previous year.² Barriers to seeking diagnosis and treatment for depression could be related to seniors' feelings of shame and stigma associated with mental illness, or to financial and/or mobility issues. People who experience depression along with other chronic conditions may experience worsened symptoms of both and are less likely to follow through and succeed with treatment plans. These seniors visit the doctor and emergency rooms more often, use more medication, sustain higher outpatient costs, and have longer hospital stays.³ Depression is also closely associated with suicide in older

adults. It is interesting to note that although adults age 65 and older made up 12.5% of the US population in 2007, they accounted for 15.7% of all suicides.⁴

Understanding the necessity to meet the needs of this growing population, the Santa Clara County Mental Health Department (MHD) has increased its focus on the mental health needs of seniors. In June, 2011, the MHD convened an Older Adult Summit. Recommendations from this summit included improving the effectiveness of referrals, cross-service follow-up, and cooperation between mental health and other health care providers. However, resources are limited; the 2012 Santa Clara County Seniors' Agenda: *A Quality of Life Assessment* identifies the need for departments, agencies, and organizations to pool resources. By forming partnerships amongst community service providers, more efficient strategies can be devised to address the mental health needs of seniors.⁵

The Sonoma County Older Adult Collaborative

The Older Adult Collaborative (OAC) in Sonoma County is an innovative program that is in harmony with the recommendations made for SCC. The OAC leveraged already existing case-management resources with newly available Mental Health Services Act- Prevention and Early Intervention funds to address depression within its senior population. The OAC is comprised of the County of Sonoma Health Services Department (DHS), the Sonoma County Human Services Department (HSD), Adult and Aging Division, Council on Aging (COA),

Petaluma People's Services Center (PPSC), Community and Family Services Agency (CFSA), and Jewish Family and Children's Services (JFCS). The various agencies recognized a common need among their clients to address depression more effectively and comprehensively. In forming the collaborative, the partner agencies serve a larger number of residents in a more comprehensive manner than if any one agency had obtained the funds independently. The goal of the OAC is to establish and operate a county-wide program that addresses depression and suicide prevention among seniors. The program incorporates funding needs and a framework for depression screening in seniors as well as intervention and services for those who meet criteria.

Older Adult Collaborative: Roles and Responsibilities

The OAC agreement is detailed in a Memorandum of Understanding between the DHS and HSD, as well as through an annual report to and authorized by the Sonoma County Board of Supervisors. The HSD then establishes annual contract agreements with each of the four partner agencies (COA, JFCS, PPSC, and CFSA). The DHS provides \$243,378 through its MHSA-PEI funds to the HSD. In turn, the HSD distributes funding among the four community based agency partners and also receives funding for its own responsibilities. The specific amount received by each agency was based on its capacity to reach seniors as well as the services it offered. Each agency has specific goals for providing services and these were applied to establish the targets for service delivery through the collaborative. Each partner uses some funds for administrative costs though funds are primarily used for service delivery. The partners all contribute "in kind" funds of their own. In addition to funding, the DHS is also responsible for monitoring and evaluating the collaborative through audits, interviews, and reviews of records and statistics. MHSA also requires a three year review cycle that is administered by the DHS.

The HSD serves two roles in the collaborative.

First, it coordinates the collaborative, compiles data/statistics, reviews invoices, and distributes the funds to the partners. Its second role is that of direct service provider through the In Home Support Services Program (IHSS), and the Linkages Program. All IHSS clients age 60+ are offered depression screening by the IHSS social worker. The Linkages program is able to offer case management, follow-up services to those clients who screen positive for depression utilizing an evidence-based intervention called Healthy IDEAS. In addition, the agency has a Marriage and Family Therapist (MFT) who serves as a mental health liaison and who is employed by DHS but is partially housed at HSD. The MFT offers consultation to HSD employees, additional depression screening, and referrals to IHSS clients.

Through existing services and programs, the community based agencies refer seniors for depression screening and intervention. These programs include Meals on Wheels, as well as senior peer counseling and other case management programs. Various OAC participants were asked about cooperation between the agency partners and there was agreement that the partners tend to reach consensus and there are no noticeable conflicts or issues. The on-going decision-making process does not present barriers.

Depression Intervention Model: Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors)

Healthy IDEAS Step-by-Step	
Step 1	Screen and Assess Client for Symptoms of Depression
Step 2	Educate Client about Depression and Treatment
Step 3	Refer and Link Client to Treatment
Step 4	Empower Client through Behavioral Activation
Step 5	Assess Client's Progress

When the collaborative was searching for a strategy to address depression, they felt strongly that they needed to adopt an evidenced-based model. After researching various options, the collaborative concluded that Healthy IDEAS was the best fit for their level of funding and resources. Healthy IDEAS was initially developed by the Huffington Center on Aging at Baylor University College of Medicine. Healthy IDEAS is a well-regarded, evidence-based model that targets seniors ages 60 and older and can be implemented by an existing case management or caregiver support program. The model does not require clinic-based services or a significant number of graduate level staff. A contract was established with Baylor University that included a three-day training program for necessary staff. The cost for the initial training was approximately \$3,000 plus travel expenses from Houston Texas. These costs were covered through a training grant.

The Healthy IDEAS program was adopted and integrated into the existing case management services that OAC partners offered. The program consists of five steps that occur during a 3 to 6 month intervention plan. The collaborative chose to use the Patient Health Questionnaire 2 (PHQ2) and the Patient Health Questionnaire 9 (PHQ9) as their depression screening tools. These tools were widely used by health providers in Sonoma County allowing for more productive communication about results and concerns with the clients' health providers. The PHQ2 is offered to all clients ages 60+ who receive IHSS or other services through the collaborative partners. When clients screen positive for depression, case managers conduct a suicide screening and follow their agencies' protocols to address indicators of suicide. Clients can decline either screening tool and the agencies follow protocols which might include consultation with a supervisor or the DHS mental health liaison.

Clients who screen positive for depression are offered a list of community resources that provide behavioral health services, treatment, and an educational pamphlet about depression in older adults. Offering the pamphlet and resources allows the case

manager to begin the process of educating the client about symptoms and causes of depression, treatment options, and services available. The client is also referred to the mental health liaison for a more thorough depression screening using the PHQ9. The client is assessed for major depression and may be linked to behavioral health services available in the county.

During the "behavioral activation" step the client learns about the positive connection between mood and activity. The aim is to help seniors combat the inactivity that often accompanies depression. The client then sets personal goals to complete meaningful activities in a measurable way. The case manager monitors the client's progress and together they modify goals if needed.

The last step involves follow-up depression screening of the client. If the client's score has improved, he or she is encouraged to maintain his or her behavioral activation goals and to develop others. The client is then screened again at an annual agency reassessment visit. If the client does not show improvement or has worsened, other strategies are developed.

The program has demonstrated success in various areas. For example, since the program began in 2011, it has offered depression screening to over 11,000 seniors. Between 80 to 90% accept the depression screening. The depression screening process is valuable as clients are offered education about depression and treatment options. The number of seniors who are referred to community resources and receive mental health and counseling services consistently meet or exceed annual goals. The clients who receive services are then more likely to benefit from other programs, such as IHSS and/or chronic condition and medication management services. The various agencies are able to work collaboratively without duplication of efforts and efficiently leverage the resources available.

The OAC acknowledges challenges with clients completing the behavioral activation component of the program. Since many seniors do not complete the behavioral activation they do not receive a final

outcome measurement. Some of the reasons seniors do not complete the “behavioral activation” component are illness, hospitalization, issues with housing, and other complexities of life. The OAC continues to explore potential strategies and training to increase the completion rate of the “behavioral activation.”

Recommendations for Santa Clara County

Many of the goals and recommendations outlined by the Older Adult Summit are in agreement with the goals and function of the OAC. Establishing a collaborative in Santa Clara County should be explored. However, much of the structure and the established partnerships that exist in Sonoma County are not found in Santa Clara County. To begin, Santa Clara County does not have extensive community case management programs. There is also a lack of formalized relationships between agencies and programs that may share clients.

While development of a program, such as the OAC, in SCC would be difficult, there may be ways to replicate the OAC on a smaller scale. For example, the SCC MHD has accessed \$150,000 of MHSA funds to establish The Connections Program along with the County of Santa Clara Adult Protective Services program (APS). The Connections Program provides for a licensed mental health professional that is charged with providing in-home mental health services to APS clients, case consultation to APS staff, and serves as a liaison with MHD. This licensed professional is currently an LMFT who is an employee of MHD but located at APS and receives only APS client referrals. An inter-agency agreement is in place that formalizes this partnership between MHD and Social Services Agency Adult Protective Services.

A program could be developed in which APS social workers offer depression screening to clients age 60 and older as part of their normal assessment. APS sees approximately 2,300 clients age 60 and over per year. APS social workers already informally assess for mental health conditions but do not consistently utilize a depression screening tool. SCC APS case-carrying social workers all have MSW degrees, and a few are Licensed Clinical Social

Workers (LCSW's). APS social workers are capable of administering the PHQ 2 and the PHQ 9 with additional training. When clients screen positive for depression, staff would refer them to the LMFT for further assessment. The LMFT would then provide intervention or refer a client to available mental health service programs. The LMFT and APS staff would be trained in the Healthy IDEAS program that already lends itself to short-term case management. The cost of the training from Baylor University is approximately \$3,000 plus travel and expenses from Texas. This cost could be paid for by using currently available realignment funds received by APS in April, 2015. Since APS clients are typically characterized by multiple stressors that include, abuse, neglect, isolation, chronic health conditions, and disabilities, they are at high risk for depression. Over time, the MHD and APS would collaborate with other available community based programs throughout the county to formulate partnerships and grow this program. In the meantime, the APS program would be identifying seniors in need of depression treatment and would provide them education about depression as well as tools to address this issue. APS would also see additional benefit in that depression and other mental health conditions often impair a client's ability to follow through with solutions aimed at ameliorating abuse and neglect. By addressing depression, APS should see less recidivism of clients and observe better outcomes for APS clients. Utilizing the Sonoma County OAC as a blueprint to address depression in seniors would prove to be a proactive and worthy pursuit.

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References

1. Aldrich N, Benson W F. CDC Promotes Public Health Approach To Address Depression among Older Adults. http://www.cdc.gov/aging/pdf/CIB_mental_health.pdf
2. Council on Aging Silicon Valley, Area Plan on Aging, July 1, 2012 – June 30, 2016 <http://www.mysourcewise.com/sites/default/files/COASiliconValleyAreaPlan2012.pdf>
3. Centers for Disease Control and Prevention and National Association of Chronic Disease Directors. The State of Mental Health and Aging in America Issue Brief 2: Addressing Depression in Older Adults: Selected Evidence-Based Programs. Atlanta, GA: National Association of Chronic Disease Directors; 2009
4. Centers for Disease Control and Prevention and National Association of Chronic Disease Directors. The State of Mental Health and Aging in America Issue Brief 1: What do the Data Tell Us? Atlanta, GA: National Association of Chronic Disease Directors; 2008
5. Institute on Aging, Center for Suicide Prevention. <http://www.ioaging.org/collaborations-elder-protection>
6. Santa Clara County Seniors' Agenda: A Quality of Life Assessment http://www.sccgov.org/sites/ssa/Department%20of%20Aging%20-%20Adult%20Services/Documents/2012_04_quality_of_life.pdf
7. National Institute of Mental Health: Transforming the understanding and Treatment of Mental Illness <http://www.nimh.nih.gov/health/publications/depression-and-stroke/index.shtml#pub4>
8. Healthy IDEAS – Care for Elders http://careforelders.org/files/DDF/HealthyIdeas_vF.pdf
9. Healthy IDEAS- Action Brief: Depression Care Management: Evidence-based Programs Healthy http://careforelders.org/files/DDF/Healthy_IDEAS_feb09.pdf

