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Caring for Older Adults

By Michael B. Friedman, MSW Lisa Furst, MSW, MPH and Kimberly A. Williams, MSW

e are now eight years into the "elder boom." Sadly, the implications of this vast demographic shift are still not taken seriously. Yes, there is anxiety about sustaining Social Security and Medicare. And yes, there's increasing talk about "healthy aging." But even with these most obvious concerns there is little happening beyond handwringing. And when it comes to mental health, older adults are barely on the radar screen. Does it matter? Indeed, it does. Not only can mental and substance use disorders cause significant unnecessary suffering and dysfunction in old age, but mental health is essential to aging well. It is long past time for our nation to face up to the behavioral health challenges of old age—including mental and substance use disorders, developmental challenges, and the psychological conditions essential for living well in old age.

In what follows we (1) review the demographic projections for the first half



of the 21st century, (2) provide an overview of the mental and substance use disorders of old age, (3) note the developmental challenges of old age, and (4) propose a policy agenda to address the critical mental health needs of older adults.

Demographics

- The number of older adults (65+) in the U.S. will more than double from 48 million to 98 million from 2015 to 2060.
- The proportion of older adults will in-

crease from about 15% to about 24% of the total population, more than the population of children under 18, while the proportion of working age adults declines 5%.

- The proportion of non-white older adults will increase from 20% to over 40%.
- The population of older adults will include more people who are 85+, of whom about half will have a disability and need help with activities of daily living.
- Older adults will be more likely to live alone and not to have family support due to the increase of the number of people who never marry or who divorce after 50, the growing number of older adults with no children living nearby, changes in family values regarding care of elder family members, and our failure as a society to adequately address the needs of family
- The health status of the next generation of older adults will change.

A portion will be healthier than ever before. But a portion of the next

see Older Adults on page 12

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Reaching Out to Meet the Mental Health Needs of the Aging

By Ann Sullivan, MD Commissioner NYS Office of Mental Health (OMH)

here are more than with 3.7 million individuals aged 60 and older in New York State. It's expected that this number will increase to 4.63 million by 2040. At the same time, the number of older adults with mental illness will increase by 80 percent, to 900,000.

Studies have shown that the community mental health program service penetration rate for adults 65 and older with serious mental illness is far lower than it is for adults age 21 to 64. This means it's vital that mental health and substance use services are coordinated and tailored to meet their specific needs. New York State is responding by developing partnerships to find innovative ways to provide services to address this issue.

Key to this process has been the Geriatric Mental Health Act. Enacted in 2005, the Act designed to provide for highquality, integrated services to meet the behavioral health needs of older adults and to prepare for the coming elder boom. The Act established an Interagency Geriatric Mental Health Planning Council to help state agencies collaborate on initiatives to integrate physical and behavioral health care in outpatient clinic settings. In 2008, this body was expanded to include chemical dependence and mental health care for veterans and was renamed the Interagency Geriatric Mental Health and Chemical Dependence Planning Council.

The Act also established the Geriatric Service Demonstration Program to provid -e a means for developing these initiatives. The planning Council makes recommendations for requests for proposals. Grants are administered by OMH in cooperation with the State Office for the Ag-



Dr. Ann Sullivan

ing, Office of Alcoholism and Substance Abuse Services, and other state agencies. The program awards Service Demonstration Grants to providers in the areas of community integration, improving quality of treatment, integrating services, workforce, family support, finance, specialized popu-lations, information clearinghouse, and staff training.

Since the program started in 2007, more than 50 demonstration grants have been awarded. Programs funded through the grants include:

- The Community Gatekeeper program to identify at-risk older adults in the community who are not connected to the service delivery system. The program helps to connect them with needed behavioral health services and supports.
- The Bi-Directional Mental Health and

Physical Health Integration to integrate physical and behavioral health care in either behavioral health care settings or physical health care settings.

• The Triple Partnership Program, which is designed to pull together the resources of mental health, substance use disorder, and aging services. OMH selects health providers to establish such partnerships in their communities to help adults age 55 or older whose independence or survival is in jeopardy because of a mental health, substance use, or aging-related concern.

These grants are flexible to allow each provider to design its own program. This way it can use its current resources and relationships in the most efficient and effective manner possible to build a connected network that meet the particular needs of its specific population.

In addition, the Part-nership Innovation for Older Adults program com-bines resources from multiple state agencies and offers training and technical assistance for grantees through the Geriatric Technical Assistance Center, which is currently operated by the National Council for Behavioral Health.

This program awards grants to providers in the areas of community integration, improving quality of treatment, integrating services, workforce, family support, finance, specialized populations, information, and staff training. The goal is to find and offer services to individuals who could possibly end up in an institution because they're not currently connected with any services, are having difficulty accessing services, or may not even be aware that there are services are out that can help them.

Since the establishment of these programs, more than 15,000 individuals have been screened for depression, anxiety,

substance abuse, high body-mass index, high blood pressure, fasting blood sugar, and tobacco use. Eighty-eight percent of those screened were identified at risk for one or more of seven health risk indicators.

The Outcomes Have Been Promising

- Depression 61 percent no longer at risk / 78 percent showed improvement
- Anxiety 53 percent no longer at risk /74 percent showed improvement
- Substance Abuse 40 percent no longer at risk / 82 percent showed improvement
- BMI 5 percent no longer at risk / 60 percent showed improvement
- Blood Pressure 13 percent no longer at risk / 82 percent showed improvement
- Fasting Blood Sugar 19 percent no longer at risk / 49 percent showed improvement
- Tobacco Use 13 percent no longer at risk / 15 percent showed improvement

These programs are expected to increase their outreach during the next several years

As New York State's lead agency responsible for preventing and treating mental illness, OMH continues to work toward finding innovative ways of providing services that reflect the specific needs of older adults, taking into account their complex, and often chronic, medical conditions; And we always strive to provide culturally competent, coordinated – and most of all – effective care and support to help them live successfully in the community and to avoid institutional placement or readmission into institutional care.





The 2019 New York State Suicide Prevention Conference will showcase the work being done across the state in a variety of settings, including community, schools, clinical, and academic.

The event will feature presentations highlighting recent developments in suicide prevention, including working with diverse populations, community coalitions, schools and college campuses, health systems, and advancements in surveillance data.

Other highlights include remarks by **OMH Commissioner Dr. Ann Sullivan**, presentations by the New York State Suicide Prevention Council and the Governor's Suicide Prevention Task Force, a networking reception, a poster session, and display of the American Foundation for Suicide Prevention quilt.

For information, visit:

www.nyssuicidepreventionconference.org

Substance Misuse in Older Adults

By Arlene González-Sánchez Commissioner NYS Office of Alcoholism and Substance Abuse Services

n recognition of the State's commitment to healthy aging, the American Association of Retired Persons (AARP) designated New York as the first Age-Friendly State in the nation. The Office of Alcoholism and Substance Abuse Services (OASAS) recognizes that a key component of healthy aging is preventing and treating substance use disorders (SUDs) among older adults and engaging them in activities that help sustain their recovery and improve their well-being. As the portion of our population over 65 grows, the SUD prevention and treatment field will need to become attuned to the unique biological, social, and emotional needs of this age group.

Baby Boomers have been the largest demographic group in the United States for much of the late 20th and early 21st centuries. According to the U.S. Census, when the youngest of the Baby Boomers turns 65 in 2029 "more than 20 percent of the total U.S. population will be over the age of 65.1" The healthcare system needs to be prepared to recognize and treat the signs and symptoms of SUDs in older adult populations. Unfortunately, research into substance misuse among older adults is limited and medical professionals often fail to identify SUDs in older adults. In an article published in the journal Gerontology, authors Birgit Koechl, Annemarie Unger, and Gabriele Fischer point out that the effects of substance misuse "can be mistaken for depression or dementia in elderly persons, which explains why the prevalence of addiction in the elderly is underestimated."2

The consequences of SUDs among



Arlene González-Sánchez

older adults are already apparent. A study published in the Journal of the American Geriatrics Society indicated that consuming "14 or more drinks per week is associated with an increased risk of subsequent falls in older adults.³" The 2016 Behavioral Risk Factor Surveillance System (BRFSS) indicated that nearly 8% of New Yorkers over the age of 65 engaged in binge or heavy drinking. In New York State, in 2017, 19% of all opioid deaths occurred among adults over age 55. Between 2011 and 2017, opioid overdose deaths among those 55 and older increased by 198%, which was the highest rate of increase among any age group.⁴

The number of people 55 and older admitted to OASAS-certified treatment programs with heroin or other opioids as their primary substance of abuse increased by 44% from 4,200 in 2012 to 6,100 in 2018. During the same period, the number

of people 55 and older admitted to OASAS-certified treatment programs for alcohol as the primary substance increased by 39%, from 10,400 to 14,400. In 2010, those 55+ accounted for less than 10% of all admissions, but by 2018 they accounted for about 15% of all admissions. The Substance Abuse and Mental Health Services Administration (SAMHSA) notes that the number of older adults in need of substance abuse treatment nationwide is projected to be 5.7 million by 2020 which is more than double what it was in the early 2000s.⁵

Older adults are particularly vulnerable to the consequences of substance misuse for both biological and social/emotional reasons. As adults age they experience higher blood alcohol concentrations than younger peers due to decreases in body mass, liver function, and blood-brain permeability, as well as increases in neuronal receptor sensitivity to alcohol.⁶ Aging adults also process prescription medicines such as opioids and benzodiazepines differently than younger adults. Furthermore, other age-related health conditions can lead to an increase in prescription medicine use among this population. Using these medications improperly or in combination with alcohol can lead to devastating health affects among this population. Social isolation is also unfortunately associated with aging. Older adults may misuse substances to combat the loneliness associated with social isolation.

New York State has recently adopted the Prevention Agenda 2019-2024 with the goal of making "New York the Healthiest State for People of All Ages." The Prevention Agenda 2019-2024 is New York State's health improvement plan, the blueprint for State and local action to improve the health and well-being of all New Yorkers and to reduce health disparities for populations who experience

them. OASAS, along with other stakeholders in the SUD field, participated in developing the priorities and goals of the Prevention Agenda, particularly the "Promote Well-Being and Prevent Mental and Substance Use Disorders" priority area. Preventing substance misuse among older adults is a key element to achieving the goals listed in the Prevention Agenda.

In 2018, Governor Cuomo issued Executive Order No. 190 "Incorporating Health Across All Policies into State Agency Activities" which requires every State agency to create policies that advance healthy aging across the State. This Executive Order will help fight isolation among older adult populations through community design, planning, zoning and development principles that foster social connection, civic participation, and promote well-being with a special consideration for the needs of older adults. These principles in concert with the Prevention Agenda's focus on preventing SUDs will help to combat substance misuse among the older adult population.

The challenge of preventing and treating SUDs among older adult populations is daunting but not insurmountable. More research is needed to understand the prevalence and consequences of SUDs among this population as well as which evidence-based interventions are most effective in older adults. The myriad interactions between the older adult population and the healthcare system create numerous opportunities for health professionals to diagnose and treat SUDs. Outreach and education among geriatric health providers about SUDs in older adults is critical to assisting this population to thrive and flourish. OASAS is committed to working with our partners in the SUD field to prevent and treat substance misuse among

see Substance Misuse on page 33



Approaching the Tipping Point: It's Time to Re-Think Mental Health Care for Older Americans

By Nancy Harvey, LMSW **Chief Executive Officer Service Program for Older People**

he statistics are clear: Older adults are the fastest-growing segment of the U.S. population - in fact, Americans over age 65 will soon outnumber children. Data indicate that older adults are at increased risk for mental health disorders, and elder suicide in particular is a growing public health crisis, especially among men. The need for mental health care is clear, yet the health care community is poorly equipped to handle increased demand and the complex challenges of caring for a population that may be isolated, fearful of treatment, or unsure of how to seek help.

Now is the time for a national conversation about how to meet the growing need for mental health care for older adults. Preventive care and early intervention can save lives, improve overall health and quality of life, increase independence, and reduce unnecessary demand on the health care system. Recent high-profile suicides have shed light on mental illness and suicidality, and hospitals have a strong incentive to include behavioral health in discharge plans to reduce readmissions. The mental health community now has an opportunity to develop creative strategies to serve older adults.



Nancy Harvey, LMSW

As one of the longest-serving agencies in the U.S. entirely dedicated to meeting the mental health needs of older adults living in the community, Service Program for Older People/SPOP has unique experience in the field. SPOP was established in 1972 in New York City to provide comprehensive mental health care for adults age 55 and older, regardless of financial need, language, or disability. Our founding mis-

sion was to treat homebound seniors, and we have provided community-based care and home visits for nearly 50 years

There is no shortage of mental health providers in our region for adults with financial means and a high degree of medical literacy; however for those who are financially-disadvantaged, homebound, non-English-speaking, or unfamiliar with the health care system, the options are limited. SPOP is often the only appropriate provider for a referral, and we are known for our service to the most fragile and marginalized older adults in the community.

Most important, SPOP has demonstrated that geriatric mental health care saves money. In a recent clinic survey half of all respondents reported decreased usage of hospital emergency rooms since the start of treatment, and nearly 90% reported that they are now equipped to handle daily problems more effectively outcomes that have a direct impact on health care costs.

'Alice," age 67, is an example of how SPOP works in the community. "Alice" is homebound due to severe arthritis and at the time of admission was identified as an emergency room "super utilizer" (more than four visits per year). She was diagnosed with an anxiety disorder, and during the weekly home visit with her therapist she worked toward treatment goals of learning to manage anxiety symptoms and develop coping skills and relaxation strategies. Over two years of treatment Alice has made only two emergency room visits, and she recently initiated discharge on the basis of having achieved her goals.

Drawing on our own experience in advocacy, direct service, and fostering strategic alliances, we recommend a broad discussion to explore ways to meet the fast-growing need for geriatric mental health care. Among the topics we might consider are:

- Addressing the shortage of qualified professionals trained in geriatric mental health care, including psychiatrists, nurse practitioners, and bilingual psychiatric social workers, and advocating for Medicare coverage for service at different credential levels (e.g. LMSW vs. LCSW)
- Expanding the use of technology and Medicare coverage for it, particularly telehealth in urban settings
- Creating a clear interface between Medicare and Medicaid for the dual-eligible population
- Educating government leaders and the philanthropic community on the need for funding for geriatric mental health
- · Advocacy to restore or increase Medicaid

see Tipping Point on page 33



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Addressing the Urgent Treatment and Housing Needs of Older Adults

By Peter Provet, PhD President and CEO Odyssey House

In the midst of a devastating opioid epidemic, much of the attention has focused on the impact on younger populations, but there is another group struggling with substance use disorders: senior citizens. As baby boomers head towards their senior years, the number of older Americans with substance use disorders is growing dramatically, and with it, the need for specialized treatment has increased.

Odyssey House's ElderCare program has focused on providing age-appropriate services for this population for more than 20 years by establishing specialized residential and outpatient services, developing a peer-run, community-based mentoring program, and more recently, helping seniors find stable housing in New York City after they have completed treatment.

Meeting the Needs of an Underserved Population

Older adults represent one of the fastest growing segments of the US population in need of treatment for substance use disorders (SUD). The Substance Abuse and Mental Health Services Administration (SAMHSA) expects the number of adults aged 50 and older needing SUD treatment to double by 2020, from 2.8 million (2002 to 2006 annual average) to 5.7 million. In New York, the Office of Alcoholism and Substance Abuse Services reported a 39% increase in older adults admitted to SUD treatment from 2010 to 2016.

This data, coupled with national surveys that show older adults experience increased depression, isolation, and chronic medical conditions, point to the need for



Peter Provet, PhD

services that are age-specific and address the unique physical, psychological, and social changes that may occur during this life stage.

Odyssey House has a record of accomplishment in meeting the needs of this overlooked and underserved population. In 1997, we created the first-ever residential treatment program dedicated to treating older adults with SUDs, known as ElderCare. Since its inception, Odyssey House has increased capacity from 15 to 113 beds, reflecting the ever-growing demand for treatment among older adults.

While enrolled in the ElderCare program, residents receive specialized services and supports in addition to SUD treatment designed to help them to function independently within the community, such as life skills training, adult basic education, entitlements assistance, internal medicine, dentistry, and psychiatry.

In 2004, Odyssey House expanded

treatment track specifically for older adults. Because many elderly people are at risk of being cut off from their communities as they age, the treatment priorities of the ElderCare Outpatient Program, located in the Bronx, are to encourage older people to develop social support networks among their peers in recovery; provide them with individual and group therapy; and visit them in their homes as necessary. Counselors trained in geriatric care develop individualized treatment plans, incorporating age-related individual and group therapies targeting symptoms of depression and anxiety, bereavement counseling and life planning, and access to primary medical care.

To date, Odyssey House has served well over 2,500 older adults in residential and outpatient settings and serves an average of 150 ElderCare clients annually. The program consistently operates at full capacity and has a waiting list, reflecting a constant community need.

Older People in Recovery Face Housing Crisis

For older adults who have completed treatment, the lack of affordable housing is a major barrier to their ability to lead independent lives and maintain a healthy recovery.

In New York, Odyssey House is one of the only SUD treatment organizations to offer services specifically tailored to the needs of older people. Counselors trained in geriatric substance abuse provide treatment services that address underlying behavioral issues in an intensive program that helps older adults develop relapse prevention strategies, reunite with families, and build a supportive peer network. But key in helping them move on to independent, healthy lives in the community is affordable housing.

Almost half of the ElderCare population at Odyssey House (adults age 55 and older) were homeless when they entered treatment, stay in residential care for an average of 100 days longer than younger clients, and 25 percent fail to find independent housing, forcing them to cycle back to institutional living in community residences.

This is where the Fan Fox & Leslie R. Samuels Foundation plays an essential role. With their support, Odyssey House has hired a housing specialist to assist approximately 150 residents, who cycle through our ElderCare program, find, secure, and maintain independent housing.

By supporting this effort, the Fan Fox & Leslie R. Samuels Foundation is helping to serve more seniors in need by helping Odyssey House transition clients out of intensive residential care and freeing up beds for seniors on our waiting list. This grant also aligns with the mission and objectives of the Foundation's Healthy Aging Program to improve the overall quality of life of New York City's older adult population.

While the shortage of affordable housing affects all low-income New Yorkers, the need of this specific population to secure housing is urgent and becoming more acute as the number of older adults in recovery from SUDs increases.

In addition to their increase in numbers, the changing demographic and substance use pattern of older adults indicates that a wide array of psychological, social, and physiological needs will continue to grow, including demands for appropriate housing

Odyssey House helps New Yorkers in need overcome drug and alcohol abuse, improve their physical and mental health, and defeat homelessness. For more information, please visit odysseyhousenyc.org or call 866-888-7880.





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Healthy Aging Requires More Than Health

By Ashley Brody, MPA, CPRP Chief Executive Officer Search for Change, Inc.

ur nation's population is rapidly aging. According to the U.S. Census Bureau, by 2030 all members of the Baby Boom generation will have reached or surpassed 65 years of age, and the population of older adults will outnumber children for the first time in our nation's history (United States Census Bureau, 2018). It is commonly known the "Golden Years" pose unique social, medical, financial and environmental challenges to those who have been fortunate enough to achieve such longevity. These challenges are often compounded for individuals with serious mental illness (SMI) and related behavioral health concerns for whom the aging process is anything but golden. Those with SMI between the ages of 55 and 64 are four times more likely to die as individuals without SMI (Olfson, Gerhard, Huang, Crystal & Stroup, 2015). This fact, as much as any other, illustrates the plight of these individuals. It should also serve as a clarion call to health and behavioral healthcare providers who aim to alleviate suffering and to improve the quality of life for members of this population.

A comprehensive analysis of integrated care for older adults with SMI revealed deficiencies within our existing systems of care along with potential opportunities for improvement that must be explored lest we fail to address a looming mental health crisis among our aging citizens. Comorbid physical health conditions are common among individuals with SMI, and the incidence of comorbidity rises rapidly during the aging process (Divo, Martinez & Mannino, 2014). Nevertheless, authors of the aforementioned analysis found most Evidenced-Based Practices (EBPs) applicable to older adults address components of their mental or physical health, but few address both in a concurrent or coordinated fashion (Bartels, Di-Milia, Fortuna & Naslund, 2017). Aging individuals - and especially those with SMI - frequently experience potentially preventable Emergency Department (ED) and inpatient hospital encounters, and a dearth of coordinated, whole-health interventions is bound to perpetuate this unfortunate trend. Nevertheless, various healthcare reform initiatives of the past decade have recognized integrated and coordinated care are integral to the achievement of desired outcomes among vulnerable populations, and Bartels et al. (2017) have identified some promising approaches specifically targeted to older individuals with SMI.

The Health and Recovery Peer (HARP) program (not to be confused with a Medicaid Managed Care product line of the same acronym) is an illness self-management program derived from the Chronic Disease Self-Management Program (CDSMP) and calibrated to the needs of older individuals with SMI (Druss et al., 2010). This program deploys peer specialists to guide participants through sessions that incorporate elements of exercise and physical activity, symptom management, nutrition, medication



Ashley Brody, MPA, CPRP

management and principles of effective collaboration with primary care physicians. Participants proceed in stepwise fashion and are encouraged to develop short-term goals related to positive behavioral change. This program has produced favorable outcomes among its participants who reported greater perceived ability to manage their illnesses, improved medication adherence and use of primary care services, and enhanced quality of life (Druss et al., 2010). The Targeted Training in Illness Management (TTIM) program is another peer-facilitated initiative designed specifically for adults with SMI and comorbid diabetes (Sajatovic et al., 2017). Diabetes Mellitus is a chronic condition that afflicts approximately 6% of the population, but its incidence is considerably greater among individuals with SMI (Medved, Jovanovic & Knapic, 2009). Thus, interventions that target this comorbidity are of special importance to this cohort. TTIM bears some resemblance to the HARP program inasmuch as it addresses medication management, nutrition, exercise, substance use, socialization and the development of problemsolving and personal empowerment skills, among others. It, too, has produced favorable results among participants who evidenced overall improvements in their psychiatric symptoms and enhanced knowledge of diabetes (Sajatovic et al., 2017). Other approaches that have demonstrated promise for older individuals with SMI incorporate elements of the Collaborative Care Model (CCM) through which primary and behavioral healthcare services are delivered in the same setting(s) (Pallavi et al., 2017). These approaches promote both service coordination and access for their recipients, and the latter benefit is especially important to older adults with SMI, many of whom cannot navigate the logistical challenge of coordinating multiple appointments with both primary and behavioral healthcare providers. Technological innovations such as Telehealth (and Telemental health), biometrics and social media, among others, have enabled many individuals, especially older adults of limited mobility, to access health and social services from the relative comfort of their homes (Bartels et al., 2017). These advances may permit seniors to enjoy longer periods of independence and community tenure than would otherwise be possible for them.

Notwithstanding the potential of the foregoing practices to improve the health of their beneficiaries, few of them address Social Determinants of Health (SDoH) in a systematic or comprehensive manner. SDoH include such constituents of health as safe and stable housing, food and income security, and access to social and emotional supports, among many others (Centers for Disease Control and Prevention, 2019). These constituents often elude individuals with SMI for whom widespread unemployment and other significant life challenges lead to chronic poverty and its attendant ills. These challenges are especially pronounced for many older adults whose diminishing social networks and increasing reliance on fixed (and limited) incomes produce heightened stress and dissatisfaction. In addition, older adults, including those with SMI, are vulnerable to the existential crises that afflict other generations and must be successfully navigated in order to achieve optimal health and fulfillment. In other words, these crises are not the sole province of the aggrieved adolescent or

the middle-aged man. Older adults who cultivate a sense of meaning that locates their lives in a broader context and transcends their daily challenges are more likely to experience enduring health and fulfillment (Graham, 2017). This is not to suggest we must become practitioners of logotherapy in the tradition of Viktor Frankl, nor should we expect our seniors to divine a definitive meaning of life in order to find happiness. We must simply recognize they, like most of us, aspire to something more than an absence of infirmity. They desire the presence of purpose and all it entails.

Interventions that aim to promote health and to mitigate suffering among older adults with SMI must effectively address chronic and comorbid conditions unique to this cohort. They must also address other impediments to enduring health and satisfaction common to all. Comprehensive, whole-health orientations that explore the medical, emotional, psychosocial, environmental and spiritual underpinnings of wellness are essential to the welfare of their beneficiaries. Our seniors deserve nothing less.

To reach the author contact him at abrody@searchforchange.org or (914) 428-5600 (x9228).















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Aging Through a Strengths-Based Lens: Dreaming Big, Living Longer

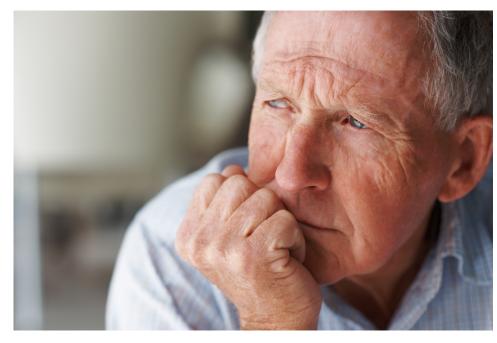
By Elisa Chow, PhD David Kamnitzer, LCSW-R and Eleanor Lalor, LMSW Institute for Community Living

early 50 million Americans are over the age of 65; by 2030, that number will surpass 70 million and account for about 20% of the population. While for some, late adulthood can be a time of great fulfillment, for many, our culture's emphasis on youth and a fast -paced life leads to a declining role for older adults in their social and work life. Often they are victims of false cultural expectations and stereotypes. And for people living with serious mental illnesses (SMI), all of these experiences have exacerbated greater physical and social challenges. For them, it can be a time of tremendous despair and isolation.

In his 1963 seminal work on the eight stages of development, Erik Erikson referenced the later years of one's life as a period where one endures either integrity or despair. From their mid-60s to the end of life, he believed that people in late adulthood reflected on their lives and felt either a sense of fulfillment or a sense of failure. He concluded that people proud of their accomplishments felt a sense of integrity and looked back on their lives with few regrets while people who did not feel successful felt their life had been wasted. They felt great regret, dwelling on "would haves" "should haves," and "could haves". They often faced the end of their lives with bitterness, depression, and despair.

While Erickson's work was important and groundbreaking for its time, today we live in a world offering many more opportunities in one's later years. Today many older adults are thriving and enjoying life well into their 80's and 90's, celebrating accomplishments, re-connecting families, working, volunteering and more than ever - engaging in intimate relationships. As behavioral health practitioners, it is our responsibility to help older adults see well beyond Erikson's premise and encourage the understanding that, regardless of age or life situation, people are capable of living a fulfilling and satisfying life.

To be most effective in this work, we have a shared responsibility to help our staff recognize the innate strength and resilience of all individuals we serve. While complex on its face, this process is actually very simple and parallels the principles that many in our field learned in their training on recovery constructs. If we examine SAMHSA's 1991 "recovery roadmap," we believe that the 10 principles outlined are applicable to older adults. For example, the idea that there is "not one single pathway to recovery" is



very true for older adults, many choose to participate in social activities every day while others spend their later years caring for grandchildren. The SAMHSA principle that "recovery is supported by peers and allies," can be very powerful for older adults. For those who have struggled with mental health challenges, making amends and re-connecting with family members after many years of trauma and family abandonment can be powerful and healing. Viewing older adults through a "holistic" lens supports the practice of whole person health that takes into account the "emotional dimensions of health." In his 2017 book of the same name, Woodlock discusses the importance of "feeling needed and having a sense of self-worth" and argues that human beings - regardless of age- have "a desire to thrive and people who are merely existing and not thriving suffer from diseases of the emotions, the body or both.'

Some argue that the main issues concerning aging and mental health are prevention, early diagnosis, recognition of major diseases, treatment and quality of life interventions, at both individual and community levels (Fernandes & Paul, 2017). Many in our field say that staff tend to take on a parental stance when working with older adults and we can do a better job of involving individuals around their personal choices and significant decisions that impact their lives.

To work successfully with older adults requires us to support the concept of a person-driven approach to health care and to embrace the value of hope and dispel myths and stereotypes about the aging process. By doing this we can affirm that later adulthood is much more than simply matters of integrity or despair but a time where many individuals continue to celebrate their accomplishments, engage in meaningful activities,

connect with social supports— to live life to the fullest extent possible.

Ageism or negative attitudes toward older adults serve an ego-protective function for the stereotyping individual. (Snyder & Meine, 1994) Stereotypes help younger people deny the threatening aspects of old age such as the idea that one will become frail and eventually die (Nelson, 2005) When younger people encounter people who represent a threat, their perceptions of and behaviors toward the threatening person tend to be more negative. So younger people may lessen their own anxiety associated with aging to avoid their own inevitable future selves (Edwards & Wetzler, 1998).

To more effectively help older adults, a strengths-based approach to care rather than a paternalistic approach is essential. Older adults have a vast wealth of knowledge as well as a wide range of skill sets and while their quality of life may decline in the face of their life circumstances, we should not view them as "high risk" but instead "able and capable". When we look at the individual we should not see them as a victim but rather someone that has hopes and dreams, someone who is powerful, someone who has been through adversity and developed coping mechanisms. Often older adults hold on to their spiritual belief system which contributes to their openness to accept help and support as their lives change. Of course, growing older brings on very complex challenges that threatens health and wellbeing and the ability to successfully adapt. However, working with older adults from a strength-based approach allows us to focus on promoting health and wellness rather than on deficits. This will further allow the individual to be more receptive to a healthier life. In layman's terms, we are talking about a self-fulfilling prophecy.

It is important throughout life to dream big and never give up on what you really want. Older adults should be afforded those same opportunities to live boldly and to take risks. This approach also allows for a greater sense of empowerment with people becoming more involved in the decisions regarding their own lives.

We must educate our staff that aging is filled with opportunities and that individuals should never give up on what they really want. Having an optimistic view of aging has a positive effect on subjective health and life satisfaction (Wurm et al. 2008). More and more we see the behavioral health industry focusing on strengths rather than deficits of people with serious mental illness. A paradigm shift toward self-management and self-direction is even more critical among older people. Professionals need to continually assess their own attitudes toward older people, understand and confront ageism where it arises, and become well-informed on what happens when we age (Nelson, 2005). Adjusting oneself to growing older and the changes that comes with it can be daunting for many of the people we serve. To be successful in our work, we need to understand that older adults can adapt if we take the following approaches:

- Understand the person in their environment and having conversations about their hopes and dreams.
- Help them to see how they can live, happy, healthy and active lives
- Affirm the individual's resilience; discuss openly and honestly their vulnerabilities and recognize that there are widely accepted social and health care strategies
- Imagine a new way of conceptualizing risk by seeing older adults as strong and capable
- Connect individuals to resources that will help the person maintain a balanced and whole health approach to living

As behavioral health professionals it is incumbent upon us to lead this charge and help shape this important ideological shift. The premises we've presented here are a starting point -- this critically important work takes time and a true commitment. Yes, the population is aging – but great opportunities abound.

About the authors: Elisa Chow, PhD, is Vice President, Innovations, Outcomes Evaluation; David Kamnitzer, LCSW-R, is Chief Clinical Officer/Senior Vice President; Eleanor Lalor, LMSW, is Vice President, Residential, Rehabilitation and Support Services. ICL at the Institute for Community Living.

Older Adults from page 1

generation will be less healthy, in part because there are more people living with serious chronic disorders, and in part because the current generation of workingclass men—who will become a significant part of the next generation of older adults—is at high risk for drug addiction, suicidal depression, and alcohol-related disorders.

• It is more than a little worrisome that because of population growth there will be more older adults with disabilities and because of shifts in population mix there will be proportionally fewer working age adults to help them. Immigration policy, which may become increasingly restrictive, could make the shortage of helping workers more acute.

• But, on the positive side, many more older adults will continue working or will be active volunteers. They may become a significant part of the helping workforce of the future.

Geriatric Behavioral Health Disorders

Unless there are long-promised, but thus far unrealized, breakthroughs in the treatment of mental and substance disorders or there are social catastrophes that make human life much harder, the

see Older Adults on page 32

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AGES (Assessing, Guiding, and Empowering Seniors): Supporting Seniors Aging in Place in Supportive Housing

By Rebecca Heller, LCSW Director of Aging Services The Bridge

he Bridge's Aging Services program addresses critical gaps in the mental health system by offering individualized care to seniors with behavioral health and physical health conditions living in supportive housing. In 2014, with approximately 800 beds in service, The Bridge recognized that we were not adequately equipped to support older residents who were experiencing geriatric conditions such as cognitive deficits, memory loss, and difficulty completing self-care tasks. These conditions, exacerbated by chronic health conditions, trauma, stress, and the long-term effects of psychotropic medications, were putting clients at an increased risk for unnecessary institutionalization in higher levels of care.

In response to this challenge The Bridge developed AGES, a practice-based approach that uses enhanced engagement, assessment, and monitoring protocols to link older adults living in supportive housing with appropriate community-based services to manage their age-related health challenges and maintain community tenure. Our approach offers a client-centered and cost-effective model that helps people stay in familiar surroundings and partici-



Rebecca Heller, LCSW

pate more actively in their own care.

Delivering specialized care to seniors living in community housing is a challenge that is not unique to The Bridge. The supportive housing system is not equipped to support and advocate for older adults to continue to live in the community as their needs change. Through the AGES intervention, The Bridge's Aging Services program offers an innovative solution. We have developed a low-cost, team-based approach to harness knowl-

edge and resources, internal and external to the agency, that enable older adults to remain in the community with their safety, dignity, and independence intact.

Program participation requires that individuals reside in Bridge housing, be age 55 or older, and require a geriatric intervention within the realms of physical health, mental health, and/or reducing hospitalizations. Clients are referred from a range of sources – residential staff, outpatient programs, The Bridge's incident review committee recommendation, or clients who self -refer after an educational event.

Annually, AGES conducts an agency-wide Older Adult Needs Assessment (OANA) to identify high-risk clients who require support in a range of functional areas. Besides gathering critical demographic and clinical information on all residential clients age 50 and older, this is another avenue for identifying persons in need of service.

Once referred, AGES staff assess a client's behavioral and physical health functioning, using the PHQ-9, AUDIT, DAST-10, and MOCA, among others, to create a comprehensive picture of the client's needs. Together with the client, staff uses the results of these assessments, and the client's self-identified goals, needs and barriers, to determine a plan of action. This plan may include referral to homecare and/or meal services, referral to a

PCP, enrollment in a pooled trust, or escort to appointments. The RN provides education, coaching, and concrete services, e.g., insulin management and wound care. The team can provide inhome counseling, referrals to mental health services, and connection to appropriate treatment. All these services are closely integrated and coordinated with the client's residential case manager and Health Home Care Coordinator, if the client has one.

One of Aging Services' central aims is to reduce preventable hospitalization/ER visits through facilitated access to community-based outpatient physical and mental health services, elder care programs, and agencies that provide services that improve quality of life (SDOH). If a client is hospitalized, staff work to ensure a safe discharge by attending case conferences and advocating for comprehensive discharge plans. Staff consult with providers to ensure clients stabilize after crisis and coordinate with inpatient and rehabilitation settings for clients returning to residential housing, using a holistic, personcentered approach.

The Aging Services team blends into the rest of the supportive housing team and the broader array of Bridge programming, complementing the agency's work while

see AGES on page 32



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Leading the Way in Older Adult Mental Health: Recommendations for New York State

By Lisa Furst, LMSW, MPH Kimberly Williams, MSW and Michael Friedman, MSW

In 2005, New York State enacted the Geriatric Mental Health Act, the first act of its kind in the nation. With this legislation, New York demonstrated a significant commitment to older adults with mental health challenges, allocating \$2 million per year in funding for statewide geriatric mental health demonstration grants, creating the Interagency Geriatric Mental Health and Chemical Dependence Council ("the Council"), and developing an annual report that describes the state's progress in addressing the needs of this population.

The service demonstration grants have enabled organizations throughout the state to develop integrated models of care for older adults with mental health needs. The current programs funded by these grants are implementing models that integrate behavioral health treatment as well as aging services, with an emphasis on reaching out to older adults not connected with any service systems and leveraging technology to better serve this population. Programs funded in prior years have proven to be able to sustain themselves in the community, making such demonstration grants a sound investment in the health



Lisa Furst, LMSW, MPH

and well-being of older New Yorkers.

While these accomplishments are considerable, and have established New York State as a national leader in geriatric mental health, there is more to be done to further enhance the state's capacity to anticipate and address the needs of older New Yorkers. To that end, the Geriatric Mental Health Alliance of New York (GMHA) partnered in the last year with the Council to establish a Planning Subcommittee.



Kimberly Williams, MSW

This subcommittee was charged with developing recommendations to assist the Council in setting statewide program and policy priorities, and these were submitted to the Council in December, 2018.

The Recommendations Include

1: OMH and OASAS should make older adults a priority population and should develop a substantive plan that compre-



Michael Friedman, MSW

hensively addresses the behavioral health needs of older adults.

Older adults are a rapidly growing subset of the population, and will increase in New York State by 75% between 2010 and 2040. The number of older adults with clinically significant mental health needs will grow by approximately 40% in the same period. This population increase

see Recommendations on page 37

Help Us Improve Mental Health Care For Older Americans!

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To Join the Geriatric Mental Health Alliance, contact Lisa Furst at Ifurst@vibrant.org.





The NYSPA Report: Mental Health and the Geriatric Population

By Jeffrey Borenstein, MD, President, New York State Psychiatric Association (NYSPA) and President & CEO, of the Brain and Behavior Research Foundation

am pleased to share with you an interview we conducted with Dilip Jeste, MD, Professor, Department of Psychiatry at the University of California, San Diego. He is also a past President of the American Psychiatric Association and a member of the Brain & Behavior Research Foundation Scientific Council.

Q: What made you enter the psychiatric field, and why do you particularly focus on late-life mental health issues?

A: As a teenager growing up in India, I was fascinated by Freud's books regarding interpretation of dreams and everyday errors of life. I felt that these books were similar to detective stories and murder mysteries—except that they sought to uncover secrets of the mind. I decided to go to medical school in order to become a psychiatrist—which was considered, to put it mildly, "a very unusual choice" by others. My goal was to study the science of the mind.

My interest in aging began much later and was driven by the fact that the population of the world is aging. The number of people over 65 in the U.S. will double in the next two decades. I also found on reading the relevant literature that the numbers of older people with mental illness will rise even faster than those in the general population. Therefore, this seemed like an exciting area for new studies.

Q: What are the particular challenges of late-life mental health?

A: The challenges include deteriorating physical health, neurocognitive impairment associated with aging, financial and psychosocial stressors—and importantly, the stigma of aging. Older people with mental illness have to fight the dual



Jeffrey Borenstein, MD

stigma of aging and mental illness. They don't have resources to advocate for themselves, and as a result, they constitute one of the most disenfranchised groups in society. Also, there is far less research on older people than on younger adults. The tendency is to transfer findings in younger adults to older ones; yet, this is inappropriate because of various psychobiosocial differences between the two groups as well as increasing heterogeneity with aging.

Q: You have done extensive research on late-life psychosis and its treatment. What are the challenges in this area and how is it different from other psychosis (early-onset or other)?

A: Late-life psychosis includes late-onset psychosis as well as persistence (or recurrence) of psychosis that first manifested earlier in life. The amount of published research on psychosis in late life is miniscule compared to that in younger people. Whereas schizophrenia and bipolar disor-

der are the two most important causes of psychosis earlier in life, the etiology becomes more complex and varied in later life. For example, psychosis associated with Alzheimer's disease and other dementias is more or less restricted to older adults. The number of people with psychosis associated with dementia is comparable to the number of people with schizophrenia across all age groups.

There is an interesting gender difference between early-onset and late-onset schizophrenia. Whereas males with schizophrenia markedly outnumber their female counterparts until about 30 years of age, the gender proportions reverse after age 45, possibly hinting at a role of hormones such as estrogens in late-onset schizophrenia.

Q: You are a widely recognized expert in the field of geriatric mental illness and received a Brain and Behavioral Research Foundation (BBRF) Distinguished Investigator Grant. What did the BBRF Grant enable you to do?

A: My younger colleague Elizabeth Twamley, PhD, and I initiated a study of work on rehabilitation in middle-aged and older adults with schizophrenia. The conventional wisdom is that persons with schizophrenia, especially the older ones, would be incapable of gainful employment. Yet, we found that, with appropriate support and guidance, many middle-aged and older people with schizophrenia not only could be employed, but they stayed on the jobs, and had an improvement in their functioning as well as quality of life. The critical element in making this possible was societal support.

Q: Please highlight the discovery you have made that you are most proud of and tell us why.

A: In recent years, I have been working on successful psychosocial aging. I have found that, even in people with serious mental illnesses such as schizophrenia,

the functioning improves with age. People who have suffered from a mental illness for decades learn from their experience slowly but surely. Many of them develop insight, begin to differentiate psychopathology (delusions, hallucinations) from normal experience, become more adherent to their treatment in order to avoid relapses, stop using substances of abuse and become happier. While some of this may be due to survivor cohort effect (i.e., the sickest individuals die young and do not live into older age), that is not the whole story. We have been following people with schizophrenia for the past 25 years, and have commonly noticed progressive improvement of this type. Whether one may call it recovery or sustained remission, the improvement with aging is often remarkable. With better treatments and greater social support, this should become

Q: What is the most important question you would like to answer about the aging brain and late-life mental health?

A: While most people associate aging with degeneration, deterioration, disability, disease, and then death, I am fascinated by psychoneuroplasticity of aging. Aging is often associated with increasing wisdom through better social decision making. The most important questions for me relate to the underlying neurobiology and the behavioral and environmental factors that promote the neuroplasticity of aging.

Q: What else would you like to say about late-life mental health?

A: Older people (with or without mental illness) are an invaluable resource for the society in terms of their wealth of experience and wisdom. It is unfortunate that they are usually considered a drain on the society. The more we learn about regeneration of an aging brain and about how to promote and use the resulting wisdom, the better the society will be.



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Stability, Wisdom, and Strength: Older Adults in Supported Housing

By Fausto, Gregory, and Robert

his article is part of a quarterly series giving voice to the perspectives of individuals with lived experiences as they share their opinions on a particular topic. The authors of this column facilitated a focus group of their peers to inform this writing. The authors are served by Services for the Under-Served (SUS) a New York City-based nonprofit that is committed to giving every New Yorker the tools they can use to lead a life of purpose.

Relishing the simple joys of life. Spending time doing activities that make us happy. Getting through the day "without any drama." Building fulfilling relationships with family and friends. Planning for the last stages of our lives and even our own mortality. These are some of the things that came up when three of us, tenants of S:US supported housing and all over the age of fifty, gathered to discuss our needs as older adults.

Our priorities have shifted vastly from where they once were. Collectively, we

have lived through homelessness, substance use challenges, incarceration, and service in the US Marine Corps. During the most difficult years, these experiences immersed us in subcultures and lifestyles where survival became our main priority. This slowly isolated us from family and friends, sometimes for decades, severing relationships with people who cared about us the most. Through S:US' supported housing and the stability is has granted us, we have finally had the opportunity to build back what was sacrificed during the most turbulent and unstable years of our pasts. Now, in our advanced years, we have new capabilities, opportunities, and goals we want to achieve with a new urgency. But we also experience new limitations. Our discussion took us through these contrasting elements, and more. Here is some of what came up during our

> Accessing Quality Healthcare Can be Challenging

As our ages advance, maintaining our physical and mental health has taken

precedence in our lives. We work to regularly see our providers, maintain our sobriety, or address health issues we haven't been able to address in the past. In some ways, we are happy with the care we receive. For one of us, a veteran, our mental and physical healthcare and medications are free as part of our veteran benefits, and easy to access in a central location at the Department of Veterans Affairs health care system. For others, access has been challenging and frustrating. Having limited incomes often restricts our care selections and choices. One of us spoke about waiting eight months to receive his dentures because the free transportation service he was offered was unreliable, leading to several missed and rescheduled appointments. Proximity and ease of access is central to our ability to receive the care we need. This is something we feel our service providers should be aware of when recommending providers and scheduling appointments.

"I've been trying to get an MRI on my knee for about 20 years. I hurt my knee when I was 14 years old, and to this day I

can't squat down. I've never gotten an MRI because they would always send me for an x-ray instead. I did physical therapy for a few months, then they sent me for an MRI and the appointment was far from my house, and it was the day of a Nor'easter. I went all the way out there and the lady filled out the paperwork wrong and I never got the MRI."

Poverty and Financial Hardship

Another source of frustration for us, which we also observe in those around us, is economic hardship and poverty. While housing is a huge source of stability and security for us, many of us have very limited incomes even with our social security and retirement benefits. We spoke about the struggle of finding employment at older ages and the challenge that presents. Without a lot of disposable income for transportation and other activities, it's easy to become socially isolated and spend the majority of our time alone at home. Because of our turbulent pasts,

see Supported Housing on page 37

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What Do Age and Disability Mean in Our Culture

By Ashton Applewhite Author, Speaker, Advocate

eople with disabilities come in all ages, and almost all of us encounter some change in physical or mental capacity as we grow old. Yet, we act as though old people never become disabled and disabled people never grow old. Academics and policymakers approach disability and aging as separate fields. Why? Because people in the aging field are understandably leery of seeming to equate aging and disability, and because disability activists tend to be younger and mainly focused on issues that affect people of working age. Because we're short-sighted and we're all prejudiced. This does none of us any favors. Ageism feeds ableism (prejudice against people with disabilities), and vice versa.

Disability and aging are different. They also overlap in important ways. Both olders and people with disabilities encounter discrimination and prejudice. And both groups face stigma. Many olders refuse to use wheelchairs or walkers, even when it means never leaving home. My uncle wouldn't use a white cane even when he grew completely blind, preferring to rely on the kindness of strangers and taxi drivers. As for the ageism stigma, after breaking a bone in her foot, a not-yet-forty-year-old friend likewise declined a cane, deferring to crutches because they signal



Ashton Applewhite

"injured," not "old" or "disabled." Cognitive impairment is even more stigmatized.

Being older or having a disability doesn't keep us from being ageist or ableist. People with disabilities make me uncomfortable! People with serious mental illness scare me! That's how prejudice works: it frames the other group—what we think of as the other group, that is—as alien and lesser than ourselves. This defies common sense, because people with disabilities come in all ages, after all, and most of us, if we live long enough, will

encounter changes in physical or mental capacity. Healthy aging can, and does, involve disability. Ignoring the overlap leaves the stigma unchallenged, and rules out collective activism.

We have a lot to learn from the activists who in the 1970s and '80s reframed the way we see disability. They changed it from an individual medical problem into a social problem—bingo!—and then demanded integration, access, and equal rights. Olders and people with disabilities share the same goal: a culture that rejects narrow definitions of "productivity" and "attractiveness," finds meaning within limitations and takes a realistic and inclusive view of what it means to be human. Let's join forces.

I'm an activist against ageism, much of which is rooted in fear of becoming disabled. Likewise, much stigma around disability has to do with what I've dubbed "age cooties." Of course, people with disabilities come in all ages; of course, healthy aging can and does involve disability; of course prejudice is not rational. And of course, disability and aging are different, but ignoring the ways in which they overlap compounds stigma and blinds us to the potential of collective activism.

Both aging and disability are incredibly diverse; how could we create some kind of shared identity or campaign in order to dismantle shared stigma? How could age equality activists learn from the brilliant advocates who got the ADA

passed, and institutions for people with mental illness shuttered by changing disability from a personal problem into a social one? How might we apply those strategies to reframe the way most people see aging—the one universal human experience? How might the disability justice movement benefit from growing global activism against ageism?

My goal is to help catalyze a movement against ageism that's genuinely inclusive, which means bringing people of different races, classes, abilities, genders etc. to the table from the get-go, and making sure all voices are heard. I'm scouting for those voices and wondering if some of you readers of BH News might be interested in being one of them, and/or if you'd pass along this query to others in your community who might be.

When groups within companies don't share information or knowledge, it's called a "silo mentality." It reduces efficiency and compromises the culture. Siloing is just as damaging in the social justice sphere, where it fosters disconnection and marginalization.

The antidote is to think and act intersectionally—a clumsy word for a powerful idea. Black feminist Kimberlé Crenshaw coined the term intersectionality in the 1970s, to address the ways that different forms of oppression—like racism, sexism, discrimination on the basis of behavioral health

see Age and Disability on page 38





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Behavioral Health 👀 News Desk



Cal Hedigan to Succeed Retiring CEO Steve Coe at Renowned Housing and Mental Health Organization

By Staff Writer Behavioral Health News

al Hedigan will become the next Chief Executive Officer of Community Access, a nationally award -winning nonprofit that provides supportive housing, training and healing-focused services to people living with mental health concerns. Hedigan has served as Deputy CEO since 2011 and has been with the organization in an executive capacity since 1999. She will succeed retiring CEO Steve Coe, effective July 1, 2019.

"As someone who has been with the agency for almost 40 years, I feel fortunate and excited that Cal Hedigan will be Community Access' future leader. We have worked together for twenty years to jointly plan and create the innovative and high-quality programs that are considered a hallmark of the agency. Her passion and commitment to the mission and values of Community Access are without equal," said Steve Coe, CEO.

Stephen H. Chase, Board President said, "Cal combines insightful executive skills with a true dedication to Community Access' mission and those we serve. The board conducted an exhaustive executive search to ensure the organization's future, and unanimously agreed that Cal Hedigan is the passionate leader who will



Steve Coe

carry Community Access forward to new generations. I look forward to seeing Community Access continue to thrive under Cal's exceptional leadership.'

Cal Hedigan said, "I am enormously grateful to have found a professional home at Community Access. At the outset, I was drawn to CA's rights-based approach to mental health work. The organizational commitment to selfdetermination, harm reduction and social



Cal Hedigan

justice has sustained me over the years. I appreciate the strong foundation that Steve and so many others have built at Community Access, and I'm excited to move into this new leadership role. As we grow and develop as an organization, our values will continue to shine through in everything we do."

Cal Hedigan joined Community Access in 1999 as the Director of Policy and Program Evaluation. She held roles of

Director of Corporate Compliance and Chief Operating Officer before being promoted to Deputy CEO in 2011. Prior to her tenure with Community Access, Cal spent nine years in a variety of direct service and management roles at the Bowery Residents' Committee in New York, ultimately serving as the Director of Planning. She received her undergraduate degree from Brown University and completed graduate studies in social work at Hunter College, as well as training through the National Council of Behavioral Health's Executive Leadership Program.

Community Access has established an ambitious goal to develop at least 1,000 additional units of affordable and supportive housing, and already has more than half of these units under construction and in the pipeline. Under Cal's leadership, the agency will also continue to invest in workforce development, infrastructure and services that further its mission and five core values: human rights, peer expertise, self-determination, harm reduction, and healing and recovery.

About Community Access

Founded in 1974, Community Access creates environments where people living with mental health concerns can build lives

see Retiring CEO on page 38

NYAPRS Regional Forum Held at CoveCare Center

By Staff Writer **Behavioral Health News**

ndividuals served by and representatives from agencies in Putnam, Westchester and surrounding counties participated in a special forum hosted by CoveCare Center in Carmel, NY. "The Power of Grassroots Advocacy" and "The Promise of Pioneering Service Innovations" were the main topics presented and discussed throughout the afternoon.

The forum began with a presentation by Harvey Rosenthal, Executive Director, New York Association of Psychiatric Rehabilitation Services, Inc. (NYAPRS). NYAPRS is a statewide coalition of people who use and/or provide recoveryoriented community-based mental health services. NYAPRS is dedicated to improving services and social conditions for people with mental health and/or traumarelated challenges by promoting their recovery, rehabilitation and rights.

"It is so exciting to be able to bring a nationally-known figure, such as Harvey Rosenthal, to Putnam to discuss with individuals and providers in the mental health system the legislative advocacy efforts that are being brought forth on our behalf. It is



Leaders at Regional Forum - Names Listed at End of Article

equally exciting to hear from peer agencies what new and innovative projects they are bringing to us," stated Alison Carroll, CoveCare Center Vice President of Strategic Initiatives and member of the Board of Directors for NYAPRS.

Following Mr. Rosenthal's presentation, Raquelle Bender from The Mental Health Association of Westchester presented on the agency's Intensive and Sus-

Engagement and Treatment (INSET) program. A pilot program, IN-SET is available to Hudson Valley residents aged 18 years or older who have been diagnosed with a mental health condition, have experienced multiple hospitalizations, and/or have a history of incarceration or substance abuse. The INSET team, which focuses on providing mobile support by meeting people at community locations of their choice, offers integrated peer and professional services and referrals when they are needed.

Lastly, Bryan Cranna from Independent Living, Inc. in Newburgh offered insight into the agency's Self Directed Care Services initiative. Also a pilot program, Self Directed Care Services is personcentered, allowing individuals to exercise greater control over the funding used for their care. Individuals are helped to pursue specific opportunities once thought out of their reach as they take control of their lives and work toward recovery. In order to be eligible for this program, individuals must be enrolled in a Health and Recovery Plan (HARP) and be eligible to receive Home and Community Based Services (HCBS).

CoveCare Center thanks the representatives from NYAPRS, The Mental Health Association in Westchester, and Independent Living, Inc. for their engaging and thought-provoking presentations.

CoveCare Center is the only private non -profit agency providing recovery-based mental health and substance use treatment and prevention services in Putnam County, NY. CoveCare Center offers hope and

see Forum on page 38



Annual Leadership Awards Reception

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Collaborations Make Aging in Place a Reality for People Living with Mental Illness

By Karen Choens, LMSW, Program Manager, Bureau of Program and Policy Development NYS Office of Mental Health

Then we say someone is "aging in place" what do we mean? If a person remains in the same home or setting as they age, does that qualify? The New York State Office of Mental Health (OMH) has been exploring this question in the context of the service delivery system, most integrated setting initiatives, such as Olmstead, and the diverse perspectives of individuals living with mental illness. A working, and still evolving, concept of what aging in place means for individuals living with mental illness has started to emerge: Living in a place you consider your home, with friends, neighbors and family, with community-based supports that address changing mental, physical and social needs to sustain a meaningful quality of life.

Aging in Place with Mental Illness: Addressing the Double Demographic Imperative

Certainly, one of the leading reasons for increased interest is the demographic imperative is the sustained growth in older adults that necessitates national pol-

icy changes to address the special needs of aging populations. Older adults aging with mental illness creates a double or compounded call to action. Everyone is aging who is alive, and the number of individuals aging into the older adult demographic (65+) in NYS will increase to 4.63 million by 2040, bringing with it an 80% (900,000) increase in older adults with mental illness. Further, the percentage of older adults with mental health conditions being diagnosed with a serious mental illness (SMI) that negatively impacts their daily functioning is significantly high. During a one-week survey in 2017, 94% of the 16,381 older adults who received services from New York's public mental health system were diagnosed with a serious mental illness and 79% reported at least one comorbid health condition.² Added to the demographic impact, is the well-established body of research showing that individuals living with SMI and Substance Use Disorders (SUD) are at increased risk for accelerated aging and disability.3 For individuals living with SMI, it has been described as a 50-year-old being equivalent to a 75-year-old in terms of daily activity and cognitive functioning.

OMH recognizes that long term care (LTC) services, such as personal care and home health, are key supports that enable individuals living with mental illness to age in integrated settings as well as suc-

cessfully return to the community after an acute care episode or transition from a more institutional setting. To address the increasing LTC needs of individuals living and aging with SMI, OMH has collaborated with home care agencies and their trade associations to identify opportunities to foster deeper partnerships between community-based long-term services and supports (LTSS) and behavioral health providers. This collaborative work resulted in legislation signed into law on October 1, 2018 that amends language in the Mental Hygiene Law related to the Geriatric Service Demonstration Program to specifically "foster and support collaboration between providers of home care services licensed or certified under article thirty-six of the public health law and mental health providers." The encouraged collaboration between homecare and BH providers is now codified into NY's Mental Hygiene Law, setting the foundation for partnerships that foster aging in integrated settings for New Yorkers living with mental illness.

Housing First with LTSS

Inherent in meeting the needs of an aging Boomer population is increasing access to Medicaid funded services and supports that can be provided in the home. OMH outreached to housing providers

across the spectrum of OMH residential programs to identify strategies to increase access to community-based LTSS. In particular, OMH's supportive or supported housing model inherently offers a pathway to successful aging in place through marrying affordable housing with inhome services designed to maximize recovery, independence and community integration. OMH housing providers shared anecdotes of successful collaborations of home care agencies, residential support staff and community-based medical and behavioral health providers and highlighted the significant time this advocacy requires in an often-siloed service system with competing regulations and reimbursement mechanisms. Providers identified the following LTSS needs as being most prominent in their housing programs:

- Housekeeping, personal care, home health care, skilled nursing and specialized therapies, environmental modifications to increase independence, access to elevators, medication management and administration.
- Adapting to a more-independent environment and integrating into community when transitioning

see Collaborations on page 34





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A Comprehensive Look at What's Needed to Age in Place with Dignity

By Judy Fink, LCSW and Heidi Weiss, LMSW, MHA Westchester Jewish Community Services (WJCS)

ormer First Lady, Rosalynn Carter stated, "There are only four kinds of people in the world: those who have been caregivers, those who are currently caregivers, those who will be caregivers, and those who will need caregivers."

Caregiving for the elderly is a growing phenomenon in the United States, especially in Westchester County, New York. It is predicted that by 2030, the country will have about 71.5 million people over the age of 65-more than double the amount in 2000! In New York State, 13% of the population is 65+ and will increase to 20% by 2050. In Westchester, we have already reached the 20% mark, years ahead of the rest of the country. The fastest growing segment of our population are individuals 85 years of age and older. About 64% of older persons depend on informal caregivers (family, friends, and neighbors) rather than services provided by professionals, as their only source of assistance.

The goal for most families is to help seniors age safely and well, with dignity, in the homes and communities that they love. There is no one perfect program, as needs vary depending upon each individual's situation, family, friends, and the community in which he or she resides. A thorough assessment of each senior's situation must be conducted in order to find the best solution to meet his or her needs.

At Westchester Jewish Community Services (WJCS), one of the largest human service organizations in Westchester, a geriatric assessment is made to ensure that our clients have: safe transportation options, comprehensive health care, including treatment for mental health challenges, affordable housing, access to affordable food, and the best caregiving situation possible.

The assessment takes into account



physical, emotional, financial, and social needs. There is a significant number of seniors who live alone and have limited means. They tend to be at greater risk for isolation, loneliness, and depression. Common stressors among older people include chronic medical problems or disabilities, and the loss of close friends, family, neighbors, and acquaintances. Many seniors have families who live a distance away, adding to a feeling of isolation. And when relatives live in close proximity and assume the role of caregivers there is the additional challenge of family members feeling stressed and often pressured by 'sandwich generation' demands.

At WJCS, we are committed to addressing the comprehensive needs of seniors. Our diverse range of services include: geriatric care management; home health services, mental health counseling; kosher home-delivered meals; in-home respite; assistance for caregivers with loved ones with Alzheimer's Disease and other dementias; a program for people with lifethreatening illnesses; Project Lifesaver (GPS emergency tracker); and a program

to help seniors in institutions return home with the aid of wrap-around services.

One of our key roles is to provide clients with information about programs, services, benefits, and entitlements as well as referrals to appropriate Westchester County agencies. We are very fortunate that in Westchester County, the Department of Senior Programs and Services (DSPS) and the Westchester Public Private Partnership for Aging Services provide a wide range of services for caregivers: Care Circles, Care Prep, Caregiver

Coaching Program, Next Stage, Livable Communities, Older Driver Family Assistance Program, home care, Caregiver Resource Centers throughout the County, elder abuse education, benefit/entitlement counseling, long-term care insurance education, info on Adult Day Care Centers, etc. In addition, Westchester County is rich with other agencies who are able to assist with housing issues, benefits/entitlements, Medicaid application, and Medicare advice.

Knowing that the well-being of caregivers is a key component in the care of seniors, WJCS offers support groups for individuals with Alzheimer's and Related Dementias as well as for caregivers in assisted living centers throughout Westchester County as well as in our own offices. Whether a caregiver is feeling stressed, angry, resentful, or fulfilled in their role, the opportunity to share feelings in a safe and comfortable environment is helpful. Knowing that they are not alone, that it is all right to ask for help, and that there are resources and referrals that can help them, enable seniors to age safely in place, with dignity, in the homes and communities that they love, and support caregivers in their compassionate task.

Judy Fink, LCSW, is Director of Geriatric Services and Heidi Weiss, LMSW, MHA, is Coordinator of Addressing Alzheimer's at WJCS-Westchester Jewish Community Services, located in White Plains, New York.



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Senior Volunteer Programs Provide More than Service

By Barbara Faron, LMSW, CPRP CEO Federation of Organizations

The United States Census Bureau estimates that the 65 and older population will reach 73 million by 2030. Baby boomers are the fastest growing population in the United States and by 2029 will comprise 20% percent of the total national population. With that in mind, social service providers are thinking critically about what services are needed to help individuals as they age. In the 1970s and early 80s, Federation became the sponsoring agency for two senior volunteer programs in Suffolk County, NY, the Foster Grandparent Program and the Senior Companion Program. As an agency, over the last 40+ years, we have seen remarkable improvements in the quality of life of our senior volunteers through service to others and that experience has shaped our strategy on offering meaningful, helpful services to meet a rapidly growing aging population.

Federation has been the sponsoring agency of the Foster Grandparent Program (FGP) in Suffolk County on Long Island since 1977. This program along with the Senior Companion Program, are national volunteer programs that are administered through the Corporation for National and Community Service. They fall under the Senior Corps umbrella and



Barbara Faron, LMSW, CPRP

provide volunteer opportunities for low-income seniors. Volunteers receive a sti-pend (which is not considered income for the purpose of state and federal benefits), paid vacation, personal, and sick days as well as a transportation allowance.

In the Foster Grandparent Program, we recruit and place low income senior volunteers in elementary schools, day cares, and Head Starts. There, volunteers work one-to-one with students who the teacher has identified as needing additional sup-

ports. These students may need help focusing and staying on task, need more individualized attention or social support, or need more academic support with assignments. The volunteer works with these individual students but serves the class as a whole. They become an integral part of the classroom, and very much loved by the students they serve and the teachers in the classroom.

Federation started the Senior Companion program in 1981. This program provides volunteer opportunities for low-income seniors to serve other frail, elderly seniors in their community. They visit with the senior in their home and help with light housekeeping and meal preparation, provide medication reminders, offer accompaniment to appointments, and most importantly provide companionship, socialization and conversation to individuals who may be isolated.

At the same time, we also added the Senior Companion Program to serve individuals who had been released after decades from psychiatric hospitals and who were living in adult homes along the south shore of Suffolk County. Volunteers (in our case individuals with a history of psychiatric treatment and often long-term hospitalization) provide friendly visiting and peer support, encourage adult home residents to explore their community, help with accessing community resources, and help individuals learn to use public transportation. Both programs have demon-

strated to be successful in enhancing the lives of both the volunteer and the recipient of services.

Benefits of Service to Others

Many times, we tout the benefits of those in receipt of volunteer service. which are truly great in number. But what about those who are volunteering? How does the volunteer experience affect the seniors who provide the service? For one, senior volunteers are given purpose again. For many who have long retired, volunteerism gives them a place to be each day. There, the people they serve count on them to be there, and miss them when they are not there. They are given meaningful work that makes a difference and also helps them connect to others at a time in their life when many family and friends have passed on. Many of our volunteers have lost a spouse, child, or close family member and have reported to us that this volunteer work saved them. Volunteers also attend monthly in-service meetings where they get together with other volunteers for continuing education. It's a chance to learn, socialize, make friends, and once again feel needed.

According to a recent national study, volunteers in both the Foster Grandparent and Senior Companion programs reported improvements in general health and

see Volunteer Programs on page 34

From Our Recent Children's Issue: An Innovative Solution for Family and Home Day Care

By Shannon Van Loon, EdM Assistant Director of Children, Youth and Family Services, Westchester Jewish Community Services (WJCS)

estchester Jewish Community Services (WJCS), a nonsectarian, not-for-profit multiservice agency founded in 1943, has a long history of focusing on early childhood as a key component to its program for children and families. Research has proven the crucial importance of the first years of life on the development of children and their life-long learning potential but, unfortunately, the quality of child care offerings provided to middle and low income families has not improved in response to this research. Though children's development is dependent on the quality of their social, emotional, and cognitive education and experiences, childcare workers remain among the lowest paid workers in the United States.

WJCS launched the Child Care Home Program for Family Child Care (CCHP) to address the scarcity of high-quality early learning programs for children of low-income families and to support our goal that all children start school ready to succeed. CCHP was introduced in 2007 after the Westchester County Child Care Utilization Study reported the lack of



Shannon Van Loon, EdM

quality care for young children, with a special concern regarding home day care programs, also known as family child care. The study noted that only 2% of family day care programs in Westchester County were accredited by the National Association of Family Care (NAFC).

CCHP's goal is to provide Family Child Care (FCC) providers, who frequently feel isolated and work alone and who have no ongoing support or professional development, with the educational and material support they need to offer young children a strong foundation for school success. CCHP trained staff have three key goals when working with childcare providers and their families:

- To foster an adult/child bond that gives children the support necessary to develop pre-literacy and on-going literacy skills while in providers' care.
- To increase the quality of early childhood educational experiences for children in Family Child Care settings to ensure they enter school ready to learn; and
- To support parents and caregivers as their child's first and more important teachers

How it Works

FCC providers join CCHP for a two-year period during which they commit to twice-weekly, hour-long, one-on-one visits from an Early Learning Specialist (ELS) with whom they are paired. The ELS offer one-on-one instruction from a developmentally appropriate early child-hood curriculum and guidance about cultivating a strong Parent/Provider/Child Partnership. The ELS uses toys and books to model positive interactions between children and providers and to demonstrate ways of using the materials to spark language-rich interactions and support social

and emotional development. Childcare providers are offered encouragement and praise so that the program not only models positive interactions with children but also increases the provider's sense of competency and confidence.

In 2016, WJCS added another component to the CCHP program: the Family Engagement Specialist (FES), who focuses on boosting early literacy and verbal interaction at home and strengthening the communication and involvement between parents and child and providers. CCHP provides consultation for parents so they can enrich the home environment and more fully engage with their children. Educational backpacks and "Family Playbacks," focusing on topics like nature and transportation, and containing books, puzzles, activities, and songs that enrich early learning, are available to be borrowed for up to three weeks by the Family Child Care provider. The provider and FES collaborate on parent engagement goals, by using a family bulletin board onsite, issuing a quarterly newsletter, and improving communication with parents. Providers often request the help of the FES in accessing community resources and learning how to handle behavior issues with challenging children in their care. The FES help the providers understand child development

see Solution on page 33

Flushing Hospital Medical Center: Leveraging the Geriatric Service Demonstration Program to Sustain Integrated Care for Patients

By Ira Frankel, PhD, LCSW Daniel Chen, MD, and Emily DeLorenzo, PhD, MSW

n order to lay the groundwork for systems change to better meet the needs of older adults in New York State, the Geriatric Mental Health Act was enacted on August 23, 2005. The law authorized the establishment of the Interagency Geriatric Mental Health and Chemical Dependence Planning Council, the geriatric service demonstration program, and an annual report to the Governor and the Legislature regarding the geriatric mental health needs of the residents of New York. Since the inception of the Geriatric Demonstration Grant Program in 2007, there have been four rounds and over 50 demonstration grants awarded. The grants are flexible and allow for each grantee to design a program model that best suits the needs of their particular communities by leveraging and coordinating local services for older adults. The grants focus on providing integrated physical and behavioral health and aging services to older adults in their communities and in their homes. These integrated, mobile models of care assist older adults in more easily accessing a wide-ranging array of services in the most convenient manner possible.

In order to create lasting change, the geriatric service demonstration program seeks to integrate sustainability planning into each round. Expert technical assistance is made available to each grantee in order to tailor sustainability planning to the unique structure of each agency. Utilizing this assistance, grantees have the opportunity to focus effort on the sustainability of their program, and many have found innovative ways to ensure they can continue to implement the successful practices established by the demonstration grants. Flushing Hospital Medical Center (FHMC) is an example of a grantee who has been able to successfully sustain the integration of behavioral health and physical health services for over a decade.

Flushing Hospital Medical Center (FHMC) is an accredited 299-bed voluntary, not-for-profit teaching hospital, founded in 1884. FMHC is located in the one of the most culturally diverse county in New York State. FHMC's Department of Psychiatry and Addiction Services consists four divisions, including: a 30 bed medially managed detoxification unit, which is the only medically managed detoxification unit in Queens County and is the highest census medically managed detoxification unit in New York state; an 18 bed voluntary Psychiatry Inpatient Unit, which is one of the only voluntary psychiatry inpatient units in New York

State; a Mental Health Clinic; and, a Chemical Dependence Clinic.

Daniel Chen, MD, is currently the Vice -Chairman of the Department of Psychiatry and Addiction Services. Ira Frankel, PhD, LCSW, is currently the department's administrator. Drs. Chen and Frankel have been collaborating together around successful aging projects since 2001.

At FHMC, the concepts of integration of services within an aging population were gradually infused into the entire culture of the hospital. In 2003, FHMC's Department of Psychiatry and Addiction Services sponsored an annual conference entitled, "The New Gerontology: Towards and Expanded Vision of Successful Aging." The basic theme of the conference was that the probability of successful aging was achieved through diet, exercise, the pursuit of mental challenges two of which are diet and exercise, self-efficacy, which is the belief that if one engages in successful aging practices, then the likelihood is greater that one will be successful in aging successfully, and, finally, social support, that is, individuals helping each other to engage in the ingredients of successful aging.

Going forward from 2003, FHMC's Department of Psychiatry and Addiction Services incorporated the ingredients of successful aging into its culture. The ideas were discussed in Grand Rounds, Case

Conferences, Journal Club presentations, and generally, disseminated throughout the entire department as a way to think about helping individuals with mental illness and substance use disorders achieve recovery. In addition, the ideas about successful aging were disseminated throughout the department as ideas that held true, not only for patients, but also for staff, as well.

FHMC was initially funded in the first round of Geriatric Demonstration Grants to integrate behavioral health services into primary care, and they have successfully sustained the integration work for the past 12 years. FMHC accomplished this by creatively tapping into statewide initiatives that are funding integration. Specifically, they applied for and received a newly created Integrated Services License that was being piloted by the NYS DOH, OMH and OASAS. FHMC was awarded two Integrated Services licenses- one was to integrate physical health care in the Mental Health Clinic, and the second to integrate physical health care into a Chemical Dependence Clinic. The Integrated Services Licenses allowed them to continue the integrated care work that was initiated through the Geriatric Demonstration grant, by retaining the Adult Nurse Practitioner who was hired by grant funds,

see Integrated Care on page 35



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Aging with I/DD as a Paradigm for the Aging Population at Large

By Elizabeth Lynam, Chief Program Officer, and Monica Santos, Vice President of Residential Services AHRC NYC

mericans are getting older—by 2030 one in five will be 65 or older according to the U.S. Census Bureau. These demographics are driven by young adults having fewer children and baby boomers living longer. Individuals with intellectual and developmental disabilities (I/DD) are also living longer, with those 65 and older expected to reach 1.2 million in 2030, nearly double the 2000 figure. As the elderly population grows, the cost of healthcare and other entitlement programs will strain the economy.

As policy makers grapple with how to address this aging phenomenon, they should look to solutions that have proven effective for people with I/DD. These include: 1) Focusing on social determinants of health and supporting meaningful social roles; and 2) Promoting Whole Person-centered planning and support.

Focusing on Social Determinants of Health and Supporting Meaningful Social Roles

Research shows that social conditions such as economic stress, inadequate housing, and persistent isolation can

negatively impact a person's physical and mental health. In response, health care systems are pursuing partnerships with community-based organizations to address these social determinants of health. Although this integrated approach is new to healthcare, it is the norm for high quality I/DD support and service organizations.

Partnering with community-based organizations to promote opportunities for community inclusion and integration is the foundation of high quality I/DD services. The richness of community-based options available for individuals with I/ DD is an important measure of quality care. By supporting people in employment, volunteerism and other socially meaningful community engagement (e.g., friend, congregation member, constituent), I/DD service providers have led the way in helping people gain independence and address systemic devaluation that reduces opportunities and recognition and. ultimately, leads to discrimination.

Meaningful employment and community engagement contribute to both economic and social growth. Recognizing this, I/DD providers have been creating opportunities for employment and supporting individuals at job sites with job coaching and training programs for three decades. AHRC NYC operates one of the largest supported employment and community services programs in the nation, tailoring job supports and volunteer op-

portunities to nearly 3,000 people. In light of the economic shift underway, translating this to the general aging population by engaging more seniors in paid jobs or volunteer activities, would significantly benefit the economy. In 2015 almost 25% of adults 55 and older in the U.S. volunteered, resulting in an economic benefit of \$77 billion dollars (Corporation for National and Community Service).

Promoting Whole Person-Centered Care Planning and Support

Person-centered planning, long used in the I/DD community, considers the lifegoals and plans of the individual, placing the person at the center of the care delivery system. It is a self-directed but supported process that helps providers discover how a person wants to live and what supports need to be in place to help them achieve a meaningful and productive life. The I/DD community is also incorporating the use of various assistive technology solutions to further promote more independent living. This highly customized support and service planning process leads to lower reliance on institutional settings to meet individual needs.

Person-centered planning is gaining momentum in eldercare, where it has the same potential to provide a platform for tailored supports across the continuum of care. This planning process can help maintain a high quality of life, while reducing reliance on nursing homes. It may also improve end-of-life care by encouraging conversations about personal goals and preferences during the last stages of life, when the focus of the traditional healthcare system is often on intensive, physicianprescribed medical interventions.

Methods proven successful in addressing social determinants of health and helping individuals with I/DD live socially connected and meaningful lives can be used to provide proactive, creative approaches to prevent or forestall more serious declines in health and functioning among the general aging population. This would help curtail rising health care costs and improve the quality of life for older adults who will soon represent 20% of the US population.

Below is an example of how whole person planning and a focus on social determinants of health can help build a long, fulfilling independent life – please meet Rose.

In her early 30s Rose moved from a certified group home setting to an apartment with her mother on the Lower East Side of Manhattan. There, she thrived with supports and programs from AHRC NYC. Rose attended a day services program where she became socially connected with friends and participated in a workshop where she was also employed.

see Aging with I/DD on page 38

Caring for the Caregiver

By Julie Alvira, MD MBA Executive Coach Founder, Coach Dr. Julie

aregiving is a labor of love but can affect with extreme challenges both physically and emotionally. It does not matter if you are an individual working as a professional caregiver for an agency or by yourself and have this specific role every day or a partner or relative that had become caregiver of a loved one. Or maybe you are a healthcare professional which is considered a provider of care and is used to treat patients. Caregiving can affect in terms of family pressures, financial well - being, and social isolation. Stress can take a toll and result in burnout. Nowadays professional burnout, which often is the result of stress manifested in the form of emotional and physical exhaustion had become a national health crisis among professionals, mostly in the healthcare industry. It can involve competition, poor sleep, pressures, skipping exercise, skipping social events, poor eating, feeling of not good enough, depression, dealing with patient deaths, inability to accomplish obligations out of the healthcare setting, not having quality time with loved ones, a decrease in the sense of personal accomplishments, and in more recent years...all the times spend in administrative activities.



Julie Alvira, MD MBA

A physician and caregiver for his wife with breast cancer (Finkelstein, 2013) points out, "I compartmentalized my fears about what might happen, and I pushed forward – exactly as I would do with my patients at work. As I was trained to do. But while this strategy works effectively with the strangers that I care for in the operating room, it proved to be less successful at home. I started to have trouble sleeping, and I noticed many odd new physical symptoms – muscle fatigue and

see Caregiver on page 35

Caregiver Support Group

By Staff Writer Behavioral Health News

hen serious illness strikes an older adult, the family is usually on the front line for care and support. Because the burden is often so extreme, friends may be called upon for a ride to a doctor's appointment or a home-cooked meal once in a while, but it is the spouse, domestic partner, and/or children who bear the brunt of the life altering aftermath of a loved one's stroke, heart attack or other serious illness. The adjustment a person makes to revolve their life around the care of a loved one should not be underestimated. How do caregivers cope physically, mentally, and emotionally under the weight? The isolation and loneliness many caregivers face while they meet the day to day: errands, chores, decisions and the physical labor involved can be overwhelming. Many people are afraid to share how they feel about their situation for fear of judgment.

One participant in the VCS Caregiver Support Group, Renee Kadan, puts it this way: "you can have empathy, but unless you are in it, you don't get it. It's a big adjustment." Renee's husband, who is a veteran, suffered several strokes and when his care became her primary responsibility she needed help. Her children encouraged her to find a support group but as Renee says "I wasn't one to join

any groups and it was hard for me to get out". Renee found out about the VCS Caregiver Support Group through the Rockland County Office for the Aging Moving Forward newspaper and when she saw there are evening groups as well as daytime, she found a way to make it in the evenings. She's been a faithful participant in the evening group on Wednesdays since it began in November 2017 and is a great fan of the evening facilitator, Darcy Bauer. Renee values her time at the support group and states "It's the best thing I've ever done (for myself). We get a chance to vent our feelings without embarrassment and we know whatever is said stays within those doors. I go, no matter what.'

The Coordinator of Services for Older Adults and their Families at VCS, Jill Bieber, knows very well how important this service is to the well-being of caregivers. "The biggest help is seeing people coming together and not feeling alone. People in the same situation get the feelings of frustration and anger that caregivers sometimes have. The CARE Program at VCS offers the Caregiver Support Group providing a safe place to discuss the challenges associated with aging parents and relatives as well as information. resources and alternatives. Jill recounts: "We started with one monthly support group; now we have two and a plan to

see Support Group on page 33

New Partnership Between Coordinated Behavioral Care and Technology Innovator, Karuna Health

By Staff Writer Behavioral Health News

oordinated Behavioral Care, Inc. (CBC), a not-for-profit organization dedicated to improving the quality of care for New Yorkers with serious mental illness, minors with serious emotional disturbances, chronic health conditions and/or substance use disorders, has partnered with Karuna Health to enable care managers to communicate with patients over SMS, WhatsApp, phone calling, and email—all from a single, shared inbox that integrates bi-directionally with CBC's current electronic care management platform. CBC IPA seeks to create a healthcare environment where New Yorkers most impacted by social determinants of health inequity and behavioral health problems receive coordinated, individualized and culturally competent community-based care that is effective in preventing and managing chronic physical and behavioral health conditions.



Jorge R. Petit, MD

"Patients use SMS, MMS, email, WhatsApp, and phone calling with friends

and family. Karuna gives organizations a HIPAA-compliant way to join the conversation," explained Joe Kahn, CEO and cofounder of Karuna Health. "At heart, Karuna is about increasing access to high-value services. Our software makes it easier for patients to ask for help, or for care management programs to proactively offer support. CBC's care managers demonstrate the very best of relationship-based care—with Karuna, we hope they can spend more time on the amazing work they do and less time waiting on hold, documenting interactions, or repeating themselves unnecessarily."

The partnership between CBC and Karuna Health will save front-line care management staff time while helping them to improve their interactions with members. Karuna is designed to be used on web and mobile. The platform includes pre-made templates for voice and text, automation tools, and scheduled messages for ease of use in the field. It also records all interactions (including phone calls) to the EMR to reduce time spent on docu-

mentation. By aggregating all patient touch-points into a single app, Karuna makes it easier for care managers to collaborate with each other and respond to patient needs.

"CBC as an Innovations Hub is best positioned to facilitate the development and implementation of practice-based evidence that recognizes the importance of achieving impact at the practice level while considering the perspectives of those delivering the interventions as well as the recipient of those services," said Dr. Jorge Petit, CBC's President & CEO. "The CBC Innovations Hub is committed to the dissemination of emerging technology solutions that are focused on improving outcomes and driving value, but are also potentially replicable and sustainable across different settings for the populations served by our Network. The partnership with Karuna is an example of how we are driving innovation through adoption of emerging technologies.'

see Partnership on page 36

Telephonic Care Management Program for Patients with Medicare

By Katie Bierlein LMSW, MPH and Michaela Frazier LMSW, CCM The Institute for Family Health

In this important issue on care for the elderly in Behavioral Health News, we hope to highlight the success of our telephonic care management service to the aging population at The Institute for Family Health's (IFH) network of community health centers in New York City and upstate New York. Innovative approaches to addressing the physical and behavioral health needs of the elderly are critical at a time when federally qualified health centers (FQHCs) face cuts to funding and must adjust to a restructured healthcare delivery system.

Chronic Care Management (CCM) is a telephonic care management service targeting the needs of patients with chronic conditions and Medicare insurance. The Center for Medicaid and Medicare Services (CMS) introduced CCM in January 2015 as a separately billable non-face-toface service. The goal is to improve Medicare beneficiaries' access to chronic conditions management within primary care, thus reducing the rate of functional decline and improving health. FQHCs were able to bill beginning January 1st, 2016, and IFH began enrolling patients in December 2017. Patients with original Medicare have not traditionally qualified for reimbursable care management programs at FQHCs, creating additional burden on physicians to coordinate their care. IFH is one of very few FQHCs around the country implementing CCM, and we believe other community health centers can learn from our challenges and successes.

IFH's Care Management program has existed since 2014. Care Navigators provide support to patients with multiple chronic conditions, many of whom face significant social barriers to engagement in the healthcare system. Service components include ongoing assessment and care planning. When we began developing CCM in December 2017, we felt it was very important that it be well integrated into our existing care management infrastructure. We wanted our CCM Navigator to be able to route patients to inperson support if necessary, and to be included in weekly group supervision. We

also wanted to utilize the same panel management tools built for in-person navigation. We did have to accommodate some programmatic differences. CCM is conceptualized as a 'service' by CMS, as compared to the 'program' model of our in-person care management, meaning it assumes lighter touch services over a shorter period of time. The service itself is provided via phone and not meant to exceed 20 minutes per month. It is meant to support primarily patients with *only* Medicare, and the marketing materials from CMS target patients 65 and older.

As a safety net health center, we provide care to a medically underserved population. We serve anyone who walks

see Telephonic Care on page 35

Behavioral Health Care Agencies Join Together to Provide Access to Care Across Diverse Populations in New York City

By Staff Writer Behavioral Health News

en community-based behavioral health care agencies announced that they have joined together to establish the Behavioral Health NYC IPA, LLC (BHNYC), an independent practice association (IPA) in New York City. BHNYC was established with a mission to provide rapid access to mental health and substance abuse services that are embedded in the community and delivered by culturally-competent and linguistically diverse clinicians serving individuals and families with complex needs across their lifespan. This new collaboration brings

together a myriad of meaningful crosssector partnerships with social service agencies, hospitals, and primary care physicians, as well as a variety of evidenceand population-based service models, to fill critical service gaps to care.

The majority of BHNYC network agencies initially partnered in 1960 to form the Federation of Mental Health Services, a trade association and lobbying organization, under the common goal of serving underserved, low-income populations. "BHNYC represents decades of behavioral health advocacy efforts by the Federation of Mental Health Services and its members to improve patient access and engagement with quality mental health and substance use services," said Robert

Basile, Psy.D., Co-Chair of BHNYC and President of the Federation of Mental Health Services. "The formation of BHNYC is a key milestone not only for our individual agencies, but also for the communities we serve. With this formal collaboration, we now bring together our best minds and community advocates under one entity to collectively improve the health of the population we serve."

The establishment of BHNYC enables each of the ten network agencies to preserve their unique relationships with the individuals and communities they currently serve, while offering opportunities for care coordination that provides patients with easier access to care and improved health outcomes. The thirty-five

affiliate providers, which include health systems, primary care providers, and community-based organizations will collaborate with the IPA to further improve care across the continuum.

"We are pleased to work with BHNYC to help meet the behavioral health needs of our shared communities," said Isaac Kastenbaum, Director of Population Health at the NewYork-Presbyterian Performing Provider System, one of BHNYC's affiliate providers. "We look forward to working together to improve the health of the diverse populations we serve."

BHNYC was established as a Behavioral Health Care Collaborative (BHCC),

see Join Together on page 36

How Senior Centers Combat Isolation

By William J. Dionne Executive Director Carter Burden Network

hether it's due to distance or the passing of friends and family, many older adults find themselves outside of the social circles to which they once belonged. Now aged and reliant on others for help, many seniors become isolated and depressed, which can have devastating effects on physical and emotional health. But senior centers across the country, including those that are part of the Carter Burden Network, are working to combat the isolation and loneliness our elderly neighbors are facing.

According to "U.S. County Profiles" published by the Institute for Health Metrics and Evaluation, 'with New Yorkers across the state living longer than ever before, the population ages 85 and above is also booming' ("U.S. County Profiles", Institute for Health Metrics and Evaluation, www.healthdata.org/us-health/datadownload). So, addressing the needs of this population is becoming increasingly significant. No matter the programs these senior centers offer, the goal, by and large, is to establish a supportive community that offers vital resources that support healthy independence and provide opportunities to form enriching connections with others. Senior centers serve as resource hubs for seniors that address their comprehensive needs in an environment without stigma, offer a stimulating atmosphere, and help them achieve a better quality of life, while often keeping or getting - them healthy.

Many senior centers offer congregate meal programs, and their benefits extend beyond nutrition by also addressing socialization needs. In a study of national nutritional services programs for older adults by the Administration for Community Living (Mabli, J., & Gearan, L. The Nutrition Services Program Outcomes Evaluation (Fact Sheet) (No. cfe476fed06d4533a8c20a9c4eb7874b). Mathematica Policy Research), congregate meal participants experienced higher levels of socialization than nonparticipants. Daily meal service at senior centers allows for consistent, meaningful interaction with staff, volunteers, and other seniors.

Delivering more than just food, senior centers' home-delivered meal programs address the loneliness experienced by homebound seniors. For homebound individuals, a visit from a home delivery volunteer or staff member is very often their only friendly interaction for the day. Studies consistently link loneliness and social isolation to increased risk for chronic health conditions such as diabetes, arthritis, emphysema, depression, and cognitive decline (Lipman, M. & Waxman, E. (2017, May 31). For Socially Isolated Seniors, Meals on Wheels Delivers More Than Food. Retrieved from https://www.urban.org/urban-wire/ socially-isolated-seniors-meals-wheelsdelivers-more-food). In a 2015 study of homebound older adults, after 15 weeks, those who received home-delivered meals (often delivered by senior centers) had lower rates of self-reported loneliness2. These services ensure that vulnerable seniors can safely remain in their homes and still experience meaningful engagement with others and remain connected to their community.

In addition to meal service, recreational senior center activities provide further opportunities for seniors to socialize with others while exploring their interests and talents. Many centers offer a wide array of art classes and performance groups, which allow seniors to make new friends, learn new skills, and build on ones they may already have. Educational activities, including computer and language classes, help seniors improve their communication skills, stay in touch with friends and family, and engage in the digital world. Health and wellness programs, from Zumba to yoga and everything in between, encourage seniors to make health and fitness a priority in a supportive and encouraging environment. By inspiring their creativity and empowering their sense of purpose and value, we combat the negativity of ageism and the societal stigmas associated with it.

It is important that senior centers provide critical social services as well. Case managers or social workers provide onsite social service assistance to help seniors with things like government benefits, landlord/tenant disputes, and traditional healthcare. Many seniors do not have friends or family to help them navigate these complicated situations. And, while so much of staff attention is focused on enhancing our seniors' quality of life, we also focus on advocacy for them and protection from those who seek to take advantage of our isolated, vulnerable neighbors. Sadly, elder abuse and

see Isolation on page 38

Seniors and Substance Use

By Diane Lotto, LCSW Seniors Team Leader CoveCare Center

fter her husband died, Sandra began having trouble sleeping. She tried many over- the-counter remedies to help her sleep, but nothing worked. Sandra was hesitant to speak with her doctor about it as she knew that many prescription sleep aides were addictive, and she was concerned about becoming dependent on them. Instead, Sandra found that when she had two glasses of wine before bed, she was able to fall asleep just fine.

This is a common scenario for millions of seniors across the United States. In fact, drug and alcohol use is rapidly rising among the 65+ population as the Baby Boomer generation is moving into older adulthood. According to the National Institute of Health (NIH), approximately 2.8 million Americans over the age of 50 struggled with alcohol or substance use from 2002-2006 (www.nih.gov). It is estimated that by the year 2020, that number will reach nearly 6 million.

While we are aware of these statistics, treatment options for older adults remain scarce. Seniors are often left to suffer in silence with their addictions, afraid of facing judgment, rejection, and shame from their families, friends and medical providers. And despite the statistics, in a study by Project SHARE and NIH, only 11% of older adults were asked about alcohol use in the previous year during their annual physical exam (www.nih.gov). So while substance use issues have become a major part of the dialogue about health across the country, older adults are nearly always left out of the conversation.

There are many factors that can influence seniors, their use of substances, and their seeking treatment. Older adults are more likely to be facing issues related to grief and bereavement due to the loss of spouses, parents, and sometimes even children. At times, grief can lead to depression and other mental health issues, which in turn can lead to substance use if left untreated. Also, many older adults face issues related to chronic pain and illnesses and may be prescribed medications that are potentially addictive or come with a risk of adverse interactions with alcohol and other drugs. Older adults are more likely to be living alone, thereby allowing their behavior to go undetected by friends and loved ones.

Older adults also face a distinct set of barriers when identifying substance use issues and looking for support in their communities. When it comes to treatment options, many seniors feel that they don't even know where to start. Medicare only covers a very small range of substance use treatment facilities, and often for a very limited duration of time. Also, there are few treatment facilities with programs specifically designed for seniors, meaning that many individuals feel out of place. Many seniors in recovery rely on Alcoholics Anonymous (AA) for support in their recovery; however, some feel uncomfortable attending AA because of the potential stigma and resulting shame. Other individuals face more practical barriers, such as being homebound, lacking transportation, or not knowing how to find the nearest meeting.

One positive way to engage seniors and help them secure the substance use treatment they need is through a combination of peer support and home-based services. The Senior Partnership Services mobile team at CoveCare Center integrates peer support into home-based services and helps seniors find the treatment they need. A certified peer recovery coach meets with seniors in their homes or at a convenient place in the community and helps them create an individualized plan to begin their path toward recovery. Recovery coaching gives individuals the opportunity to talk face-to-face with someone who has lived experience with mental health and substance use and is on his or her own journey to recovery. This type of coaching empowers seniors to determine what type of treatment they are interested in and how they envision a life without alcohol and drugs while eliminating many of the barriers to joining the recovery community. Recovery coaching allows seniors to feel supported, hopeful and less alone on their journey toward recovery.

Diane Lotto, LCSW, is the Team Leader for Senior Partnership Services at CoveCare Center in Carmel, NY. CoveCare Center partners with individuals, families, and the community to foster hope, wellness, and recovery, and to restore quality of life by addressing mental health needs, substance use, and social and emotional issues. For more information, visit CoveCareCenter.org or call (845) 225.2700.

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The Mental Health Needs of Older Adults

By Thomas R. Grinley, BS, MBA Director, Office of Consumer and Family Affairs, New Hampshire Dept. of Health and Human Services

ur society continues to age and it is estimated that by 2030 there will be more than 75 million Americans over the age of 65. The population of older adults (60 YO+) is growing faster than any other age group. According to Institute of Medicine, 1 in 5 older adults will experience at least one mental health or substance use disorder. Worldwide, mental health issues are a greater cause of disability than Alzheimer's and dementias by far.

Psychosis in older adults is relatively common and may be related to late-onset schizophrenia, mood disorders, delirium, or dementia. Neurological or medical issues may also manifest as psychosis. Psychosis in Alzheimer's has a prevalence rate of greater than 41%. With Lewy Body Dementia the prevalence rate of hallucinations is 78% and 25% for delusions. Proper diagnosis is crucial to determine appropriate treatment. Antipsychotics are not recommended if the underlying diagnosis is dementia. These powerful medications must also be administered with caution in older adults as older adults are more sensi-

tive to the side effects of antipsychotics.

Mood disorders and anxiety are also common as older adults deal with other medical issues, the loss of friends and spouses, poor quality of life, and diminishing capacity. It is important to remember that depression is not an inevitable part of aging. 80% of depression in older adults is treatable. However, we also know that depression is frequently either untreated or undertreated in older adults. 40% of the nursing home population has clinically significant symptoms of depression. Mental health issues that are not addressed are one of the drivers of institutionalization in this population.

Depression in homebound older adults is greater than the general population of older adults and ranges from 13% to 48%. We also know that 78% of that group is not getting proper treatment. This group is at higher risk for both medical and mental health issues. Depression in older adults is also more likely to be accompanied with psychotic features.

Anxiety disorders are also prevalent in the population of older adults and we often see increased disability, a poor quality of life, and cognitive impairment. As with mood disorders, anxiety disorders are untreated or undertreated. It is also typical to see mood disorders and anxiety disorders to co-occur

Older adults are also prone to phobias. In this population one of the most common phobias is a fear of falling. It is important to remember that to be classified as a phobia and not a general fear, it must impair daily functioning. The prevalence of this specific phobia increases with age as does impairment when the phobia leads to social withdrawal and avoidance of daily activities.

Hoarding is another disorder we often see in the older population. With the publication of the DSM 5, hoarding became a disorder. It is defined as "persistent difficulty discarding or parting with possessions, regardless of their actual value". At its extreme, hoarding increases the risk of falls and generally decreases the safety of the living environment. Because older adults are more likely to live in subsidized housing, this becomes a major issue with property managers. Again, we frequently see cooccurring disorders such as anxiety, mood disorders, dementia, and/or physical illnesses.

Far more alarming is the suicide rate for older adults. Adults over 65 have the highest rate of suicide across all age groups. Men over the age of 75 have a suicide rate that is double that of any other age group. Suicide risk increases dramatically for men over 50 and women

over 70. In addition to mental health issues, physical illnesses and other stressors of aging increase the risk of suicide. In one study, 37% reported that they felt like a burden to others and 15% felt that others would be better off without them. These are easily recognized as risk factors for suicide.

The more disabling conditions in older adults are delirium and dementia. Delirium is reversible where dementia is not. Delirium is typically the result of medical causes which are easily treated. Dementia is "an acquired impairment of mental function". Dementia often sees impairment in at least three areas of cognition and mental activity. Dementia is a common symptom of Alzheimer's disease, cortical Lewy Body disease, and other degeneration of the brain.

It is vital that these issues be identified early so that we may encourage appropriate treatment. Timely and appropriate treatment can dramatically improve the quality of life for older adults. One of the more important parts of treatment for this population is psychoeducation. Psychoeducation should clearly differentiate between the symptoms of mental disorders and physical disorders. One of the goals must also be to address stigma and misinformation. Psychoeducation can be key to getting good treatment adherence.

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Collado Joins The Shield Institute

By Staff Writer Behavioral Health News

armen Collado, LCSW-R, has joined The Shield Institute's Executive Leadership Team as Chief Relationship Officer. The Shield Institute is fast-approaching its 100th year of providing support and innovative services to children and adults with autism spectrum disorder (ASD) and intellectual/developmental disabilities. Ms. Collado will be responsible for developing a "relationship ecosystem" among The Shield Institute and government officials, managed care companies, as well as supported individuals, their families, staff, funders, donors and other key stakeholders.

Ms. Collado comes to The Shield Institute, from ICL, where she served as Chief Networking and Relationship Officer for over four years. Her major accomplishments there include: coordinating two (2) pioneering conferences on Behavioral Health Issues in the LGBTQ and Black communities; and securing \$1.75 million in new government funding. Additionally, she raised the profile of ICL by both increasing the number of attendees at the annual gala and attracting a number of new and highly influential members of the community at large to become supporters of the agency.

Prior to ICL, Ms. Collado was a Senior Executive at the Jewish Board of Family & Children's Services [[JBFCS"]



Carmen Collado, LCSW-R

for 12 years, most recently as its Chief Government and Community Relations Officer. At JBFCS, Ms. Collado was instrumental in promoting "cultural competency" as a core agency value, focused her energy on at-risk youth, secured millions of dollars of government support, and served as the Emergency Services Coordinator in the aftermath of Superstorm Sandy.

Ms. Collado is a graduate of Queens

see Shield Institute on page 36

Impact of Social Isolation Among Older Adults Living with a Mental Health Diagnosis

By Heidi Billittier, MSW Director of Older Adult Services Compeer of Greater Buffalo

isk of social isolation and resulting loneliness becomes increasingly more prevalent as we age, lose friends and family, and navigate chronic health conditions. Situational factors including diminished social and familial roles, together with physical limitations increase the incidence of isolation and loneliness. For individuals living with mental health challenges, the impact of loneliness can be devastating. Isolation coupled with mental health challenges may result in loss of social connectedness and purpose, as well as heightened symptoms and subsequent hospitalizations. Additionally, the prevalence of depression, anxiety, and myriad mental health diagnoses common among older adults suggests that we may be positioned for a large-scale crisis as our population's median age continues to rise (Valtorta & Hanratty, 2012).

Older adults who experience isolation and loneliness are at greater risk for developing symptoms associated with dementia and cognitive decline as well as physical and emotional manifestations. Loneliness is associated with an increase in sleeplessness, eating disorders, suicidal ideations and attempts (Mann et al., 2017) all of which are associated with an increase in



Heidi Billittier, MSW

morbidity. Isolation places older adults at greater risk for experiencing elder abuse including: physical, emotional, financial abuse, and neglect. Elder abuse occurs less often when individuals are connected to their families, communities and social networks (Bonnie & Wallace, 2002).

Mental and medical health care providers are realizing the value in prescribing social interventions together with traditional therapies as a means to eradicate the symptoms associated with loneliness. So-

cial interventions may include: continuing education, social day programs and supportive, caring friendships that encourage older adults with and without mental health challenges to remain engaged in their communities. Giummarra et al. (2007) interviewed health professionals together with older adults and found that social and emotional connectedness was strongly associated with overall health while the absence of those connections indicated an increase in physical symptoms.

Programs that provide social support, for example, seek to reduce isolation and loneliness for older adults who are living with a mental health diagnosis by providing companionship; supportive, caring friends are uniquely positioned to act as a catalyst between the individual and their community. Evaluations suggest that the supportive friend model holds value for older adults as a conduit for positive change. The supportive relationship claims to promote social connections that extend beyond the relationship and into the community, thus building a sustainable support network for the individual (Drury, 2014, p. 125-28). Additionally, individuals who visit their program friends regularly are likely to notice changes in behavior, health and/or personal hygiene, all of which might indicate that the person is experiencing a mental or physical health crisis. Social support programs, such as these, may provide training so that volunteers are able

to identify potential problems, and report back to the organization for appropriate linkage and referrals.

Caring friends are often in a position to help strengthen an individual's ties to their community by reintroducing them to activities they once enjoyed, or perhaps by sharing new experiences. Activity theory suggests that older adults who remain engaged in activities previously enjoyed, even with modifications, tend to experience full lives into and through late adulthood (R.J. Havighurst, 1961).

Humans need social connections. Whether they are one-to-one, in groups, or via technology, the supportive relationship aims to encourage personal growth and foster feelings of self-worth. As an option to face-to-face friendships, technology has been introduced as an effective means to communicate with isolated individuals. Telephone support, or "befriending" is a cost-effective tool for providing regular contact and encouragement for isolated older adults. A study by Cattan, Kime, and Bagnall (2010), demonstrated that telephone support not only alleviates loneliness but provides a sense of belonging, lowers stress and anxiety, increases confidence and encourages engagement not only with the caller, but with the community at large. Currently some programs are incorporating the

see Social Isolation on page 36

A Geriatric Substance Abuse Recovery Program

By Orah Burack, MA Verena R. Cimarolli, PhD Gregory Poole-Dayan, MS Irene Liu, MSW, Margaret Bondy, MSW and Roberto Perez, MSW

bustance abuse among the geriatric population is often overlooked or ignored, despite the finding that almost a fifth of older adults misuse drugs and/or alcohol (Center for Substance Abuse Treatment, 2012), and evidence showing the detrimental impact of substance abuse on elders' quality of life. As the number of older adults in the United States increases, there is a growing demand to develop programs that can reach, recognize, and provide effective help for older adults struggling with alcohol and substance misuse and addiction.

This urgent need prompted The New Jewish Home in New York City to develop a Geriatric Substance Abuse Recovery Program (GSARP) designed to identify and support older adults with alcohol and drug misuse issues who are admitted to the organization's skilled nursing facility (SNF) for post-acute rehabilitation following a fall, hip fracture, surgery, or other medical event.

Post-acute rehabilitation units of SNFs are uniquely positioned to serve as a gateway to alcohol and substance abuse

screening and recovery for the aging population. Older adults stay in these inpatient rehabilitation settings for a period of time to regain physical strength. This length of stay gives substance abuse health professionals an opportunity to build trusting relationships with older adults in post-acute settings, and to increase the likelihood that these older adults will be willing to participate in abuse-related interventions both during their stay and upon discharge back to the community. Post-acute care is also an important intervention point because substance-use problems can interfere with successful rehabilitation. Unaddressed substance misuse, when compounded with insufficient rehabilitation, could lead to re -hospitalizations for such conditions as fall-related injuries.

The Geriatric Substance Abuse Recovery Program

The New Jewish Home created GSARP in 2014 to help identify and address alcohol- and substance-abuse issues among older adults. The program is designed to screen all incoming post-acute patients for drug and/or substance-abuse issues, and to offer a program that integrates medical rehabilitation and substance abuse counseling services for those who are identified as prospective program participants. Additionally, GSARP par-

ticipants are connected to communitybased substance abuse rehabilitation programs and are encouraged to attend these programs once they return home from the post-acute setting.

GSARP's brief intervention lasts for the older adult's entire stay in the postacute setting. During that stay, a substance abuse counselor meets with the individual on a regular basis. Program components include:

- Identifying older adults struggling with substance abuse issues.
- Assessing the older adult's addiction and support needs.
- Developing a comprehensive, individualized care plan to meet each person's inhouse needs during the post-acute stay. Care plans include psychology consultations, substance abuse counseling, group and individual therapy, family therapy, and community-based self-help groups, such as Alcoholics Anonymous, which meet on-site.
- Reaching out to involved family and friends and including them, with the older adult's permission, in the rehabilitation process.
- Connecting program participants with community services before discharge to

ensure continuity of the recovery process once the individual returns home.

• Developing a discharge plan with community supports, such as individual counseling, family therapy, self-help groups (Alcoholics or Narcotics Anonymous), or even in-patient substance abuse rehabilitative programs.

Efficacy of the Geriatric Substance Abuse Recovery Program

A pilot study was conducted during the first eight months of the GSARP program to examine program feasibility and efficacy (Cimarolli, Burack, Poole-Dayan, Liu, Samaroo, & Bondy, 2017). Ninetynine (80%) of the 125 patients identified during the screening process as having drug or alcohol abuse issues agreed to participate in GSARP and 25 refused. The mean age of participants was 65 years of age; 67% were male and over 50% were minorities (28% Hispanic and 23% African American). Members of minority groups were more likely than white older adults to refuse program participation.

Among older adults who took part in the initial screening, alcohol was the most prevalent misused substance (91%), followed by illicit drugs (23%), and prescription drugs (9%). Over 20% of screened

see Recovery Program on page 39

Residential Care Considerations for Older Adults with Intellectual Disabilities and Autism

By Maggie Haag, MEd, BCBA, LSW Senior Director of Adult Services and Karen Parenti, MS, PsyD, Executive Director, Melmark PA

s individuals with Intellectual Disabilities (ID) and Autism age and become older adults, they face similar medical challenges that typical older adults face. Residential providers who are serving an aging population with ID and autism need to take several aspects of providing care for the older adult population into consideration, such as changing physical needs that require home modifications, changing healthcare needs, and changing psychiatric and neurological needs related to aging-related illnesses, such as dementia.

Needed environmental modifications can sometimes be overlooked for the aging population, as many behavioral changes are assumed to be due to the biological factors of the aging process (Baker, Fairchild, and Seefeldt, 2015). However, some behavioral changes can be improved by changing or modifying the environment for the individual (Baker, Fairchild, and Seefeldt, 2015). Residential providers need to assess the impact of the environment on behavioral changes, as well as assess appropriate behavioral programming. In addition to changing behavioral needs, physical needs for older adults may



Maggie Haag, MEd, BCBA, LSW

change as well. For example, gait issues can appear or worsen as individuals age. Previously ambulatory individuals may present as more of a fall risk, may exhibit decreased mobility, or actually become non ambulatory. Residential providers should be constantly assessing the accessibility and adaptability of their residential settings. In order for individuals to age safely in place in their residential homes, the homes must meet the physical needs of the older adults living in them.



Karen Parenti, MS, PsyD

There is also a great need for qualified and trained staff to work with older adults. Staff who are trained in not only providing care, but in helping individuals build and maintain skills, is essential to ensuring the greatest degree of independence is maintained through the lifespan.

Residential Model for Older Adults

Residential facilities that serve older adults need to have a model of service

delivery for this population. It is of the utmost importance to have an interdisciplinary approach to care for older adults with ID and autism. These interdisciplinary teams (IDT) should include physical therapists, nurses, behavior analysts, psychiatrists, primary care physicians, supervisory personnel, and of course, the individual and his or her guardian or representative if appropriate. By working as a team and reviewing the needs of the individual from both a medical and behavioral perspective, all appropriate and necessary interventions can be considered. This article will cover the treatment model for older adults of one residential facility that cares for individuals across the lifespan.

Long-Term Housing Planning

When purchasing residential homes to provide care and treatment to individuals with ID and autism, the long term accessibility of the home is considered. Additionally, all homes and their current cohorts are reviewed regularly to assess if any home modifications need to be made based on the current level of functioning of individuals. Items for consideration for accessibility include: Is there a first floor bedroom and bathroom to ensure there is no need to climb stairs if there is an acute change in the individual's status? Should

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Physical Illness, Depression, and Late-Life Suicide: Considerations and Opportunities for Enhancing Suicide Prevention

Emily S. Bower, PhD Postdoctoral Fellow, VISN 2 Center of Excellence for Suicide Prevention, Department of Psychiatry, University of Rochester Medical Center

uicide rates in the United States increased from an age-adjusted rate of 11.3/100,000 in 2007 to 14.0/100,000 in 2017 (CDC Fatal Injury Data). During that same period, rates among adults 65 and older remained higher than the national rate, climbing from 14.3 to 17.1/100,000. Increased risk for suicide in later-life is driven in large part by the dramatically high rate of suicide among white males aged 85 and older, who experience an average annual rate of over 50 suicide deaths per 100,000. Suicide rates are also rising among middle aged adults, suggesting that suicide risk in the second half of life is a significant public health concern. This article will outline the scope of the problem, describe an important area for intervening to reduce suicide risk (namely, comorbid physical illness and depression), and offer suggestions to engage clinicians and community members in efforts to reduce suicide deaths among older adults.

Identifying individuals who are at imminent risk of suicide is a daunting task

with unique challenges among older adults. Compared to younger cohorts, older adults are less likely to express intent, tend to use more lethal means, and may experience physical frailty and social isolation, thereby reducing chances of rescue and survival after an attempt (Conwell, 2001). For these reasons, although older adults attempt suicide at lower rates compared to younger adults, they are more likely to die from a suicide attempt. To reverse late-life suicide trends at a time when the median age of the United States population is advancing, suicide prevention efforts must be redoubled with a focus on public health approaches that intervene on risk factors that could have the broadest impact across the largest number of people.

Late-life suicide risk factors include psychiatric illness, physical illness, functional disability, neurocognitive disorder, and social isolation (Conwell, Van Orden & Caine, 2011). Whereas depression is frequently and strongly associated with suicide, physical illness is a precipitant in approximately 50% of late-life suicide deaths (Choi et al., 2017). Depression frequently co-occurs with physical illness, including cardiovascular conditions, diabetes, and stroke. Given their frequent comorbidity and associations with suicide, both depression and physical illness

should be considered when assessing and intervening for suicide risk.

Physical illness, suicide, and depression are complexly interrelated. Multimorbidity, the presence of more than one chronic condition, is common in later life and is associated with increased risk for depression and suicide compared to individuals without multiple chronic illnesses (Read et al., 2017; Juurlink et al., 2004). Physical illness may contribute to the development of depression due to difficulty coping with disease-related functional impairments, pain, or loss of independence. Moreover, depression may develop because of decreased engagement in physical and social activities due to physical limitations or other symptoms of illness (Fiske et al., 2008). Among older adults with physical illnesses, depression may compound feelings of hopelessness regarding health outcomes and contribute to self-perceived burden on others. Depression may similarly increase risk for physical illness through multiple pathways, including for example, inactivity, weight loss, or cognitive impairment (Blazer, 2003).

Additionally, medical care transitions (e.g., hospital to skilled nursing facility to home) may be a time of heightened risk for suicide among patients with physical illness and depression. A study of Veter-

ans found increased suicide risk during the 6 months after discharge from a skilled nursing facility (McCarthy et al, 2013). Physically ill patients are more likely to utilize inpatient medical services if they have comorbid depression (Himelhoch et al., 2004), and additional functional and mental health declines could contribute to increased suicide risk after discharge. Hospitalization is associated with physical and functional decline in the years after discharge (Ehlenbach et al., 2015), and termination of rehabilitation services is associated with increased risk of depression and anxiety in older adults (Simning et al., 2018). Enhanced care coordination, psychosocial interventions, and occupational supports to reduce activity restriction may attenuate suicide risk during medical care transitions, although more research is needed to identify effective prevention measures.

Comorbid depressive symptoms and suicide risk may be underrecognized and undertreated among older adults presenting for medical services. The reasons for this are manifold. Compared to younger adults, older adults are less likely to receive comprehensive safety assessment and safety planning, or to be referred for mental health services (Pettit et al., 2017;

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prevalence of behavioral health disorders—including dementia--will probably remain about the same—roughly 20% of the population.

But, because of population growth, the number of older adults with mental or substance use disorders illnesses will more than double.

They will be a heterogeneous population, most of whom live and want to remain in the community, including:

- People with serious and persistent mental illnesses who are aging. (This population may increase if efforts to reduce premature deaths among people with serious mental illness succeed.)
- People with dementia, often with cooccurring psychiatric disorders.
- People with severe anxiety, depressive, and other disorders resulting in isolation, dysfunction, behavioral obstacles to living in the community, and high rates of suicide.
- People with less severe, but clinically significant, disorders, especially anxiety and mood disorders.
- People who misuse or abuse alcohol, prescription drugs, and/or illegal drugs. (Marijuana use will certainly increase—for better or for worse.)
- People with co-occurring physical and mental disorders.
- Family caregivers, who are at high risk of developing mental and/or physical disorders.

Sadly, most older adults with mental or substance use disorders do not get treatment. Most who do get treatment get it from primary health care providers who are poorly prepared to identify or treat these disorders.

The low utilization of mental health services reflects problems of:

- Capacity: There simply are not enough clinically, culturally, linguistically, and generationally competent providers.
- Affordability: There is a particular shortage of geriatric mental health professionals who accept Medicare.
- Access: Many treatment programs are in hard-to-reach locations, and there is a

tremendous shortage of services in home and community settings.

 Stigma, ageism, and lack of awareness about mental illness and the effectiveness of treatment result in reluctance to seek or accept behavioral health services.

Fortunately, there are effective treatments for many, though not all, geriatric behavioral health disorders. This includes both pharmaceutical and psychosocial interventions.

Unfortunately, there is, as noted above, a vast shortage of competent providers. As a result, behavioral health services are often of poor quality.

Aging Well: Meeting The Developmental Challenges of Old Age

Behavioral health is not just avoiding or overcoming mental or substance use disorders; that is the negative side of behavioral health. There is also "positive" behavioral health—achieving well-being in old age (aka "aging well", "successful aging", "healthy aging", "active aging", etc.).

Old age is widely seen as a bleak time in life especially as health is compromised. But in fact, older adults are by and large satisfied with their lives despite objective declines in health and basic abilities. It is, therefore, critical to distinguish between objective and subjective healthy aging and to focus on achieving satisfaction despite the typical physical and mental declines of old age. ("Successful aging" in this sense is remarkably similar to the concept of "recovery" that has emerged from the field of psychiatric rehabilitation.)

Well-being in old age depends fundamentally on having satisfying relationships and engaging in pleasurable and meaningful activities. It is also correlated with having certain personality traits, including having a positive attitude, optimism, adaptability, and resilience.

Achieving well-being also depends on meeting the developmental challenges of old age, which include (1) finding alternative sources of satisfaction and self-esteem after retirement and changes in family roles, (2) coping with losses of family and friends, (3) tolerating diminished physical and mental capacities, (4) living with chronic illnesses, which often result in persistent pain and sometimes in disability, (5) learning to accept increased dependency if necessary, and (6) coming to terms with mortality.

Well-being in old age fundamentally means being at peace with oneself. This

includes (1) having a sense of authenticity, (2) having pride in the life one has lived, despite inevitable regrets, remorse, and disappointment, (3) finding sources of pleasure, and-for many older adultsfinding opportunities to continue to be productive, to make a contribution, and to feel meaningful. For some people, this is achieved through new family roles, such as grandparenting. For others, it is achieved through community or artistic activities. For still others, it is through continuing education and personal improvement. And for many, it is found through spiritual experiences of various kinds.

What most people dread about old age is dementia, the subjective effects of which are largely misunderstood. Most importantly, it is important to understand that people with dementia can experience satisfaction. This varies from one stage of dementia to another. In early stages some people continue productive activity and meaningful relationships with people. Some, of course, experience considerable emotional pain, especially sadness and fear. But these are frequently mental conditions that can be effectively treated, resulting in relief from emotional pain and sometimes improvements in functioning. In addition, people with dementia in the middle and end stages frequently get considerable personal satisfaction from creative arts, especially visual art and music. In general, even though people with dementia may have starkly limited memories, the satisfaction of being in the moment can be considerable.

In general, it is possible for society to take actions to promote well-being in old age. Reducing social isolation is particularly important, as are opportunities for paid and volunteer work, safe spaces for exercise, and access to continuing education and creative activities. Efforts now underway to develop "age-friendly"/"livable communities" will be key to supporting successful aging in the next generation.

Geriatric Behavioral Health Policy Goals

With the elder boom already wellunderway, it is long past time for our nation to respond to the problems of old age and to promote its opportunities. The Geriatric Mental Health Alliance of New York has developed a ten-point agenda to do this, including:

1. Community Integration ("Aging In Place"): Provide supports to enable older adults with major behavioral health disor-

ders, including dementia, to remain in or return to the community and avoid institutionalization. Needed supports include:

- Housing alternatives to institutions
- Community and home-based behavioral health services
- Improved behavior management skills
- Improved health care for people with serious mental illnesses
- Rehabilitation designed for older adults Family caregiver supports.
- 2. Improve Access: Increase service capacity, affordability, availability in home and community settings, and outreach and engagement services.
- 3. Improve Quality: Of behavioral health, healthcare, and aging services in the community and in institutions. This includes:
- Integrating behavioral and physical healthcare and aging services
- Increased "generational" and cultural competence in both behavioral and physical health care
- Increased clinical services, and translational research to identify evidence-based practices and to promote their use.
- 4. Provide Public Education: Combat stigma, ageism, and ignorance about behavioral health, its treatment, and how to find resources.
- 5. Promote Positive Aging via reduced social isolation and supporting opportunities for older adults to play meaningful social roles.
- 6. Workforce Development: Build a clinically and culturally competent workforce, including the use of "peers", particularly older adults.
- 7. Improve Finance Models: Assure that new finance models will:
- Support behavioral health services in the home and the community
- Support best practices and innovation
- Promote integrated service delivery

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ensuring geriatric specialists are part of the conversation to offer guidance and resources. AGES is a time-limited intervention that supplements the services provided by supportive housing case managers. Joint meetings are held that include residential staff, Aging Services, and other providers to ensure coordination of care. In addition to delivering services to clients, the program's goal is to develop the capacity of residential staff to plan and deliver services to older adults who might not need the intensity of AGES, but would still benefit from specialized services.

The Bridge's Aging Services program is generously funded by The Fan Fox & Leslie R. Samuels Foundation, van Ameringen

Foundation, The Dammann Fund, and Enterprise Community Partners, and supplemented by an annually renewed NYC Council initiative. Staffing includes a licensed clinical social worker, a full-time case manager, two part-time peer specialists, three MSW students, and an RN. Additionally, a consultant is creating an agency-wide staff training regarding advanced directives. This training will support staff in having conversations with clients about health care proxies and end of life issues, which directly impact client outcomes. Many clients living in supportive housing do not have relationships with their families. This training will ensure clients' wishes are known and staff can best advocate on their behalf and avoid ethical dilemmas during medical treatment.

AGES is a replicable model for tenants whose needs fall between nursing home care and supportive housing case management. Our approach employs traumainformed principles and culturallysensitive care to help vulnerable older adults navigate their environments and stay in community housing for as long as possible. The AGES model not only supports clients' connections to all aspects of community life, but is also a fiscally responsible option for meeting the complex health and housing needs of seniors with mental health conditions. Moving toward sustainability, The Bridge is exploring HCBS billing as an option for eligible clients, and we will be approaching at least one managed care company to develop a pilot program. In advance of approaching the MCO's The Bridge has engaged Health Management Associates to assist us in creating systems and processes to collect and analyze data that will demonstrate positive outcomes, high consumer satisfaction, and cost effectiveness. We expect the data will support our anecdotal experience that AGES can be a billable, sustainable program that could be expanded beyond The Bridge to benefit seniors across supportive housing programs; allowing older adults to successfully age in place with an improved quality of life.

The Bridge's mission is to change lives, by offering help, hope and opportunity to the most vulnerable in our community; www.thebridgeny.org. Rebecca Heller can be reached at rheller@thebridgeny.org.

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so they can adjust their expectations of appropriate behavior and work with children to modify disruptive behavior.

FCC providers share that CCHP has helped them increase their enrollment. When parents learn of the training and programming they have received or are receiving, they are more likely to choose them as their provider.

We quickly learned that the success of CCHP depends on outreach and recruitment via one-on-one discussions with the providers to establish relationships and build trust and confidence. The ELS staff recognize the need to understand and be involved in the community and join community networks and early childhood networks, visit churches, attend community events, and offer free workshops on early childhood. By becoming familiar with the providers, we eventually became recognized as caring and non-judgmental sources of support.

A graduation party is held for providers who have completed two years of CCHP. Their hard work is celebrated and they are eager to stay connected. To maintain our relationships with home care providers, we created the CCHP Alumni Association to continue the professional growth of our graduates with the mutual goal of school readiness and parent engagement. Alumni of our program appreciate the opportunity to connect with other FCC providers who face similar chal-

lenges and it helps them reduce feelings of isolation and remain motivated. Workshops and ongoing support cultivate CCHP graduates as leaders and advocates on early childhood issues, and supports developmentally appropriate practice and provider parent partnership in their sites.

Evaluation and Outcomes

The WJCS Director of Research has structured the CCHP evaluation process into multiple components, outlined below.

- Caregivers Interaction Scale is conducted at the start and end of each program year.
- Family Child Care Environmental Rating Scale is given at the beginning of the first year of CCHP for new providers and at the end of the year for all providers.
- Parent Surveys are conducted at the start and end of program year.
- Provider Surveys are given at the beginning of the first year in CCHP and the end of the second year of the program.
- Mid-Year and Final Interviews with Providers: All providers are interviewed in person at mid-year and at the close of program year by CCHP coordinator.

Year after year, the results of our evaluation reports are overwhelmingly positive and we utilize the feedback they

provide to adjust our programming, as evidenced by our increased focus on family engagement and the creation of an alumni association. Outcomes of note include:

- An overall gain of 9.5% in the Caregivers Interaction Scale, indicating that they demonstrated increased sensitivity to the children.
- Increased literacy activities, verbal interaction, and a 25% increase in parent engagement.
- A recognition of 98% of parents, who agreed or strongly agreed, that they noticed that their child care provider has enriched the curriculum since participating in CCHP.
- An overwhelming majority (85%) who report that they explore the books sent home by CCHP with their child.
- A vast increase (71%) of providers who encourage imaginary play.

Summary

The challenge to improve the quality of family child care settings is an important one because we know that high-quality care can help level the playing field for children who are at risk for entering school unprepared to succeed. Research shows that low-income children benefit and experience significant cogni-

tive, linguistic, and social-emotional gains from being enrolled in high-caliber programs (Li et al., 2012; McCartney et al., 2015). Children who receive higher quality care are also less likely to develop behavioral issues by adolescence (Votruba-Drzal et al. 2010)

WJCS is proud of our accomplishments to date. Our CCHP staff is led by an outstanding Program Director, who has been innovating in the field of early childhood for over 20 years. Her leadership and the exceptional CCHP staff offer providers the support, resources, and knowledge needed to support healthy early childhood development and build the school readiness skills for the children in their care. The active participation of day care providers and their dedication to improving their skills is inspiring, and their comments about the benefits of CCHP are rewarding. The effects of CCHP are exponential. The child care providers will carry what they have learned to the next group of children they serve in years to come.

While this article highlights the work of CCHP, it is just one of many WJCS' innovative programs. Our professionals provide mental health, trauma, disability, youth, and geriatric services. We strive to foster an environment where our staff weave their expertise across domains to address the needs of those we serve.

To reach Ms. Van Loon, email her at svanloon@wjcs.com or by phone at (914) 761-0600 ext. 137. Please visit WJCS at www.wjcs.com.

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coverage for in-home treatment for clients who are disabled and homebound

• Correcting a "silo" mentality and fostering greater coordination between mental health systems and government agencies

A national conversation will be an important first step toward developing a plan to provide care for all older Americans. Strategies to provide service may vary in rural communities, senior residential facilities, or urban settings, but the need is universal: let's work together to keep older adults healthy, independent, and engaged in the community.

About SPOP: Founded in 1972, Service Program for Older People/SPOP was one of the first agencies in the U.S. to focus entirely on meeting the mental

health needs of older adults living in the community. It is New York City's only agency dedicated exclusively to mental health care for an older population and is the region's leading provider of long-term in-home geriatric mental health treatment. SPOP will serve over 2,000 adults this year through its licensed mental health Clinic, Training & Education services, Bereavement Support Program, and PROS/Personalized Recovery Oriented Services program for adults with severe mental illness. SPOP is the recipient of local and national awards, including the American Psychiatric Association Community Gold Award and the Joan H. Tisch Community Health Prize for distinguished accomplishment in the field of urban public Health.

Nancy Harvey, LMSW has served as chief executive of SPOP since 1990. You can reach her at nharvey@spop.org.

Substance Misuse from page 5

older adults so that New York can lead the way as the healthiest state for people of all ages.

Footnotes

- 1. https://www.census.gov/prod/2014pubs/p25-1141.pdf
- 2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3540205/
- 3. https://www.ncbi.nlm.nih.gov/pubmed/15209658
- 4. https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-age-group
- 5. https://www.samhsa.gov/data/sites/default/files/report_2792/ShortReport-2792.html
- 6. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4146436/
- 7. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4146436/

Support Group from page 26

begin a third beginning January 28th called Mindfulness Mondays which offers the same support, within a broader context of self-care."

CARE support groups are held at VCS at 77 South Main Street, New City and thanks to the Rockland County Office for the Aging they are FREE and no sign-up needed. Just show up. For more information call 845-634-5729.

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Collaborations from page 22

- Re-instituting, applying for, and coordinating available benefits across several systems such as aging; physical health; behavioral health; public benefits including Medicaid, Medicare, SNAP, HEAP; and the Veterans Administration.
- Managing chronic disease(s) and making lifestyle changes

To further understand the LTSS being received by OMH housing residents, OMH reviewed Medicaid service claims for the year 2017 to identify regional, demographic, housing and service type trends. Statewide, only 10% (3,026 residents out of 28,790) cumulatively over the course of 2017 received any LTSS; as approximately 53% (nearly 17,000 residents) of these residents were age 50 or older in 2017, coupled with the known risk of premature aging and disability associated with having a mental illness, it seems unlikely that all OMH housing residents with LTSS needs had them addressed. Regional differences in LTSS received are significant, with OMH's

NYC Region clearly driving up the statewide percentage.

Recognizing some regional variance, preliminary analysis of statewide Medicaid LTSS claims in 2017 shows concentrations in the following demographic and programmatic areas:

- Most fall into the Transitioning Seniors or adults age 55 to 64 years old age category (42%)
- A majority are dually eligible for Medicaid and Medicare (55%)
- Many live in OMH supportive housing (54%), the most independent level of housing designed for permanent living
- Most paid for LTSS through fee-forservice (FFS) Medicaid (34%) or MLTC partially capitated plans (33%)

Statewide in OMH supported housing community service settings, those in FFS trended toward institutional LTSS that required them to leave their residence to receive care in a skilled nursing facility, while those who enrolled in MLTC re-

ceived nearly all LTSS in the community at their home or nearby neighborhood. In addition, the type of LTSS received varies widely based on managed care enrollment status, with those enrolled in MLTC having received:

- More than double the percentage of home health aide services than received by people with FFS
- Considerably more social and environmental supports designed to maximize independence

OMH shared these findings with OMH Field Offices and OMH housing providers, many of whom shared the difficulty of navigating the MLTC enrollment process and the challenges in connecting with culturally competent homecare staff trained to work with individuals living with mental illness. OMH continues to provide individualized data presentations based on specific OMH region and OMH housing community, demonstrating how to identify potential action areas to increase access to the full range of community-LTSS available as well as homecare

and managed care partners who have shown success in providing these services to residents.

OMH has also begun a long-term care pilot project with State-operated residences in Long Island and Queens to identify key elements needed for successful transition and aging in place in community-level OMH housing. A collaborative model of shared responsibility enables OMH housing staff, home care agency and community providers (medical and behavioral) to work together closely to make living in the most integrated setting possible for individuals with serious mental illness.

References

- 1. New York State Office for the Aging. (2011). County Data Book [Selected Characteristics].
- 2. New York State Office of Mental Health. (2018). 2017 Patient Characteristics Survey [Data Download- Survey Week].
- 3. Wolkowitz, OM. World Psychiatry 2018; 17(2): 144–145.

Volunteer Programs from page 24

greater life satisfaction; they felt less socially isolated, and had fewer symptoms of depression. (Georges, A., Fung, W., Smith, J., Liang, J., Sum, C., & Gabbard, S. (2018). Longitudinal Study of Foster Grandparent and Senior Companion Programs: Service Delivery Implications and Health Benefits to the Volunteers. North Bethesda, MD: JBS International, Inc.). Over the past 42 years, we have seen similar data reported each year within our own program as well.

Experience Shapes the Future

While we see many of our senior volunteers benefiting from service, we also understand that many individuals have different aging experiences and may require various services to help them live as independently as possible. Our years of experience working with seniors give us an understanding of these needs and aspirations.

According to a recent article on WebMD.com, right now, 9 out of 10 older

adults has a chronic disease with 8 out of 10 having more than one chronic condition. In addition, since 1980, the number of middle aged and older adults with diabetes has almost doubled. One in 9 people age 65 and older and 1 in 3 people age 85 and older develop Alzheimer's Disease. (Wheeler, T. (2009, November 9). Over 50? These Problems Can Sneak Up on You. Retrieved from www.WebMD.com.) The aging of our population is both a blessing and a challenge. Blessed with a long lifespan, the challenge remains for seniors to create a life that is healthy and satisfying.

Now, a variety of our programs directed to meeting the needs of older people are available in the New York City and Long Island area and we are expanding and diversifying our offerings as we meet the changing needs of our growing senior population. As our older population grows dramatically in the next 20 years, we need to heed some of the lessons we have learned while engaging seniors in meaningful activity and supporting them in the least restrictive environment of their choice.

Seeing the strong need for additional

services for the aging, Federation developed housing and care coordination specifically directed to the needs of older people. In 2014, we were able to divert over 100 people in Nassau and Suffolk counties from nursing home placement and link them with the community-based services that they needed to live independently. We also operate the first and only licensed community residence specifically for individuals who are 50 and over on Long Island. In addition, we are now in the planning phase of constructing a housing site in Brooklyn which will provide 119 affordable apartments for frail elderly seniors. Supportive services will be provided and space on the ground floor will be used for food assistance programs. Social workers, case managers and nurses will also operate on site.

On Long Island, our Suffolk County Respite Program supports caregivers of the frail elderly by subsidizing the cost of a respite worker to provide time off from their responsibilities to take care of their own needs. This assistance often means the difference between maintaining their loved one at home and nursing home placement. Many family members struggle with taking care of an elderly parent while balancing the needs of their own children, work schedules, and daily responsibilities. The respite worker provides much needed relief for the caregiver, allowing time to take care of themselves, recharge, and alleviate stress.

If we ask the question, "What do sen-

iors want and need to age successfully in settings of their choice?" there are probably as many answers as there are seniors. For some that are able, it may be volunteer opportunities to keep them active and cognitively sharp. For others, it may be affordable housing with supportive services to keep them living independently and avoid costly nursing home care. Whatever it may be, agencies like ours need to think critically about how we will best serve this population that is rapidly growing each year. One thing we can all start to do now as we prepare for our future is to plan for a longer lifespan and engage in activities now which promote health and wellness and provide meaning.

Suicide Prevention from page 31

Simons et al., 2019). Depression may also be masked or misdiagnosed due to somatic and cognitive symptoms that overlap with medical and neurocognitive conditions. Finally, patient and provider attitudes toward mental health and aging may affect the type and focus of care provided. Older adults who hold negative attitudes about aging have poorer mental and physical health as they grow older, are more likely to endorse suicidal thoughts, and do not live as long as older adults who hold positive attitudes. Health care providers may unintentionally promote negative health behaviors and dependence through use of elderspeak (i.e., speech that is slower, louder, and simplified) or providing assistance when it is not needed (Schroyen et al., 2015).

There is a clear need to enhance suicide prevention strategies for older adults with physical illness, but what can healthcare providers and community members do today to manage and reduce suicide risk?

Older adults are more likely to be seen by a medical than a mental health provider within the month before suicide death. Because older adults may not disclose suicidal thoughts or intent, healthcare providers may wish to consider assessing for additional risk factors when patients present with comorbid depression and medical conditions. Assessment of suicide means (e.g., firearms), nutritional status, and social isolation could provide insight regarding risk level and potential intervention targets. When concerns are present, initiate safety planning and offer referral to mental health services in addition to considering medication. Collaborative models (https://aims.uw.edu/ collaborative-care) can improve mental health treatment outcomes within primary care. In areas where resources are limited. telemental health services may be an option.

Safety plans should be developed col-

laboratively with the patient and can be framed as "crisis plans" or "bad day plans" if the patient disagrees with the provider's assessment of risk. Identifying methods to make the environment safe (i.e., means reduction) when risk is high is an important component of the plan. Include family or care providers when possible and provide the patient a copy of the plan. The plan should also include contact information for the National Suicide Prevention Lifeline, which provides free, confidential support available 24 hours 7 days a week by calling 1-800-273-8255 (press 1 for the Veterans Crisis Line).

Encourage and seek resources to support increased social connection and activity engagement for at risk patients to reduce loneliness and social isolation. There are several nonprofit and community service organizations that offer volunteer companionship, social activities, or support groups for patients. Local Area Agencies on Aging can offer information re-

garding available resources (Directory of New York State Offices for the Aging: https://www.aging.ny.gov/nysofa/LocalOffices.cfm)

Both functional impairment and pain may co-occur with physical illness and depression, increasing suicide risk. Adequate pain management and strategies to support functional independence could reduce feelings of helplessness and burden. Occupational therapists can help identify environmental adaptations or other aides to support maximum functioning. Motivational interviewing and/or cognitive-behavioral interventions may improve outcomes for patients who struggle with treatment engagement due to ambivalence or depressive thoughts.

Ageism is common and unavoidable, but not immutable. Negative messaging about aging may contribute to misperceptions that depression is a normal part of aging or that disability is always burdensome. Education

see Suicide Prevention on page 38

Integrated Care from page 25

to become a permanent employee in both the Mental Health Clinic and the Chemical Dependence Clinic.

FHMC then turned to the Delivery System Reform Incentive Payment (DSRIP) program as another source of sustainability. Within DSRIP, safety net providers such as FHMS were required to collaborate to implement innovative projects focusing on system transformation, clinical improvement and population health improvement. One of the most important innovative projects supported by DSRIP was integrated care. FHMC was able to leverage the integration work that was funded by the geriatric demonstration program to participate in the DSRIP pro-

gram. Because their senior administration saw the successes achieved in the integrated services grant project in the Ambulatory Care Center and because it already had integrated services in their Mental Health Clinic and Chemical Dependence Clinic, senior administration approved the hire of a clinician to continue integrating behavioral health services into the Ambulatory Care Center in order to meet DSRIP objectives.

Drs. Chen and Frankel also decided to use data to support their sustainability plans. They retrieved and analyzed data on ED visits, hospitalizations and cost of care for all of the patients seen and served by grant funded clinicians for at least one visit during the duration of the grant project from 2007-2012. One significant

finding that came from this analysis was that emergency department visits were reduced during this time. Drs. Chen and Frankel then wrote about their findings in an article that is currently in press in the Journal of Integrated Care (The citation is: Daniel Chen, Alex M. Torstrick, Robert Crupi, Joseph E. Schwartz, Ira Frankel, Elizabeth Brondolo, (2019) "Reducing emergency department visits among older adults: A demonstration project evaluation of a low-intensity integrated care model", Journal of Integrated Care, Vol. 27 Issue: 1, pp.37-49).

FHMC worked creatively to support sustainability by leveraging individual level client data, along with the Integrated Services Licenses and the DSRIP initiative, to maintain the viability of the work

that began 12 years' prior with the Geriatric Demonstration grant award. In this way, FHMC is a model of what may be accomplished when sustainability plans are prioritized and when service providers work creatively and strategically within the existing structures available to support sustainability.

Daniel Chen, MD, is Vice Chairman of the Department of Psychiatry and Addiction Services at Flushing Hospital Medical Center. Ira Frankel, PhD, LCSW, is Administrator, Department of Psychiatry and Addiction Services at Flushing Hospital Medical Center. Emily De Lorenzo PhD, MSW, is Program Manager of the Bureau of Program and Policy Development, at the NYS Office of Mental Health.

Caregiver from page 26

weakness, numbness and tingling in my fingers and arms, and palpitations." This doctor was having symptoms of anxiety and was not expressing them. He then learned through a therapist how to recognize them and take control. Also, he learned to listen with more patience and practice compassion with his own patients.

As one can see, a caregiver gives their love and time with compassion and empathy but needs to learn how to connect to self. The idea of "feel your feelings" by becoming aware of them, take control, have emotional support, and know when to ask for help is important. One great thing that I have learned as a caregiver to my mom that is a widow and had a hip replacement is to practice self care. Remember, you might not be able to do anything about the person's disability

(Craighospital, 2015), but you can do something on how your life is impact. As I mentioned at the beginning of this article, whether you are in the healthcare industry or a professional caregiver or caring for a loved one, if you let the stress and complex of emotions lead to exhaustion, many times you might become vulnerable to many problems including alcohol and other drugs.

Self-Care: Self compassion and self care are priorities. Yes, you feel compassion for your loved one, client or patient but in order to help that person you have to help yourself first. This is not selfish or self centered (Chopra Wellness Center, 2017), it is part of caring for your well being and have a balanced lifestyle to prevent the manifestations of stress. "Self care is not selfish, you cannot serve from an empty vessel" (Eleanor Brownn).

It is healthy to live with limits, balance

and boundaries. According to Chopra Wellness Center (2017), there are 6 areas of self care that we should work on.

Six Areas of Self Care

- Physical adequate sleep, nutrition, and physical movement to raise your energy levels.
- Emotional "feel your feelings" and talk about them. Get in touch with your thoughts.
- Mental instead of getting caught in stagnation, try a new challenge or project.
- Spiritual connect with the self by practicing yoga, tai chi, meditation, relaxation techniques or trying solitude. Remember that solitude is not isolation. It is a time to connect with yourself and recharge. Sometimes it is called "me time." Some

people walk in nature while others read a book. Your type of solitude time is special, and it is your own. If the feeling of loneliness kicks in, be aware of where is coming from and come back to the present moment. Mindfulness helps when our fears and own emotional wounds from the past show up and try to take over.

- Social cultivate connection with people.
- Practical pay attention to other areas of your life that are part of your chores and routines such as financial, projects, etc.

It is important to know that you are not alone. It is not easy but to become a compassionate caregiver, love with a whole heart (Orange, 2018).

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Telephonic Care from page 27

through our doors, regardless of their ability to pay. It is no surprise that our CCM enrollment is a reflection of the population we serve. Fifty-eight percent of patients who have enrolled in CCM are dually eligible for Medicare and Medicaid, and 55% are 65 years or older. This means that the majority of the patients we've enrolled have income at or below the poverty line, and almost half are disabled, as opposed to over the age of 65. Our patients' racial, ethnic, and economic circumstances increase health disparities that impact engagement in the healthcare system and increase risk. We recognized the development of CCM as an opportunity to impact these disparities for our Medicare population by increasing the uptake of prevention, including Annual Wellness Visits (AWVs) and cancer screenings. Given CCM's limits on engagement, focusing on gaps in care for of our disabled and aging patients allows us to implement a lighter touch model among a high risk population. A telephonic model also allows us to provide remote opportunities beyond limited clinical space, and we are proving we can meet the demands of our patient population without having to add expensive workspace into low-resourced clinics.

To optimize outreach, we created a registry in our electronic medical record that identified approximately 5000 patients as eligible for CCM. Patients are added to and removed from the registry automatically due to insurance and diag-

nostic changes. Recognizing the ineffectiveness of cold-calling our patient population, we organized outreach to patients both overdue for their AWV and with a future scheduled appointment within 30 days. Not only did this increase conversion rates from outreach to enrollment and improve our efficacy, it targeted our enrollment to patients overdue for valuable preventive screenings, giving us the opportunity to impact population health. If the patient chose not to enroll, the call still served as a reminder for their visit and the visit itself was converted to an AWV. In our eighth month of program implementation we shortened outreach to 30 days, decreased the number of patients outreached each month, and increased the number of attempts made. We saw a 4% improvement in conversion from the previous month. To date, 157 patients have enrolled in CCM.

Since our outreach strategy was predicated on the importance of the Medicare Annual Wellness visit, it's important to understand the contents of this visit and its associations with prevention. The Medicare Annual Wellness Visit is a yearly appointment with a primary care provider to create or update a personalized prevention plan that helps prevent illness based on current health and risk factors. The provider checks vitals, gives a health risk assessment, and reviews functional ability and level of safety. They learn about medical and family history, create a list of providers and medications, and develop a $\hat{5}$ -10 year screening schedule. This visit has strong implications for behavioral health, as the patient is screened for cognitive impairment such as Alzheimer's and other forms of dementia, and depression. They are provided with health advice and referrals to health education and/or preventive counseling services aimed at reducing risk and promoting wellness.

Our chronic care navigators develop care plans with enrolled patients that focus on gaps in care and, as a result, we have made significant progress in closing these gaps. AWV completion for enrolled patients has increased 11.44%. CCM enrolled patients complete their AWV at a rate of 82%, compared to 73% for CCM eligible, and 42% for the total IFH population. Cervical, Breast, and Colorectal cancer screening rates have increased for those enrolled in CCM by 5%, 11% and 12% respectively.

One of the ways in which we identify risk within our patient population is through a hospitalization risk score, generated by a predictive risk model in our EMR. We want to enroll those at medium to high risk so we can perform interventions that mitigate readmission. These interventions include case conferencing with hospital discharge teams and skilled nursing facilities, coordinating home care, scheduling follow-up visits in primary care, and coordinating specialty appointments. Navigators also review safety plans telephonically for patients with suicidal ideation. 15% of CCM enrolled patients have at least 76% risk of hospital admission, compared to 7% of the CCM eligible population with this high level of risk. We have observed an average decrease in risk of 16% after enrollment in CCM. By enrolling appropriate patients, we more effectively utilize limited resources.

A key challenge is the low reimbursement rate for CCM as compared to Health Home Care Management, with a potential difference of up to \$320 per patient per month. Due to low rate and low touch, the panel size for CCM is over double what it is for face-to-face care management. We acknowledge the limitations of this service to patients who have access to telephonic communication, although we try to work directly with proxies and caregivers if access is a barrier for the patient.

In the future we hope that enhancements to our electronic medical record will improve usability of the patient portal, improving care plan sharing and communication beyond the telephone.

We are currently building assessment tools specific to elderly and disabled patients that complement the contents of the AWV, capture the social determinants of health, and better inform our interventions, for example elder abuse, financial strain, food insecurity, and transportation needs. There is potential for us to align our efforts with telemedicine in the future, a very exciting prospect given the isolation faced by many of our elderly and disabled patients. We also plan to adapt CMS's marketing and educational materials to our patient population.

Addressing the physical and behavioral health needs of an aging population

see Telephonic Care on page 38

Partnership from page 27

About Coordinated Behavioral Care

CBC is a not-for-profit organization dedicated to improving the quality of care for New Yorkers with serious mental illness, chronic health conditions and/ or substance use disorders. CBC brings together over fifty community-based health and human services organizations which provide access to quality treatment, housing, employment and other needed services. CBC operates a Health Home that provides care coordination services to tens of thousands of New Yorkers of all ages, with 50+ community -based care management agencies located in all five boroughs. CBC also operates an Independent Practice Association (IPA) including a citywide network of New York State-licensed primary care, mental health and substance use treatment services, thousands of units of supportive housing, primary medical, recovery and support services, and assistance with concrete needs such as food, employment and housing. Among CBC's innovations is the Pathway $Home^{TM}$, offering care transition services during the transition back to the community following discharge from an institutional setting.

About Karuna Health

Karuna is a communication platform that helps care management teams increase their reach rates, levels of patient engagement, and staff productivity. Patients use SMS, MMS, email, WhatsApp, and phone calling to connect with friends and family every day. Karuna gives care managers a HIPAA-compliant way to join the conversation. From the patient's perspective, there is no new technologyjust the same platforms they already use every day. For care teams, Karuna aggregates every patient interaction into a single, shared inbox that can be accessed on web and mobile. Karuna saves care teams time for the conversations that matter by automating documentation into the EMR and providing powerful templating tools for voice and text.

Contact Information: Coordinated Behavioral Care, Jorge R. Petit, MD, President and CEO, (646) 930-8803, www.cbcare.org. Karuna Health, Joe Kahn, CEO and Co-Founder, (857) 999-1641, www.meetkaruna.com.

Join Together from page 27

a grant-funded entity under the Department of Health (DOH) Value-Based Payment (VBP) Readiness program for Behavioral Health providers. The collective work of the BHNYC ensures networkwide readiness in accordance with New York State's VBP Roadmap for Medicaid payment reform. The goal of BHNYC is to engage in meaningful VBP arrangements with managed care organizations, through quality improvement initiatives that will establish standardized costeffective service delivery models to improve patient outcomes. BHNYC is made up of the following ten network agencies:

- Arista Center for Psychotherapy, Inc.
- Bleuler Psychotherapy Center, Inc.
- Camelot of Staten Island, Inc.
- Elmcor Youth and Adult Activities, Inc.
- Inwood Community Services
- Long Island Consultation Center, Inc.
- Metropolitan Center for Mental Health
- Park Slope Center for Mental Health, Inc.
- Queens County Neuropsychiatric Institute, Inc.
- Shiloh Consulting LLC

For more information on BHNYC, please visit: www.bhnycipa.com.

Social Isolation from page 30

telephone connection component as an alternative or bridge to in-person support. Additionally, isolated individuals may choose to provide support to others and experience the benefits of being a caring friend for someone else in need.

As important as meaningful conversation and relationships, continuing education opportunities for isolated older adults have been shown to increase feelings of self-efficacy and boost self-esteem (Merriam & Key, 2014). The authors stress that continuing education is a human right and knowledge empowers individuals to make critical decisions on their own behalf. For individuals who may be isolated, and perhaps living with mental health challenges, the educational experience can significantly reduce feelings of depression, helplessness, and may indeed promote a sense of belongingness. Furthermore, reduced symptoms can lead to a decrease in prescribed medications, fewer visit to the emergency room and fewer medical issues in general, together with a reduction in public expenditures.

How do we move forward and what can be done? We can be mindful and aware. If we identify an individual who may be isolated and lonely, we can call to let them know that we care, are thinking about them and that they matter. We can continue to support programs that provide caring friendships together with other programs that address issues of loneliness among older adults and individuals living with mental health diagnoses. We can encourage others to volunteer to do the same. We can advocate for policy change and increased funding for all programs that support older adults with mental health diagnoses. By perpetuating the discussion around isolation and loneliness and that of mental health we can lessen the prevalence of isolation and subsequent loneliness among older adults living with mental health challenges.

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Older Adults from page 32

- Assure continuity of care from pre-topost age 65
- Create incentives to enhance the workforce.
- 8. Address Social/Economic Issues such as inadequate income, threats to the Social Security Trust Fund, and inadequate housing.
- 9. Epidemiological Research: Develop new data sources for planning and evaluation.

10. Promote Readiness of the Public and Private Sectors: including knowledgeable leadership, coordinating structures, and private sector initiatives related to access to treatment, work opportunities, retirement planning, and family support.

Michael B. Friedman is co-founder and voluntary chair of the Geriatric Mental Health Alliance of New York, Lisa Furst is its Director, and Kimberly Williams is its co-founder and the President and CEO of Vibrant Emotional Health.

Shield Institute from page 29

College and earned her Master's Degree in Social Work at New York University's Silver School of Social Work.

Dr. Susan Provenzano, Executive Director of The Shield Institute, has been impressed with Ms. Collado for over a decade and said "We are thrilled to have Carmen join our team and contribute to the future growth and resiliency of this

great organization. The people we serve, and their families, deserve the best, and Carmen brings the highest standards and long-standing relationships throughout the City and State—all of which will help us further our success."

To reach Ms. Collado: e-mail her at: ccollado@shield.org, or call her direct line: (718) 269-3859, or cell number:

Behavioral Health News Upcoming Theme and Deadline Calendar

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If You Have Lost All Hope of Going On - Don't Give Up Please Call the National Suicide Prevention Lifeline at 1-800-273-8255



Recommendations from page 15

demands that the state focus efforts on older adults in order to ensure that their needs are met in the public mental health system.

2: New York State should invest in sustainable, comprehensive community-based services for older adults with behavioral health needs, including services provided in the home in person or through the use of technology. Investments should be made in providing outreach to at-risk older adults to ensure engagement in appropriate services and supports.

The majority of older adults, including those with diagnosable mental or substance use disorders, live in the community; behavioral health services and supports should be readily available and accessible in the neighborhoods where people live and congregate. At the same time, those older adults who do live with disabilities significant enough to render them partially or totally homebound should be able to access qualified services in their homes, either by leveraging tele-mental health services or through face-to-face services, which should be fully supported by Medicaid, Medicare and commercial insurance providers.

3: New York State should provide programs/supports to ensure that older adults with behavioral health challenges can live in community settings ("age in place") including (a) movement out of institutions (state hospitals, nursing homes, adult homes, and prisons and (b) providing supports to remain in the community. This would include support for family caregivers, in-home treatment and support services, and appropriate supportive housing.

While we are unlikely to ever completely obviate the need for institutional care, most older adults wish to live and receive care in the least restrictive settings possible; their caregivers, too, typically share this goal.

4: New York State should conduct a statewide study to collect relevant epidemiological data needed to inform the planning efforts for current and future cohorts of older adults with behavioral health needs in diverse settings, particularly housing.

While some epidemiologic data is available from sources such as the NYS OMH Patient Characteristics Survey and Medicaid claims data, among other sources, there is a lack of a comprehensive data set that encompasses all that we need to know about the multi-faceted needs of older adults in the state.

5: Services for older adults with serious, long-term psychiatric disabilities are particularly important, and should include ACT teams for older adults, rehabilitation programs responsive to the goals and needs of older adults, and supportive housing suitable for people with chronic health conditions and disabilities.

There are evidence-based and innovative programs for working age adults in New York State, such as Assertive Community Treatment teams and PROS programs. Despite some adaptation and implementation of these and other models in New York State, however, there is a lack of proliferation of these program models specifically designed to address the unique needs of older adults, whose goals are likely different than their working age counterparts.

6: New York State should invest in a culturally and clinically competent geriatric mental health workforce.

This workforce should include allied service professionals, such as home care providers, to ensure older adults with behavioral health needs can age in place in the least restrictive settings possible. A network of peer support services for older adults should also be developed to harness the potential of older adults to become part of the behavioral health workforce both as employees and as volunteers.

7: New York State should ensure integration and cooperation between the mental health, substance abuse, health care and aging services systems of care to holistically address comorbidities in the older adult population.

For too long, older adults have received care from siloed service systems which may not have been able to address the complexities of their experience. As the population ages, it will be increasingly important to develop and implement innovative models of service provision that enable older adults with comorbid conditions to meet their healthcare, behavioral health, and psychosocial goals. These goals are more than just the effective management of clinically significant symptoms; they also include accessing benefits and entitlements, ensuring adequate housing and rehabilitative services, supporting the development and maintenance of significant relationships, and engagement in meaningful activities with the definition of "meaningful" driven by older adults themselves.

8: New York State should ensure that Medicaid managed care initiatives facilitate smooth transition into Medicarefunded services for older adults with behavioral health needs.

This should include multi-directional, trauma-informed integration of care across service systems, such as health, mental health, substance abuse, aging services and long-term care services and supports. Currently, the available programs and services developed under Medicaid redesign to not adequately address older adults.

9: New York State should identify and remedy the bureaucratic challenges associated with accessing long-term care services and supports for older adults with behavioral health needs.

There are a number of challenges that prevent comprehensive care for older adults living with mental or substance use disorders, including, but not limited to, the lack of mental health benefits in Medicaid Long-Term Care programs, and the challenges of embedding home care into supported housing and other programs where older adults live.

10: New York State should launch a public education campaign to raise awareness of the aging of the population and the need to better understand and identify behavioral health needs of the growing population of older adults.

Too many people, including older adults, their families, and other caregivers are not able to distinguish between the typical aging process and clinically significant behavioral health disorders. All too often, signs and symptoms of mental illness are unrecognized and misinterpreted as a function of age, resulting in missed opportunities to engage older adults in beneficial services and supports that could reduce suffering and increase quality of life. A public education campaign tailored for older adults and their caregivers can help to increase mental health literacy and help seeking where indicated

Each day in the United States, 10,000 people turn 65 years old; our nation is aging and requires that we do more to address this demographic shift. As we New Yorkers so often say about behavioral health innovation, "Where New York State goes, so goes the nation." Through its efforts over the last fifteen years, New York State has demonstrated its leadership in geriatric mental health. The demographic changes the state is facing makes it imperative to focus even more strongly on identifying and addressing the behavioral health needs of older New Yorkers in an integrated and sustained way. We can't wait – the time is now.

Lisa Furst, LMSW, MPH, is the Director of the Geriatric Mental Health Alliance of New York and Assistant Vice President, Center for Policy, Advocacy and Education, for Vibrant Emotional Health. Kimberly Williams, MSW, is the President and CEO of Vibrant Emotional Health and a co-founder of the Geriatric Mental Health Alliance of New York. Michael Friedman, LMSW, is Chair and co-founder of the Geriatric Mental Health Alliance of New York.

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Supported Housing from page 17

limited job history has had a severe impact on our economic security today.

"I was getting early retirement but I only put in 12 or 13 years of taxable income. Other than that I was selling drugs, hustling, all kinds of stuff, and there's nothing to get from that. I was getting about \$300 and change from retirement. My rent was \$15 for the first year, then it became \$85 and I had about \$60 to \$70 for ConEd [electricity and gas utility bill], that means I'm already \$200 into a \$300 income. So I never have any money. And sometimes it's gone three days later, and you have to wait another 30 days. Those are real life issues."

But one of us mentioned that their supported housing building has its own urban farm and garden where tenants help to grow vegetables, herbs, and flowers. S:US' Urban Farms program offers stipends to anyone who works on a farm. "It's like a paycheck. It's just something to give you an incentive to do something

other than waste time. And time is a very treasured thing."

Struggling with Isolation and Rebuilding Relationships

Something that many people in our age group face is social isolation and a lack of consistent, meaningful connections with people. Some of us feel particularly susceptible to this because of our limited income. It is something we see in others in our age group. Many of us have lost relationships with family and friends from years of homelessness, incarceration, addiction, and other challenges. Knowing that isolation and stagnation can be detrimental to our physical and mental health, socializing and being active are things we welcome into our lives. Again, having housing stability has helped us take the first steps in this process. For one, we have resources through our supported housing buildings and other S:US programs, such as the Brooklyn Clubhouse. which encourages us to socialize, be a part of a community, and achieve our goals. We spoke about how our stability, resources, and support from S:US staff have motivated us to reach out to loved ones we were separated from for decades.

"I was in prison three times in my life, 20 years ago. When they used to have mail call, I never responded to it. I knew nobody wrote me because nobody knew where I was at. Imagine being in prison and no one knows you are there.

"I just reconnected with my brother after 20-something years [...] One of the things that really shows my life has changed is when I fill out any kind of form that asks who they can contact in case of emergency. If you don't have anybody to put there, it will bring tears to your eyes. Now I can put my brother's name down."

Supported Housing is a Lifeline

At several points, our conversation revealed how much of a difference simply having a home has made in our lives. When times get tough, our past selves may have resorted to unhealthy coping mechanisms without our own hard-earned wisdom and the resources available to us through S:US. Now, we have supportive staff to turn to. We have a quiet space to gather our thoughts, sleep soundly, contemplate solutions, and take on the day.

"What S:US has offered is stability. With a little longevity and getting a little older and a little wiser, instead of trying to escape the problem by doing all kinds of negative things that could hurt me, I go downstairs and talk to anybody who will listen [...] I wouldn't have had the wherewithal to do all of that without the support of the people in the building."

As we enjoy these later stages of life, we know ourselves better than ever before. Overall, the simplicity and steadiness of our lives now makes us determined to make the most of the present, and optimistic about our futures. As one of us concluded, "I'm proud that I made it this far. It's a blessing, and I'm proud of the stability in my life now."

Suicide Prevention from page 34

and self-assessment (e.g., Project Implicit, https://implicit.harvard.edu/implicit/) can increase awareness of biases and help reduce the prevalence of ageist behaviors such as elderspeak. Engagement in intergenerational activities may also challenge misperceptions about age. Local libraries and YMCAs may have information about programs or resources.

In conclusion, older adults die by suicide in greater numbers than younger adults, and suicide risk is particularly high among white males 85 and older. Physical illness and depression are common precipitants of late-life suicide but identifying patients at imminent risk is challenging because older adults may not endorse suicidal thoughts or intent despite high risk. Current strategies for reducing

not represent the views of the US Department of Veterans Affairs or the United States Government. She can be reached at emily.bower2@va.gov.

Visit www.CoveCareCenter.org for

more information.

late-life suicide include routine risk as-

sessment and management within medical

settings, providing opportunities for so-

cial connection to reduce loneliness and

isolation, and increasing awareness of

ageism within medical and social settings.

Preventing late-life suicide will require

coordinated effort among researchers,

Emily Bower, PhD is a postdoctoral

fellow and is supported by the Office of

Academic Affiliations, Advanced Fellow-

ship Program in Mental Illness Research

and Treatment, Department of Veterans

Affairs and the VA Center of Excellence

for Suicide Prevention. The contents do

providers, family, and community.

Forum from page 19

healing to people of all ages through a comprehensive range of services including individual and group counseling, care coordination, family advocacy, parenting education, community outreach, and medication management. CoveCare Center is a member of Coordinated Behavioral Health Services (CBHS), a nonprofit 501(3) membership organization of forward-thinking, community behavioral health and disability service providers in the Hudson Valley Region whose shared goal is to promote recoveryoriented and outcome-based services designed to ensure high quality and low

Aging with I/DD from page 26

At the same time, Rose became increasingly integrated in her community and continued to learn skills needed to live as independently as possible (money management, cooking, shopping, housekeeping, etc.). Rose was so successful in reaching her self-determined life goals that, even after her mother passed away (over 40 years ago), Rose was able to remain living in her home well into her 90s.

As Rose aged and her needs and interests changed, AHRC worked with Rose to modify her plan of support, of Westchester and Co-Regional Coordinator for the Westchester Putnam Region, New York Association of Psychiatric Re-

Photo Credits: Dillon Browne, Peer Specialist, The Mental Health Association habilitation Services, Inc. (NYAPRS); Alison Carroll, VP of Strategic Initiatives, CoveCare Center; Eric Toth, CEO of CoveCare Center; Harvey Rosenthal, Executive Director, NYAPRS; Laura Brogan, Care Manager, CoveCare Center and Co-Regional Coordinator for the Westchester Putnam Region, NYAPRS; Raquelle Bender, The Mental Health Association of Westchester; Bryan Cranna, Independent Living, Inc.

including a shift to more in-home services. Where she was once able to travel alone by bus, Rose eventually came to need help getting to medical appointments and the various activities she most enjoyed in the community. AHRC ensured that her changing transportation needs were addressed and made arrangements for services from the Visiting Nurses program to help Rose with her medications. Rose's selfdirected planning process evolved over time to help support her ultimate goal for living an independent, meaningful and productive life.

Age and Disability from page 18

conditions, and ageism-interact and combine to undermine us all. It's also a way of thinking about the relationship between identity and power: how people and institutions use identity—old, for example, or disabled, or fat, or Muslim, or crazy-to withhold or confer advantage. In Crenshaw's words, in an article called "Why Intersectionality Can't Wait," "intersectionality isn't just about identities—race, gender, class but about the institutions that use identity to exclude and privilege.'

These relationships explain why the poorest of the poor, everywhere in the world, are old women of color. Add disability to the mix, and vulnerability increases even more. It's no wonder that so many people who are homeless around the world are people with serious mental illness or addictions. It's why, as Crenshaw wrote, "We simply do not have the luxury of building social movements that are not intersectional, nor can we believe we are doing intersectional work just by saying words.

A vivid example came my way this week in an eloquent article by Kate Bunting, the CEO of HelpAge USA called "Putting inclusion into practice." A term that came out of disability rights, inclusion means giving people with disabilities full access to society, whether by providing closed captions or building wheelchair ramps or simply inviting them into the conversation. Inclusion is core to HelpAge's mission to improve the lives of the world's poorest olders, and Bunting wants it to be a mainstream humanitarian priority.

We're not there yet, because we don't collect much information on older people and what data we do collect isn't broken down by age or disability. Without data, we can't design programs with those populations in mind. "What this translates to in practice," she writes, "are distribution centers reachable only by those who

Isolation from page 28

mistreatment is prevalent in our society. Whether physical, emotional, verbal, or by way of phone, mail, or electronic scams, senior centers must find ways to educate seniors themselves and the volunteers and staff who serve them on signs of abuse to look out for.

Many centers also recognize the importance of intergenerational activities, especially since seniors may be far away from their children and grandchildren. By bringing these generations together for fun activities, everyone has the opportunity to both teach and learn from those of a different age group.

Celebrating the cultures and customs of the seniors you serve not only creates a sense of community and helps keep individuals connected to their heritage, but it also introduces new traditions to people of different cultures and provides new understanding and growth among the community.

Perhaps one of the most visual examples of how the Carter Burden Network helps seniors maintain their individuality and vitality is through the Carter Burden Gallery in New York City, which showcases the works of professional artists aged 60 and older who live in the New York City metropolitan area. The Gallery combats ageism and isolation in the art world by offering a venue for older artists to showcase their transformative and cuttingedge work and by fostering a supportive and culturally-diverse community of artists.

By offering a wide range of activities and programming, senior centers can ensure they are addressing the unique and individual needs of the aging population. We must always remember to encourage individuality, celebrate culture, and ensure that the voices of our older adults are heard. It's easy for seniors to feel isolated, invisible, and vulnerable, but we can fight these challenges with love, belonging, and increased access to programs and services that seek to nourish the mind, body, and spirit.

The Carter Burden Network promotes the well-being of seniors 60 and older through a continuum of services, advocacy, arts and culture and volunteer programs, all oriented to individual, family and community needs. Please visit www.carterburdennetwork.org or call (212) 879-7400.

Telephonic Care from page 35

requires innovative and adaptable approaches. By reducing physician burden within safety net health centers, aging patients can remain with their primary care provider longer, delaying the need for more specialized or institutionalized care with limited availability. When we identify risk and focus on intervention, not only do we support our aging patients but we support our health center infrastructure and its ability to provide quality care to all patients.

Katie Bierlein, LMSW, MPH, is Director of Care Coordination. Michaela Frazier LMSW, CCM, is Vice President of Social Support Services, at The Institute for Family Health.

Retiring CEO from page 19

of their own choosing in the community. In addition to being one of the largest nonprofit real estate developers in New York City – with more than \$300 million in real estate investments - Community Access is also home to the acclaimed Howie the Harp Advocacy Center, NYC's oldest and largest job training academy for mental health peers, and delivers unique health and wellness, treatment, and crisis support programs that help more than 3,000 New

Yorkers every year.

The mission of Community Access is to expand opportunities for people living with mental health concerns to recover from trauma and discrimination through affordable housing, training, advocacy and healing-focused services. We are built upon the simple truth that people are experts in their own lives.

Please feel free to contact Ms. Hedigan at chedigan@communityaccess.org, and visit www.communityaccess.org to learn more about Community Access.

can walk there; food only for those capable of digesting it; and emergency warnings understood only by those who can see and hear." During wartime or emergencies, this makes people with disabilities, many of whom are older, the last to receive resources and the first to die.

What can the rest of us do? Bust out of our silos. Ask honestly whether we've been reaching out to those with less privilege, to people who don't look like us, or live far away, or don't seem to have much in common with us. At heart, there's only "us." I used to say that ageism was the only form of discrimination that affects everyone, but in fact all oppression burdens us all. Like the T-shirt says, "None of us are free until all of us are free.'

A movement against ageism is underway. If we want it to leave no one out—to be genuinely inclusive—it has to engage people at the margins of society, the ones whom people in power deliberately overlook because they can get away with it. It's no surprise that queer women of color are leading the charge. They're the ones, in the words of Rutgers professor Brittney Cooper, "who meld race, gender and queer politics into an expansive, inclusive, and just vision of the world." That world is better for all of us. It's the world I want to inhabit and that I'm learning to work towards. As a white woman of privilege not used to abandoning her comfort zone, I have a long way to go.

I'm committed to making the journey. Will you join me?

An internationally recognized expert on ageism, Ashton Applewhite is the author of This Chair Rocks: A Manifesto Against Ageism, published this March by Celadon Books. She speaks widely at venues that have included the TED mainstage and the United Nations and is a leading spokesperson for a movement to mobilize against discrimination on the basis of age.

Recovery Program from page 30

patients reported abusing more than one substance. Almost all older adults who were screened (94%) had been long-term substance abusers and a majority (72%) also had a mental health diagnosis such as depression, anxiety, or dementia.

To monitor recovery and track outcomes, program participants were called for phone interviews 30 days post discharge. Twenty-nine program participants were reached for the 30-day follow-up phone calls. One-month after discharge, 69% of telephone call participants with alcohol abuse issues, and 64% with drug abuse issues, reported that they had not relapsed. Almost three-quarters of phone call participants (73%) reported that they did not have difficulty following their discharge plan and half (50%) reported that they were continuing with Alcoholics

Anonymous and/or therapy.

Participants reporting that they did not follow discharge plans listed the following reasons: lack of transportation, not understanding the discharge plan, and dissatisfaction with available community services. During the 30-day post-discharge telephone interview, 70% of participants rated their program satisfaction as "excellent" or "good."

A new 18-month follow-up study, currently in the data-collection phase, will compare information from the medical records of GSARP participants to medical records data collected on individuals who were referred to the program but refused participation. The study is supported by a grant from the Catherine Weldon Donaghue Medical Research Foundation to The New Jewish Home, and is led by Verena R. Cimarolli, senior health services research associate at the

Leading Age LTSS Center @UMass Boston and senior research fellow at The New Jewish Home.

Guided by the Andersen Behavioral Model of Health Services Use, the study will:

- Examine whether GSARP participants have better rehabilitation outcomes when compared to GSARP refusers. The specific rehabilitation outcomes under study are improved physical functioning and likelihood of returning home as opposed to being readmitted to acute care.
- Identify individual characteristics and health behaviors associated with successful rehabilitation outcomes.
- Identify individual characteristics associated with program participation/refusal. The initial study found that the majority of patients approached about GSARP

agreed to participate. However, participation rates were lower among minorities.

Further examination of factors associated with program participation may inform strategies to increase program participation, which may potentially lead to more optimal rehabilitation outcomes and, ultimately, improved quality of life of older adults with alcohol and substance misuse issues.

Margaret Bondy, is Director of Social Work Manhattan Division; Orah Burack, is Senior Research Associate; Irene Liu, is Content Development Manager; Roberto Perez, is Substance Abuse Counselor, at The New Jewish Home. Verena R. Cimarolli, PhD, is Senior Health Services Research Associate, LeadingAge LTSS Center at UMass Boston; and Gregory Poole-Dayan, is Chief Operating Officer, at Wartburg Hospital.

Residential Care from page 31

the home be a one-floor home to ensure any changes are accommodated? Does the home have big enough doorways and turning radius around corners to accommodate wheelchairs if needs change as the individuals age? Are the bathrooms accessible to the individuals currently, and what types of changes need to be made for the bathrooms to be accessible should ambulation change as the individuals get older? Will the individuals be able to remain in the current home, or will they need to be transferred to a different home should ambulation needs change? Are there appropriate exits and entrances should ambulation needs change (i.e., ramps)? Does the home need a wheelchair van?

Ongoing Assessment by Credentialed Professionals

The ongoing physical and behavioral needs of older adults are assessed and monitored regularly by professionals such as physical therapists, Speech and Language Pathologists (SLPs), nurses, primary care physicians, behavior analysts, and psychiatrists.

Physical therapists assess regularly the person's ability to navigate his or her current environment, and make recommendations for environmental changes to increase safety and independence for each person. Primary care physicians and nurses assess the ongoing medical and healthcare needs of the adults to ensure

their current environment can meet all healthcare needs.

SLPs can provide support in both feeding issues and communication strategies. The SLP will regularly assess individuals to ensure their current diets are appropriate and will make recommendations for diet modifications based on changes with the individual. For example, if an individual who was previously on a regular diet develops difficulty chewing or swallowing, the SLP can do an assessment and may recommend a change in food texture or liquid consistency.

Behavior analysts monitor and assess any behavioral changes and may develop appropriate behavioral interventions, based on the principles of Applied Behavior Analysis. These may include antecedent-based strategies, such as the implementation of a visual schedule for an individual who did not need that type of intervention in the past. These may also include consequence strategies, such as appropriate reinforcement systems to maintain positive behaviors. Behavior analysts will review data on behavioral changes and make updates to behavioral intervention strategies based on the behavioral data.

Psychiatrists, in combination with the rest of the IDT, review behavioral data and medical changes for the individual, making appropriate medication recommendations based on this information. The behavior analyst shares information regarding any behavioral changes, sleep information, and presents all relevant data in graph format so the psychiatrist can

observe trends. All medication changes are discussed with the individual and guardian/representative, as well as presented to a Human Rights Committee (HRC) to ensure the least restrictive interventions are being utilized.

Comprehensive Staff Training

Training of direct support staff in the proper care and teaching strategies for older adults is very important. Training on all important job duties, including providing personal care, teaching skills, and following behavior support plans is done using a behavior skills training model (BST). BST includes a verbal description of the skill, a succinct written description of the skill, a demonstration of the skill by a competent trainer, and the trainee performing the skill with feedback from the trainer, until the trainee is competent with the skill (Parsons, Rollyson, & Reid, 2012). By training direct support staff on all necessary job duties utilizing this model of training, the residential provider can be sure that support staff are fully competent in the delivery of services to the adults being served.

Summary

Many aspects of care need to be considered when providing residential services to older adults with ID and autism. While taking care of the person's physical health is extremely important, ensuring the environment in which they live is ac-

commodating and accessible is just as important. As such, residential providers need to continually assess the environment of their homes in addition to the individuals who live in those homes.

It is equally as important to have a highly qualified team of professionals working collaboratively to ensure that exemplary care is being provided at all times. This, in addition to well-trained direct support staff working with individuals, will help ensure the greatest outcomes for the older adults can be achieved.

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