Curbing Depression: Prevention and Early Intervention Efforts of Sonoma County's Older Adult Collaborative

Mark Vanderscoff

EXECUTIVE SUMMARY

Depression is one of the most common mental health disorders in older adults. Seniors who are disabled, isolated, have chronic health problems, and/or lack financial resources are at the greatest risk of having undetected and untreated depression. Even mild to moderate depression is associated with decreased levels of functioning, which can lead to higher utilization of social, medical, and mental health services. Early identification and treatment can reduce symptoms and improve mental and physical health functioning, decreasing need for services. Both Sonoma and Marin counties have fast growing older adult populations. This case study examines Sonoma County's unique Older Adult Collaborative (OAC). The OAC is a prevention and early intervention model program aimed at reducing depression and suicide among older adults. A consortium of public and community-based agencies, the OAC operates with centralized goals for training, recordkeeping and funding. The model utilizes an evidence-based program, which is practiced in the home and community.

Marin County is currently engaged in creating and refining a comprehensive and proactive aging services' network to meet the county's burgeoning needs. There is a diverse non-profit landscape with which the county partners that currently offer opportunities build on to craft a home and community-based depression screening and service referral program. Many of the practices utilized by Sonoma County's OAC can potentially be implemented in Marin County to improve the quality of life for older adults with mild to moderate depression.

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Background

Increasing numbers of individuals are poised to enter their "golden years" and will be aging into a system that currently does not have the support services necessary for them. Adults aged 65 and older will make up one fifth of the American population by 2030.[1] This rapid growth in the older adult population can potentially strain an overburdened system with increasing numbers of those requiring either physical or mental health interventions. Advanced planning to strengthen the safety net of services for older adults needs to be a priority.

Depression is the number one mental health problem afflicting older adults according to the Center for Disease Control and Prevention (CDC).[2] The impact is furthered by the fact that depression is under-recognized and under-treated in older adults.[3] Some do not want to be stigmatized by seeking treatment; others may accept depression as a normal condition of the aging process. In fact, research from the CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA) agrees that depression is a medical condition that responds to treatment.[4]

A variety of issues places older adults at risk for depression, among them changes in physical health and mobility, loss of social/vocational supports, and financial stressors occasioned by retirement or illness.[5] One study of home healthcare recipients found that 73% met criteria for depression.[6] In many cases, depression is inextricably linked with chronic physical ailments, such as cardiovascular disease, diabetes, and arthritis.[7] Studies have shown that older adults with depression tend to visit the doctor and the ER more frequently and incur higher inpatient and outpatient charges. One study estimated health care costs for older adults with depression are approximately 50% higher than those without.[8]

Aside from being associated with rising health care costs, at its worst outcome, depression in older adults is a leading risk factor for suicide. Older caucasian males (85 +) complete suicide more often than any other group of people. The suicide completion (lethality of attempt) rate of older adults is 50% higher than the population as a whole.[9]

Given the prevalence and risks associated with depression, the CDC recommends that all disease prevention programs for community-based older adults should include a depression component.[10] In order to most effectively treat depression, both CDC and SAMHSA endorse the use of evidence-based practices (EBP), as these have shown to scientifically improve health and functioning.[11] This finding is further refined by a recent study that "strongly recommends interventions based on the depression care management model" for the greatest efficacy in treatment.[12]

Marin County

Marin County is currently examining the needs of its rising tide of older citizens. Older adults are the fastest growing age group in Marin County, and by

2030, one in three residents will be 60 and above. A recent study found that women in Marin have the highest life expectancy in the nation, at 85.2 years; Marin County men rank fifth in the nation at 81.44.[13] The county has begun strategic planning to ensure that this longevity is matched with access to appropriate health and social services. A survey conducted by the Area Agency on Aging in 2012 reported that periods of sadness and depression were listed as one of the top five areas of concern for older adults. The same survey noted that up to 80% of respondents had experienced a health condition, a risk factor for depression. Census 2010 found that 30% of Marin's older adults live alone, another risk indicator. In 2013, the Marin Commission on Aging recommended that the (then) upcoming three-year plan for the Mental Health Services Act prioritize the needs of older adults and specifically referenced the need for EBP to treat this population. Additionally, the goals identified in the Area Agency on Aging's current four-year plan, 2012-2016, include promoting a comprehensive service system and improving access to information and services for older adults.

Sonoma County Older Adult Collaborative

With 23% of its population listed as 60 and above, and with 30% living alone, Sonoma County began planning for the growing tide of seniors with depression in 2009. Concerned about strengthening the safety net, the county's response was the formation of the Older Adult Collaborative (OAC). This program is prevention-based and reaches an underserved population. The OAC is a five agency collaborative of public and community agencies led by the Sonoma County Human Services Department, Adult and Aging Division (HSD). The community-based organizations (CBO) participating are: Council on Aging, Jewish Family and Children's Services, Petaluma People Services Center, and Community and Family Services Agency.

Responding to a Request for Proposals from Sonoma's Behavioral Health Department, the OAC was awarded funding from the Mental Health Services Act (MHSA), Prevention and Early Intervention (PEI), to provide services to reduce depression and suicide among older adults. OAC's proposal targeted specific changes in the delivery of depression-related services to clients that included:

- increased education about depression and awareness of services available
- ensuring access to services and care management
- Increased numbers of successful referrals to treatment
- a reduction in symptoms of depression

The OAC committed to expanding and strengthening existing programs administered by member agencies. All seniors receiving services from OAC members would now be screened for depression through participation in programs administered by the collaborative (e.g. In Home Support Services and Meals on Wheels). Referrals would then be made for existing services among these agencies. It is worth noting that these agencies had an existing history of formal and informal collaborations and also that HSD already funded three of the four members through Area Agency on Aging contracts. These relationships and the desire to better leverage public and private funding opportunities for older adults helped pave the way for the formation and the streamlined delivery system of the OAC.

The OAC members further pledged to implement an evidence-based depression care management program, while strengthening inter-agency referrals within the participating agencies and the community. Culturally inclusive outreach was established as a priority. Data collection was standardized to monitor and improve service delivery and for funding purposes.

Member agencies of the OAC sign a Charter Agreement in which agencies agree to function as equal partners and to resolve any issues through consensus. These procedures remain cornerstones of the collaborative. It was also agreed that HSD functions as the lead agency (fiscal agent), signing the Memorandum of Understanding with Behavioral Health (MHSA funder). HSD assumed responsibility to monitor the scope of work, compile data, review

invoices, and distribute funds to the provider agencies. Separate contracts are also maintained between HSD and member agencies regarding budget allocations and member responsibilities, which include projecting service delivery goals and submitting data compilations in a timely manner. Communication on these issues remains key, and the Executive Committee, comprised of agency directors (or designees), currently meets quarterly to address these issues. The committee also reviews and schedules trainings associated with the EBP.

The MHSA grant was awarded to the OAC in 2009 for $243,378 and has remained stable to date. The amount represents the entire available PEI funding available for older adults in Sonoma County. The funding amount is proportioned according to the numbers of seniors served per agency. HSD receives an extra 16% of total grant monies for administrative oversight costs. As a part of the contract, upon inception and upon renewal, each agency submits fiscal provisions that outline what services and amount they are leveraging in terms of staff and facilities. The full program costs that each agency encumbers are not covered by the grant and include administrative costs, facility use, and staff time. The ratio of in kind contributions ranges per agency, but can reach 1:1 proportions.

Evidence-Based Practice

The OAC early on agreed upon implementing Healthy IDEAS (HIDEAS: Identifying Depression, Empowering Activities for Seniors) as the EBP through which services are delivered. HIDEAS was implemented in 2002 and was initially developed by Baylor College of Medicine. It has been designated as an EBP by the US Administration on Aging.14 An outcome study in 2008, while noting some challenges, concluded "HIDEAS is an effective evidence-based psychosocial intervention for depression in older adults....HIDEAS helped clients increase their knowledge of mental health issues and gain skills to self-manage depression."15

The model is home and community based. HIDEAS interventions do not rely on licensed clinicians and instead incorporate the components of the program into regular case management duties, as a part of routine phone calls or home visits. It includes 1) an outreach focused component, expanding on the usual medical model, which had historically required a client to be at a medical site for these types of services to be initiated; and 2) an embedded depression screening and education protocol that is routine for all clients. Maintaining fidelity to the model entails delivering at least three face-to-face visits and at least three telephone calls within a three to six month period. The goals are to:

- screen and assess all clients routinely for depressive symptoms using a standardized tool,
- educate the client about depression and treatment options,
- refer for appropriate treatment, and
- determine and implement activities to reduce symptoms.

At HSD's Aging and Adult Division, all clients 60 and over are offered depression screening and education as part of the In-Home Support Services program's initial assessment, and upon annual renewals. A positive screening generates a referral to the mental health liaison. The liaison, a licensed clinician supervised by Behavioral Health and embedded in the Older Adult team, then makes an in-home visit to further assess needs and to link to services.

All agencies in the collaborative that utilized a care management program, including HSD's Linkages Program, agreed to be trained in the implementation of the model. Training and set up for replication must initially go through Care for Elders, the technical assistance office for the dissemination of Healthy IDEAS.

HSD provides tracking of all OAC program outcomes quarterly. In FY 2013-2014, 2,665 seniors were screened and received depression educational materials. The screening acceptance rate was 85% with 23% of the screenings positive for depression. There were 428 referrals for mental health services, or 156% of the projected goal. As a result of the interventions, 47% of the recipients set activity goals to reduce

depressive symptoms. In-home counseling sessions totaled 339 sessions, or 212% more than projected. These numbers are representative of the previous years the OAC has been in existence, beginning with FY 2010-11. The figures attest that large numbers of seniors were receiving education about depression and mental health services that would not otherwise have been reached. The high screening acceptance rate is a testament to the efficacy of the non-stigmatizing approach, which ties the depression screening to routine services. The case of Mrs. Rose, who was able to avoid possible conservatorship proceedings and facility placement through receiving in-home depression treatment, illustrates the potential cost savings of the program.

Implications

A comparison of the service landscape between Sonoma and Marin Counties is helpful in determining if a duplicative program is feasible in Marin County. In Sonoma County, a core of robust and well-established CBOs, offering an array of services, made for an extremely effective partnership base. A number of resources that existed in Sonoma County, pre-OAC, are present in Marin County. A brief survey of services available in Marin County related to delivery of depression-oriented services include:

- **Marin Health and Human Services Department of Aging and Adult Services:** Offers APS and IHSS services and have entrée into large group of seniors who could be screened and referred. Completes intake and in-home assessments for home delivered meals. Licensed Marriage Family Therapist (MFT) is on staff.
- **HOPE (Helping Older People Excel) Program and Senior Peer Counseling:** Division of Mental Health and Substance Use Services (MHSUS). A full service MHSA funded program that provides multi-disciplinary intensive case management for seniors 60 and above suffering from mental illness. The Senior Peer Counseling program offers interns for counseling sessions and trained volunteers to visit/assist under the direction of a licensed clinical worker.
- **Jewish Family Children's Services:** Case management services are offered targeting the older adult population. Staff employs standardized depression screenings, offers referrals for mental health services, and is trained in the HIDEAS protocol.
- **West Marin Senior Services:** Case management program based in West Marin, also offers nutrition, transportation and socialization services. No depression screenings currently administered.

Primary care clinics in Marin County also screen for depression and refer to integrated behavioral health services and community resources through PEI funding. In Marin, as in Sonoma County, some of the above agencies have existing contracts with the county, through contracting for Area Agency on Aging services. Unlike Sonoma, in Marin County the agencies providing depression-related services are all contracting separately with Mental Health and Substance Use Services to obtain and utilize MHSA PEI grants. Currently there is no centralized system among these service agencies focused upon the issue of older adult mild to moderate depression, no standardized data collection and formalized referral protocols, nor routine home-based depression screenings.

Recommendations/Next Steps

1. Sonoma County's experience with the OAC has shown that a well-coordinated and comprehensive system of support for this population begins with standardization. Uniform assessments and referral delivery systems and measurable outcomes form the backbone of the OAC. Further study is needed in Marin County before determining if the time is right to seek additional funding for a duplicative program here. Next steps would include an

effort to discover if coordinating and integrating depression-related services is desirable and/or feasible in Marin. The issues that need to be investigated are 1) evaluate the ability and interest of agencies to utilize one standard depression screening tool for ease in assessment, referrals and data collection; 2) gather and maintain a centralized list of depression-related resources available for seniors for referral purposes; 3) explore the feasibility of creating and standardizing an inter- and intra-agency referral tool; and 4) compare agencies' current data practices; explore establishing a common set of data outcomes. Currently, the Aging Action Initiative, facilitated by Marin's Aging and Adult Services Division, is bringing together key aging service providers to plan collaboratively for the needs of Marin's older adults. Older adult mental health and well-being has already been identified as one of the four major areas of concern. Work groups have been formed to address themes and set goals and short term action steps. Thus, examining depression related services can be explored through this venue and has a fiscally neutral impact.

2. Examine the role of the MFT currently on the Adult and Aging team. Determine the feasibility of training the worker to administer depression screenings and referrals to depression-related services. The addition of another task for this position, and the availability and feasibility of training, has fiscal implications that need to be considered.
3. Record-keeping: Cohesive data tracking for funding and informational purposes is essential if a collaborative is to be established. At least part-time of a policy analyst position, as in the OAC, is necessary to ensure smooth data flow, provide reports, and oversee contracts and invoices. Again, potential workload issues and distribution would need to be weighed.
4. Assessment: Agencies interested in implementing HIDEAS program can complete a free online readiness survey by visiting www.careforelders.org/healthy/ideas. The survey does require data on case management and supervisory staff numbers and caseloads, and takes approximately thirty minutes of management time to complete.

With commitment from interested parties for utilizing a common treatment model, and with measurable data outcomes in place, funding would be the next priority. In Sonoma County, a significant share of the program costs are contributed by the participating agencies; thus, a comparable type of support and ability is necessary in Marin to establish a similar model. There will be stakeholder opportunities for new programs to receive MHSA monies beginning in two years, at the conclusion of the current three-year funding cycle. An OAC-patterned model does fit the criteria of PEI funding, as older adults are an underserved population and the interventions are prevention-based. This model warrants further review by Marin County, so that these types of prevention-based services and outreach to underserved populations can be initiated in a timely, proactive manner.

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References

1. U.S. Department of Commerce, Census Bureau. S0102:Population 60 Years and Over in the United States. Retrieved May 2, 2015 from http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#none
2. 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. Retrieved April 15, 2015 from http://www.cdc.gov/aging/pdf/mental_health_brief 2.pdf
3. Substance Abuse and Mental Health Services Administration. The Treatment of Depression in Older Adults: Depression and Older Adults:Key Issues. HHS Pub.No.SMA-11-4631, Rockville, MD:Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2011.Retrieved April 15, 2015 from http://store.samsha.gov
4. Ibid.
5. Ibid. pg 5
6. Bruce,et al, Major Depression in Elderly Home Health Care Patients, American Journal of Psychiatry, Volume 159 issue 8, August 2002, pp. 1367–1374. Retrieved April 20, 2015 from http://dx.doi.org/10.1176appi.aip159.8.1367
7. Chapman DP, Perry GS, Strine TW. The Vital Link between Chronic Disease and Depressive Disorders. Prev Chronic Dis 2005 Jan. Retrieved April 20, 2015 from http://www.cdc.gov/pcd/issues/2005/jan/04 0066.htm
8. SAMSHA, Depression and Older Adults: Key Issues, pg 8
9. Roy, Ratna, Depression and Suicide in Older Adults. Retrieved April 13, 2015 from http://personalityresearch.org/papers/roy.html
10. Snowden M, Steinman L, Frederick J. Treating Depression in Older Adults: Challenges to Implementing the Recommendations of an Expert Panel. Prev Chronic Dis 2008: 5(1). Retrieved April 20, from http://www.cdc.gov/pcd/issues/2008/jan07_0154.htm
11. SAMSHA , Depression and Older Adults: Key Issues, pg 9–12
12. Snowden, Treating Depression in Older Adults, pg 3
13. Wang et al. Population Health Metrics 2013, 11:8 Retrieved April 15, 2015 from http://www.pophealthmetrics.com/content/11/1/8
14. Healthy Ideas (identifying Depression, Empowering Activities for Seniors. Retrieved April 10,2015 from http://www.careforelders.org/healthyideas
15. Casado et al. Healthy IDEAS: Implementation of a Depression Program through Community Based Care Management. The Gerontologist, 48(6) 828-838. Retrieved April 16, 2015 from http://gerontologist.oxfordjournals.org/content/48/6/828.full