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Caring for Older Adults

Complexities in Caring for Older Adults: Challenges and Opportunities for Improvement

By Ashley Brody, MPA, CPRP
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It has been widely reported that individuals with chronic behavioral health conditions experience significantly diminished life expectancies (Chesney et al., 2014). This tragic phenomenon may be attributed, at least in part, to comorbid medical conditions commonly associated with the aging process. Maladies that afflict the general population, including diabetes, cardiovascular disease, obesity, and other indicators of metabolic dysfunction, are quite prevalent among individuals with serious mental illness (SMI), as are other diseases that curtail their lifespans. These conditions are often exacerbated by behaviors and lifestyle factors common among individuals with SMI, such as nicotine dependence and other substance use, nutritional deficiencies, limited access to primary and preventive care services, and widespread exposure to trauma. Inasmuch as Social Determinants of Health (SDoH), defined as the conditions in which individuals live, learn, work, and socialize, are more determinative of health outcomes than healthcare services, it is unsurprising that a population with insufficient access to SDoH would experience a disproportionate share of age-related illnesses and premature mortality. However, the plight of individuals with SMI cannot be solely attributed to diminished access to SDoH. This was affirmed by a robust longitudinal evaluation that revealed an early onset of age-related illnesses among a cohort of individuals with SMI. This investigation controlled for certain confounding variables to which premature aging might be attributed. That is, it found individuals with SMI were more likely to experience an early onset of afflictions characteristic of the aging process irrespective of habits or behaviors that would cause or exacerbate age-related illness (Wertz et al., 2021). These findings suggest providers of healthcare and social welfare services for individuals with chronic and severe behavioral health conditions must employ comprehensive approaches to mitigate adverse effects of age-related illness among individuals entrusted to their care.

An extensive body of research has affirmed the prevalence of physical health conditions among individuals with chronic and severe mental illnesses such as bipolar disorder, schizophrenia, and major depressive disorder (Buist-Bouwman et al., 2005). To uncover potential underpinnings of this relationship, researchers in New Zealand conducted a longitudinal evaluation that included 1,037 participants at the inception of their investigation, 997 of whom were still alive at its conclusion.

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Behavioral Health News Spotlight on Excellence: An Interview with Jihoon Kim, CEO of InUnity Alliance

By Staff Writer
Behavioral Health News

Watch the interview with Jihoon Kim, CEO of InUnity Alliance

In this interview, Jorge R. Petit, Founder/CEO of Quality Healthcare Solutions, LLC, speaks with Jihoon Kim, CEO of InUnity Alliance (asapnys.org / coalitionny.org). Jihoon discusses his strategic vision and priorities for addressing the growing mental health and addiction crisis in New York, emphasizing the importance of community-based care and overcoming stigma and disparities.

David Minot: Hi, and welcome to the Behavioral Health News Spotlight and Excellence interview series, where we feature exceptional leaders and innovative healthcare solutions that are raising the standards of care in the behavioral health community. My name is David Minot, and I am the executive director of Mental Health News Education, the nonprofit organization that publishes Behavioral Health News and Autism Spectrum News. Our mission is devoted to improving lives and the delivery of care for people living with mental health conditions, substance use disorder, and autism, and supporting their families in the professional communities that serve them. Today, we're speaking with Jihoon Kim, CEO at InUnity Alliance, which was founded in 2023 from the merger of two longstanding organizations, the Coalition for Behavioral Health and the Alcoholism and Substance Abuse Providers of NY.

InUnity Alliance is a leading voice for all New Yorkers living with addiction and mental health conditions, their loved ones, and service providers, offering advocacy, training, and education while working collaboratively with the robust network of diverse partners and its membership of 250 addiction and mental health care providers statewide. Leading our interview is Dr. Jorge Petit, founder and CEO of Quality Healthcare Solutions, LLC. Jorge is a community psychiatrist leading the behavioral health sector to innovate and transform healthcare for those most in need, including people with intellectual and developmental disabilities, those struggling with mental health and substance use challenges, individuals in poverty, facing eviction or homelessness, and all those marginalized, unemployed, and disadvantaged. Jorge is also a board member of Mental Health News Education. I'm excited to learn more about InUnity Alliance and its impact on behavioral health in New York State. Jorge, the mic is all yours.

Jorge Petit: Thank you, David, and good afternoon to you. I'm so excited to have this opportunity to talk with you today. I have worked for decades in the New York City health and behavioral healthcare

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Spring 2025 Issue
Behavioral Health Services for Children, Adolescents, & Families
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Summer 2025 Issue
Supporting Maternal Mental Health and Reducing Stigma
Deadline: June 19, 2025

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Meeting the Behavioral Health Needs of Today's Older Adults: Considerations for Innovation

By Duncan Bruce, MS, LPC, LBS
Director of MCO Integration
Community Care Behavioral Health

Between 2010 and 2020, the US experienced the largest-ever 10-year gain for those in the >65 age bracket, with an increase of 15.5 million people. According to the US Census Bureau, one in four Americans will be age 65 or older by 2060 (Caplan, 2023). Although today's expanding older adult population represents multiple strata of society and includes individuals who vary in their socioeconomic status, race, sexual orientation, gender expression, ethnic group, and religious and political affiliation, older Americans have similar health and wellness needs. These population shifts and needs create new challenges for healthcare systems.

With this rise in the older adult population comes a concordant increase in behavioral healthcare needs. According to the 2022 National Survey on Drug Use and Health, approximately one in five adults over 50 years old experienced a mental health condition, substance use disorder, or both in the previous year (SAMHSA State Program Improvement Technical Assistance, 2024). In addition to behavioral health challenges, older adults also often grapple with chronic health conditions, loneliness and loss, financial strain, loss of independence, and difficulty navigating an increasingly complex healthcare system – all of which can have a compounding impact on behavioral health (Reynolds, 2022). Specialized care is important for adequately and holistically addressing these needs and challenges, but there is a national shortage of gerontologists, psychiatric geriatricians, and other behavioral health providers who focus on this population. Several states address the challenges of this provider/need mismatch through strategic planning and policy change in addition to the allocation of federal, state, and local funding and resources to grow and stabilize the behavioral health workforce. For example, Pennsylvania's "Aging Our Way PA" is a 10-year strategic plan designed to help transform the infrastructure and coordination of services for the state's older adults. Federal-level regulatory changes, such as the recent expansion of the types of behavioral health professionals who can now deliver behavioral health services through the Medicare program, have also significantly increased the potential number of clinicians available to work with older adults. These advancements have catalyzed Pennsylvania's growth and innovation around developing specialized programs that address gaps in care and barriers that older adults face when seeking behavioral health treatment.

In 2018, Pennsylvania implemented the Community HealthChoices program, which moved the state's Medicaid Long Term Services and Supports (LTSS) benefits into a managed care organization (MCO) environment. Behavioral health coverage for older adults eligible for Medicaid LTSS benefits is now provided by behavioral health MCOs (BHMCOs) such as Community Care Behavioral Health Organization (Community Care), a nonprofit BHMCO that operates in Pennsylvania and is part of the UPMC Insurance Services Division. Community Care is committed to ensuring access to evidence-based behavioral health treatment and physical-behavioral health integration. In our role as a BHMCO covering 1.2 million lives across 43 of Pennsylvania's 67 counties, we have learned that seeking input from members, providers, and county and state partners is key to developing innovative, multi-faceted programming that improves care access and health system coordination, collaboration, and integration.

Community Care's New Connections program was conceived and implemented to meet the behavioral health needs of older adults who reside or are candidates for placement in a skilled nursing facility (SNF). By including direct input from SNFs about their residents and organizational needs in the planning phase, we developed an informed and flexible program that integrates well with existing processes and workflows. New Connections programming is led by a team of clinicians, including a consultant psychiatrist, a licensed mental health professional, a registered nurse, and a certified peer support specialist. Key elements of the programming include an ability to quickly assess and start working with residents, ease in tailoring the type and intensity of supports to address an individual's needs, and the flexibility to work seamlessly across SNF and community settings, especially around supporting an individual's transition from SNF back into the community.

A recent example of the program's success is the outcome of integrated behavioral health services provided to a 69-year-old gentleman residing in an SNF. He had a behavioral health history, including depression and anxiety partially related to his physical health conditions. Through the New Connections program, he received support in developing a deeper understanding of his physical and behavioral health needs. Upon receiving the individualized support and information tailored to his situation available through the program, he demonstrated a new understanding of his care and increased motivation to meet his treatment goals, which resulted in a transition plan from residing in an SNF to assisted living.

Substance use disorders are often undertreated and can create additional barriers to care in older populations. One common challenge is SNF placement for older adults requiring that level of care who also have an opioid use disorder (OUD), particularly when they are receiving medication-assisted treatment (MAT). UPMC Health Plan and UPMC Senior Communities developed an SNF transition pilot program to facilitate SNF placement for members admitted to inpatient hospital units for reasons unrelated to substance/opioid use and taking buprenorphine (a commonly used MAT to treat OUD). SNF staff responsible for administering medication are provided education about prescribing buprenorphine and case management support for SNF discharge planning. Preliminary results are pending but trending towards a cost saving in inpatient days and timelier transitions into nursing facilities.

Many older adults also have a trifecta of overlapping concerns, including behavioral, physical health, and long-term services and supports (LTSS) needs. These three domains are further impacted by an individual's social determinants of health (SDoH). UPMC Community HealthChoices, collaborators in Erie County, and Community Care developed a program to support individuals with complex physical and behavioral health clinical needs that are often exacerbated by the complexity of multi-system involvement. Through this program, a team of staff bridges three systems and works in dual roles as service coordinators and administrative case managers to provide supplementary support to manage multi-system involvement and coordination of care. They serve as a single point of contact for each system, resulting in improved coordination and access to services. Participants in the program demonstrate a decrease in physical health and behavioral health inpatient costs, reductions in emergency room visits, and a need for crisis service interventions. When surveyed, they reported more stability and less anxiety. These decreases and reductions also result in a concurrent increase in the utilization of LTSS to support participants' tenure in the community. Plans are currently in place to explore expanding this program.

As America's aging population continues to grow, it is imperative that the healthcare workforce and programming adapt and innovate to meet needs. The aging process presents continuous challenges that can impact an individual's physical and behavioral health and well-being yet also offers opportunities for growth, resilience, and fulfillment. Specialized behavioral health services that are accessible, effective, and tailored to the needs of older adults are

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Addressing the Unique Mental Health Challenges Brought on by Aging

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

Older adults are one of the fastest-growing demographics in the nation and in New York State. There are currently about 4.6 million New Yorkers who are 60 years of age or older and another 4.2 million between the ages of 45 and 59.

Individuals with wisdom and life experience are a gift to younger generations. Ensuring that they have access to the best health care and support, including behavioral health, is vital to be sure that older adults continue to contribute to their communities and share their many talents.

Older adults are at risk of developing mental health and substance use disorders as well as other chronic physical health conditions. Unfortunately, many older adults, as well as healthcare professionals, often minimize or ignore behavioral health issues, considering them to be an expected consequence of aging.

It is true that aging brings life changes that can impact our emotional well-being. The death of close friends and loved ones, for example, and the feelings of grief and loneliness these losses cause can lead to social isolation, depression, and anxiety. Facing and managing a serious illness or serving as a caregiver for a loved one with an illness can also impact the mental health of older adults.

The problem is widespread, and according to the World Health Organization, approximately 14 percent of adults aged 60 and over live with a mental illness, the most common of which are depression and anxiety. Mental health and substance use challenges are further exacerbated by the increasing need to navigate multiple service systems and the trauma many experience in applying for and potentially being denied critical benefits that make aging in place possible.

The good news is that help is available for older adults, especially here in New York, which in 2017 became the first state in the nation to enroll in the World Health Organization (WHO) Global Network for Age-friendly Cities and Communities and its U.S. affiliate — the AARP Network of Age-Friendly States and Communities. The designation is awarded to municipalities that incorporate age-friendly concepts into their policies, programs, and procurement guidelines, such as support for healthy aging and aging in place. Age-friendly housing policies, for example, not only help to ensure adequate housing for older adults but also provide opportunities for social participation, transportation, recreation, and access to healthcare.

However, New York was working to expand access to effective behavioral health care and aging support services long before its designation as an age-friendly state. In 2005, the State enacted the Geriatric Mental Health Act to address parity in the planning and coordination of, and access to, behavioral health, long-term care, and aging-related services. The law established the Interagency Geriatric Mental Health and Substance Use Disorder Planning Council, which promotes collaboration between state agencies and other stakeholders to support older adults in addressing their holistic, cross service-system needs. The Council includes my fellow commissioners and staff from the Office for the Aging, the Office of Addiction Services and Supports, the Department of Veterans' Services, the Office for People with Developmental Disabilities, the Justice Center for the Protection of People with Special Needs, and the Department of Health, as well as advocates and stakeholders appointed by the Governor, Assembly, and Senate.

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Prevention Across the Lifespan: Substance Use Education and Screening Services for Older Adults

By Patricia Zuber-Wilson
Associate Commissioner for Prevention
New York State Office of Addiction Services and Supports (OASAS)

While older adulthood is a special time of life, it is also a time when older individuals may face health issues and life transitions. It can be a vulnerable time for mental health and can lead to a change in the way people use substances. New York State has the fourth-largest population of older adults in the United States, with 3.8 million individuals over age 60. As the population ages, high-risk alcohol and substance use, particularly cannabis and prescription medications, is growing among older adults. Drug overdose deaths among older adults have been rising over the past two decades, largely due to opioids.[1]

The New York State Office of Addiction Services and Supports (OASAS) is the state agency that oversees one of the nation's largest substance use disorder (SUD) systems of care and is committed to serving all people with equity, dignity, compassion, and respect – including older adults who may find themselves dealing with SUDs later in life.

OASAS has collaborated with the New York State Office for the Aging (NYSOFA) on a nine-county pilot initiative to educate older adults on health, substance use, and mental health wellness. Established in 2023, the Wellness Initiative for Senior Education (WISE) program aims to help seniors increase their knowledge and awareness of issues such as safe medication use, the aging process, communication with healthcare providers, and healthy lifestyle choices. It is paired with Screening, Brief Intervention, Referral to Treatment (SBIRT) services using the Alcohol Use Disorders Identification Test (AUDIT-C).

The Importance of Older Adult SUD Screening and Services

With aging can come new stressors, such as loss of partners, lower income, a reduced sense of purpose or work identity, and a shrinking social network. It can also bring physical changes like increased inflammation and pain, elevated cancer risks, heart disease, and other chronic health conditions, as well as cognitive decline and sleep problems. Substance use can compound these health issues – especially since many older adults also take medications, including prescriptions, over-the-counter, or herbal remedies that can be dangerous or even deadly when mixed with alcohol.

Isolation is another risk factor for increased depression, anxiety, and substance use. The COVID pandemic exacerbated this isolation. Some research found that the percentage of adults ages 50-80 who felt isolated from others some of the time has largely improved from the height of the pandemic in 2020 but still exceeds pre-pandemic 2018 rates. Socially isolated older adults are left further vulnerable as they go through stressful life events common to aging without the buffering effects of social support.[2]

Drug Overdose Deaths Among Older Adults on the Rise

Among recent notable changes in key health indicators is the increase in substance-related deaths in adults ages 65+ between 2016 and 2021. Opioid overdose deaths surged more dramatically than the overall drug overdose death rate (involving

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Addressing the Unique Mental Health Challenges Brought on by Aging

By InvisAlert Solutions
ObservSMART

The use of technology in the healthcare industry has changed the way services are delivered, particularly in addressing the correlation between the geriatric population and behavioral healthcare. As the population grows, the need for care for various disorders, such as dementia, Alzheimer's, depression, and anxiety, is also more in demand.

Technology plays an important role in providing new innovative solutions for the unique challenges of caring for geriatric behavioral health patients and highlights the necessity for technical approaches.

The geriatric population faces multiple challenges, including limited physical motion, cognitive decline, and mental health disorders. According to the World Health Organizations (WHO), the global prevalence of dementia is steadily rising, with an estimated 55 million people currently living with the condition. Additionally, depression and anxiety are common among older adults, often exacerbated by factors such as social isolation, chronic illness, and potential grief (Gellis & Kenaley, 2008).

Traditional care settings for geriatric behavioral health often face challenges in providing timely and personalized care due to resource constraints, staff shortages, and communication barriers. Inadequate monitoring of patient behaviors and overall well-being can lead to suboptimal outcomes and increased risks, including falls, communication errors, and worsening mental health symptoms.

Digital rounding tools can improve care for geriatric behavioral healthcare units by addressing safety tasks, improving communication among staff members, and facilitating proactive patient care. These tools can improve the documentation process by allowing staff to efficiently record patient observations interventions, and analyze data in real-time. By utilizing patient data and generating reports, digital rounding tools enable staff members to identify trends, track outcomes, and make data-driven decisions to optimize patient care. By implementing technology in day-to-day tasks, geriatric behavioral health units can improve efficiency, enhance the quality of care, and increase the well-being of older adults with mental health disorders. However, digital rounding tools are not without points of failure, specifically related to compliance.

ObservSMART is a comprehensive compliance tool specifically designed for behavioral health settings, including geriatric care facilities catering to patients with dementia and Alzheimer's disease. ObservSMART stands out as a leading solution, providing validated compliance, improving and promoting staff-patient interactions, creating safe environments and efficiency, and reducing falls in geriatric care settings. The technology addresses many of the shortcomings of traditional and digital safety methods used in geriatric behavioral health care. ObservSMART ensures safety with proximity-required monitoring of patients and the patient's environment, adherence of staff to patient proximity, prevention of falling asleep for 1:1, and continuous monitoring.

Unique features of this technology include supervisory alerts when required checks are missed, encouraging proactive intervention. ObservSMART promotes staff engagement, and patients are actually seen more often than with traditional methods, which can improve well-being and reduce falls.

Improving Geriatric Behavioral Health Care

Through validated rounding and documentation of patient behaviors, staff members can gain valuable insights into each patient's needs, preferences, and patterns of behavior. This increased awareness allows for more personalized care plans and interventions, leading to improved patient engagement and satisfaction.

Effective medication management is crucial in managing geriatric mental health conditions, yet it can be challenging to track medication adherence and efficacy in traditional care settings.

Technology can streamline the medication management process and specify which medications work best per patient by monitoring behavioral patterns and side effects. Staff members can easily identify trends and patterns in medication use, enabling them to make more informed decisions about medication adjustments and interventions.

Fall Prevention and Safety Protocols

Geriatric patients, particularly those with cognitive impairments, are at increased risk of falls and injuries due to mobility issues, confusion, and environmental hazards. According to the Centers for Disease Control and Prevention, falls among adults ages 65 and older are the leading cause of injury death. Falls are a common but threatening issue in geriatric units.

The ObservSMART solution includes specialized features and modules, such as tighter rounding intervals, risk flags, assessments, environment of care, and fall protocols, that help staff members implement proactive measures to prevent falls and ensure patient safety. In a 2019 case study, a large California behavioral health facility saw a 20% decrease in falls within six months of implementation of the ObservSMART technology, and in a 12-month post-implementation study, a Pennsylvania hospital saw falls decrease by 15% and falls with harm by 60%. This improvement was achieved despite a 15% increase in the number of admissions. Prompting staff to interact with patients at regular intervals and address their needs promptly reduces the likelihood of accidents and promotes a safer care environment.

Technology solutions have the potential to be a game-changer for geriatric behavioral health units by improving staff-patient interactions and preventing falls and injuries. As the demand for quality geriatric care continues to rise, integrating innovative technologies into behavioral healthcare settings will be essential for meeting the growing needs of older adults with mental health disorders. By leveraging the power of technology, geriatric patients can receive the personalized, safe, quality care they deserve.

Technologies like ObservSMART are determined to find a solution to ensure adherence to safety protocols and positively influence patient care. For more information, reach out to cshows@invisalertsolutions.com or visit www.observsmart.com.

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Financial Insecurity in Geriatric Populations

By Alyssa Nejmeh, LCSW
Vice President of Transitional Shelters
Institute for Community Living (ICL)

People are living longer, and the cost of living continues to rise. Where does that leave our next generation of seasoned individuals once they can no longer work? Will my family have the means to take care of me? Do I have a family? Can I afford a nursing home? Are my children capable of the financial burden of caring for me? Can I continue to live my life the same way I once did? These are the spiraling anxious thoughts that many older people face.

It is a cruel reality that many older adults face: The cost of living is rising, and their savings might not be enough to live on. Saving is something many people were unable to accomplish during their lifetimes. Living in a one-income household does not give someone a safety net that allows them to live life in the same way that a dual-income household would. Even Americans in dual-income households often struggle to save. The National Council on Aging (NCOA) reports that the average person eligible for supplemental security income from the Social Security Administration received $551 per month (2024). They also report that 17 million people (or approximately one out of three) aged 65 and above live below the poverty line (2024). The challenge of living on a fixed income is that one unexpected cost can throw off an entire budget. It is important to consider that $551 does not cover most people's rent in the United States.

In June 2022, the monthly inflation rate increased to an alarming 9.1% in the United States (2024). Most people cannot plan for the cost of living to increase to this level. Consequently, many older people cannot survive on their fixed incomes. Financial insecurity means that the cost of one's needs is not obtainable due to the current cost of living and inflation. It can mean they cannot stop working when they are physically or mentally incapable of working anymore. This cycle does not just impact the person who is aging. It impacts the community they are living in, as well. Older adults could not predict that the cost of living would rise to the levels it has reached in recent years.

Alyssa Nejmeh, LCSW

As human services providers, we must review how we can support our aging population. Nursing home facilities and assisted living facilities are dreaded by most people who are aging. Many nursing homes are for-profit agencies, meaning the more money you have, the better the accommodations will be.

New York City, where I work as Vice President of Transitional Shelters for the Institute for Community Living, is one of the most expensive cities to live in, and the homeless crisis here continues to rise. Year after year, people aged 60+ grow in the New York shelter system. According to NYC Department of Homeless Services (DHS) statistics, in July 2020, 1,626 adults over 60 were in shelters. In 2023, there were 1,988 adults more than 60 years old in single adult shelters (2024). (This does not include the older adults that are in family shelters.) That is about a 20% increase in three years.

The ability to care for these older individuals is a task that the shelter system is not designed for. Shelters do not have the staffing capacity or the ability to provide the medical support necessary for someone who cannot feed, dress, or bathe themselves. When a client cannot perform activities of daily living, they actually cannot return to shelter. The burden of finding a place for these people then falls on our hospital system.

People who have worked their entire lives are struggling to retire due to not being able to maintain their lifestyle on social security income and savings. Many people in the United States do not have pensions or retirement plans. They might not have a family to help support them when they get older. According to the Centers for Disease Control (CDC), in 2021, the highest amounts of suicides for people over the age of 55 were men aged 85 and older. The thought of someone taking their life at this fragile age is alarming. Loneliness, confusion, loss of physical health, mental health, and lack of purpose are some of the factors that lead to suicidal ideation. Financial supports and relational supports should be put in place as our society is living longer. The end of life should be a time for the younger generation to learn and benefit from the elder population's knowledge and experiences. We are not experiencing that dynamic with our aging population in American society.

The older we get, the less people see us. NCOA provides help for older adults in navigating their finances and emotional well-being. Ageism is a real challenge that older adults are facing in workplaces and social settings. Regardless of our role in society, whether we are human services providers, policymakers, family members, or neighbors—at the very least, we would do well to remember to be kind to the older persons in our lives. We can say hello to the older individuals who pass us by every day. We don't know what people are struggling with and how we can motivate someone to carry on.

Alyssa Nejmeh, LCSW, is Vice President of Transitional Shelters for Institute for Community Living.

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all drug types), more than doubling since 2014 in older adults. Overdose deaths due to synthetic opioids (i.e., fentanyl and tramadol) increased 175% among older adults between 2016 and 2021[3] – and older adults are among those most impacted by the opioid crisis, as they are often prescribed opioids to help them cope with chronic pain or recover from surgical procedures.[4] In addition, the opioid overdose death rate significantly varied by race/ethnicity and gender, with rates highest among Black older adults compared with other demographics – although rates were generally higher for all groups. Further, rates are higher among males than females.

How the WISE/SBIRT Initiative Helps Older Adults

WISE is a curriculum-based health promotion program to help older adults increase their knowledge and awareness of issues related to health and the aging process. Based on the health belief model of behavioral change, WISE provides older adults with the information and resources required to maintain a healthy lifestyle and become empowered regarding their healthcare needs.

Patricia Zuber-Wilson

Program objectives include helping participants to (1) understand how lifestyle choices and behaviors impact health; (2) learn to use tools and feel empowered to manage health care, particularly regarding the use of medications; (3) understand the aging process and how it affects the metabolism of alcohol and medications; (4) develop an appreciation for cultural and generational diversity, including their own increasing age; and (5) recognize the early signs and symptoms of depression.

The six-lesson WISE curriculum is delivered by trained substance abuse prevention specialists at small 2-3-hour group sessions held weekly over a 6-week period. The lessons are presented through a mix of lectures, discussions, small-group activities, and individual exercises. Participants are also given tools and resources for use at home, which increases the likelihood that they will put into practice and share what they have learned. The WISE-SBIRT Pilot was delivered in over 29 unique locations, including Office of Aging Nutrition Sites, community centers, churches, senior centers and housing facilities, and Firehouses and Town Halls.

During the first year of implementation, 1,074 older adults participated in the WISE-SBIRT Pilot, and 1,050 older adults were screened for alcohol/substance use. Preliminary results showed increased perception of harm from alcohol use, prescription medication misuse, and combined alcohol/prescription use. There was decreased alcohol use among participants who drank, and 77% reported changing to a healthier lifestyle.

The program was well received by participants, partner sites, and prevention providers, who frequently requested additional programming. Meeting participants in familiar community settings serving older adults improved access to prevention and wellness programming. Framing interventions about substance use/misuse in a broader "healthy aging" context builds rapport and engagement.

OASAS will continue to assess and build upon the progress made through the WISE-SBIRT pilot program. That means exploring data-driven, person-centered strategies that enhance prevention, harm reduction, and treatment options for older adults. It also means ending the stigma towards substance use and SUD – while strengthening the social networks so important to an older adult's health, well-being, and recovery.

Patricia Zuber-Wilson is Associate Commissioner for Prevention at NYS Office of Addiction Services and Supports (OASAS).

see Prevention on page 36

Older Adult Recovery and Mental Health Services

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Treatment Services for Older Adults with Substance Use Disorders

By Peter Provet, PhD
President
Odyssey House

As the leader of Odyssey House, one of the largest non-profit residential and outpatient treatment providers in New York City, I have witnessed firsthand the growing need for specialized services tailored to those struggling with addiction, including older adults. While substance use disorders can impact anyone regardless of age, this population faces unique challenges that traditional treatment programs often fail to address adequately.

According to the National Institute on Drug Abuse (latest data reported in 2018), an estimated one million older people in the United States have a substance use disorder. Still, they are less likely to seek treatment, even though they are just as likely to benefit from treatment as any other age group.

The failure of public health systems to identify a vulnerable and high-risk population was recently highlighted in an in-depth article by investigative journalists at the New York Times and a local Baltimore newspaper. Their investigation pieced together previously unpublished autopsy reports and other data to unearth a staggering overdose death rate among older black men in that city that is 20 times higher than the national average.

The article described this group as part of a "forgotten generation" that has been disproportionately impacted by successive waves of drug epidemics from heroin and crack cocaine to prescription opioids and now fentanyl.

While the data in the report is specific to Baltimore, the underlying factors, such as lack of economic opportunities, the crack epidemic, over-incarceration, and the current fentanyl crisis, have impacted many American cities, albeit not likely to the same devastating degree as Baltimore.

Breaking Down Barriers

What we have learned at Odyssey House in New York is that one of the biggest hurdles to reaching this at-risk population is the pervasive stigma surrounding addiction, especially for those who grew up in a generation where it was viewed as a moral failing rather than a treatable health condition. This internalized shame can lead to denial, attempts to hide substance use, and reluctance to be open with healthcare providers.

Older adults also face distinct physical and cognitive challenges. Their ability to metabolize substances – e.g., illicit drugs, alcohol, and prescription medications - is decreased due to aging, making them more sensitive to adverse effects. Chronic pain, cognitive impairment, and co-occurring mental health issues like depression are also more prevalent and can contribute to or be exacerbated by substance abuse. Proper medical care and mental health support are critical components of effective treatment for this population.

Also problematic is the lack of age-appropriate screening tools and limited research data on evidence-based treatment approaches specifically for older adults with substance use disorders.

Healthcare providers often fail to screen or misdiagnose substance use disorders within this population. More must be done to increase training and awareness.

Odyssey House's Approach

At Odyssey House, we are committed to reducing stigma through education and offering judgment-free treatment tailored to clients' needs. We have been addressing this unmet need through our older adult program, one of the only residential and outpatient treatment programs in New York designed specifically for men and

see Treatment Services on page 37

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Supporting Changing Needs Through the End of Life for Adults with Disabilities in Residential Settings

By Maggie Haag, MEd, BCBA, LSW CDE®, Heather Hirst, PT, DPT, and Aaron Emmons, MS
Melmark PA

Everyone changes with aging, often in invisible ways. You may be surprised to learn that beginning at age 25, there is a slow decline in speed, reasoning, spatial skills, and memory (Salthouse, 2009). At the age of 30, there is a 3-8% loss of muscle mass per decade (Volpi, 2004). By the age of 65, a person has lost approximately 20% of their muscle mass. Our senses, including smell, hearing, and vision, begin to decline around the age of 50. This aging process is accelerated in individuals with disabilities. This extends to a heightened vulnerability to several serious conditions.

Individuals with developmental and intellectual disabilities (IDD) experience age-related health conditions earlier than the general population and also experience higher rates of chronic health conditions. For example, the prevalence of Alzheimer's disease in individuals with Down syndrome is 90% (Fortea, 2021). To put this in perspective, in the general population, the prevalence rate of Alzheimer's disease is approximately 10%. This vulnerability can have a detrimental impact on quality of life (Garcia-Dominguez et al., 2020). Currently, there are approximately 640,000 people with developmental disabilities over the age of 60 in the United States. This is expected to more than double by the year 2030 (Heller & Sorenson, 2013). Hence, the service delivery world needs to prepare for the challenges of serving those with developmental disabilities as they age.

There is also the consideration of where and how to support individuals as they age. Most individuals, including those with IDD, want to age within their homes and communities.

Early Identification of Need

Long-term planning should begin as early as possible in adulthood. While identifying someone's future needs is not always possible, there are factors we can take into consideration early, such as the person's current diagnosis and what type of prognosis is generally expected with that diagnosis, as well as the person's family medical history. These types of considerations can assist providers and families in determining the best living arrangement needs early.

When this is not possible, discussions about future medical needs should occur during the early stages of the medical and behavioral changes that occur with aging or other health-related conditions. For example, when a person first starts showing symptoms of memory issues, early decisions related to environmental needs can be made. Some areas to consider are whether the person can stay in their current home with some renovations for accessibility or whether they will need an alternate living arrangement to accommodate their changes in physical mobility. While these conversations can be challenging, it is important that they occur prior to the person experiencing an urgent need in a crisis context

Another set of considerations is necessary to consider when a person receives a terminal diagnosis, such as Alzheimer's disease or terminal cancer. For example, the team can consider whether or not

see Residential on page 38

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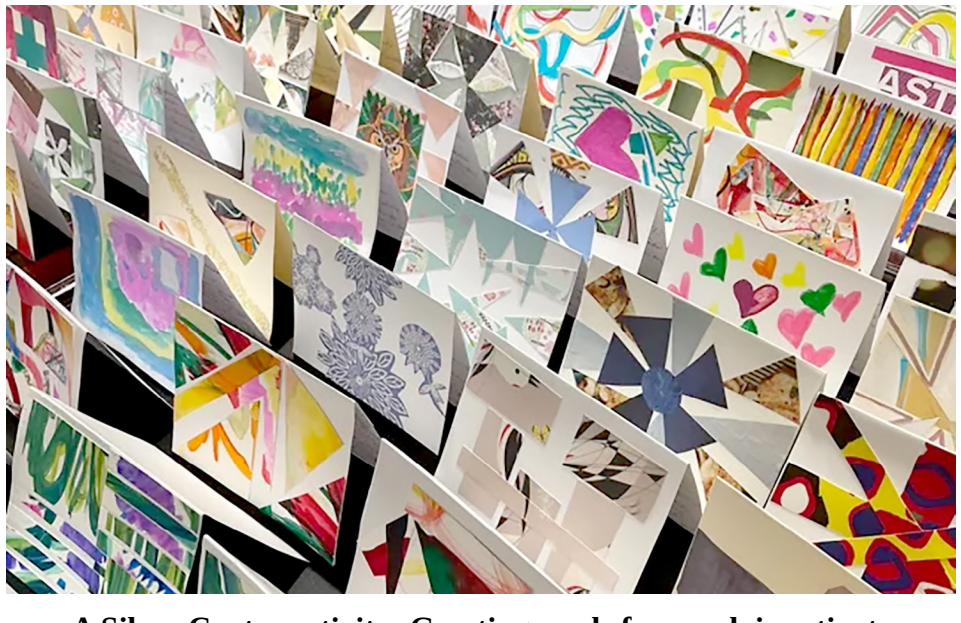
Fountain House's Silver Center for Older Adults: It Takes a Village to "Live Long and Prosper" with Behavioral Health Challenges

By Carl A. Blumenthal, MS, MA, NYCPS
Community-Oriented Recovery and Empowerment (CORE) Peer Specialist
Fountain House

What's in a name? Just as age 60 is supposedly the new 40, the silver hair on older heads is now apparently worth its weight in gold. However, the "silver" in Silver Center refers to the respect certain cultures, such as the Japanese, confer on their elders. So, when you read about the coming "silver tsunami" of baby boomers, don't let this negative image fool you into thinking society would be better off if our older folks drowned before they overwhelm us with their needs for care.

And it just so happens that Fountain House, the original psycho-social clubhouse founded in midtown Manhattan in 1948, on which some 350 others are modeled worldwide, is undergoing a growth spurt at 76 years old, with a branch opened in the Bronx 11 years ago, a new Hollywood, CA location, and a West Harlem one in the making.

Once novel, psycho-social rehabilitation that is person-centered, recovery-oriented, strengths-based, trauma-informed, and culturally humble, with staff and members acting cooperatively in a voluntary and



A Silver Center activity: Greeting cards for psych inpatients

purposeful "work-ordered day," is now widely accepted and more often practiced by such programs as intensive Psychiatric Rehabilitation Treatment (IPRT), Personalized Recovery-Oriented Services (PROS), Assertive Community Treatment (ACT), Intensive Case Management (ICM), Community-Oriented Recovery and Empowerment (CORE), and Crisis Respite Centers (CRC), as well as supported housing, education, and employment. (An acronym of care a day keeps the psych ward away!)

Such rehabilitation "can save more than $11,000 a person; when extrapolated to the current 60,000 people attending clubhouses (known as members), that amounts to a national savings of almost $700 million annually. This figure could be far higher if more of the 15 million people in the US living with serious mental illness had access to these programs."[1]

When it comes to the allocation of scarce resources, the question is whose disability is more stigmatized: the "crazy," the "demented," or the "plain old"? Given that people with Alzheimer's and the frail elderly are never accused of violence by politicians and the media, we in behavioral health care have an uphill road to climb.

Although locating the Silver Center in the basement of our senior residence might appear to be a "step down," it amounts to a repurposing of what was once storage space and what could be more symbolic of lives that are worth more when not packed away in mothballs!

For the center is a beehive of such activities as meditation/relaxation, chair exercise, reach out, words with prompts, not alone project, Wayne's movie club, literary magazine, board games, horticulture project, silver story club, standards study, joy of music, silver sports club, advocacy meeting, animal art, bingo and watercolor, newspaper meeting, plus silver jam. And this is just the fun stuff that promotes interdependence and makes for a super-charged senior center.

Silver Center participants also partake in all the Fountain House services that foster independence, such as housing, employment, education, insurance, and financial

see Silver Center on page 39

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Overdose Safety in Older Adults: The Critical Role of Zero Overdose

By Thomas McCarry, LHMC, Julian Mitton, MD/MPH, and Jorge Petit, MD
Zero Overdose

The United States is grappling with an escalating public health crisis as overdose deaths continue to rise, and recent data underscores a distressing rise in opioid misuse and related overdose deaths among older adults. In NYC, there was a staggering 12% rise in overdose deaths in 2022 alone, marking the highest toll recorded since data collection began (NYC Health, 2023). Opioids, like fentanyl, were implicated in 85% of these fatalities. Among adults aged 55 to 64, the overdose rate reached 78.7 deaths per 100,000 residents, highlighting the acute vulnerability of this age group.

Data show a quadrupling of drug overdose fatalities among older adults over the past 20 years, surpassing increases seen in other age groups. These data also point to significant racial disparities, with elevated rates among non-Hispanic Black men and non-Hispanic Black women aged 65–74, having the highest drug overdose death rates in 2019 and 2020.

The increase in substance use disorders among older adults can be attributed to several factors, including prevalent prescription and misuse of opioids for chronic pain management and a certain degree of ageism, given that doctors often don't screen for drug misuse or use disorder during appointments with older people because of stereotypical assumptions about drug use in that age group.

This rise can also be attributed, in part, to the widespread prescription and misuse of opioids in managing chronic pain among older populations. Studies indicate that approximately 15% of community-dwelling adults aged 50 and above have been prescribed opioids, with up to 35% reporting misuse.[1][2] Correspondingly, emergency department admissions related to opioid misuse among older adults have skyrocketed by an alarming 220%.[3]

With opioids at the forefront of this surge, it is crucial to develop comprehensive strategies that encompass prevention, treatment, and sustained support. Recognizing and adapting to the specific needs of older adults in an approach to substance misuse/use disorder prevention and treatment is essential.

Addressing these issues requires tailored public health strategies that consider the unique needs and challenges of the aging population, including better screening practices and targeted interventions that address both the medical and social needs of older adults. Additionally, the complex interplay of chronic pain management and opioid dependency underscores the critical need for targeted interventions tailored to older adults. Zero Overdose addresses these challenges through its innovative Overdose Safety Plan©.

Overdose safety planning is a proactive approach designed to reduce the risks associated with drug and prescription medication use, particularly for individuals vulnerable to overdose. This strategy involves creating a personalized safety plan that includes considering overdose risks and ways to mitigate them, recognizing the signs of overdose, knowing how to respond effectively, and ensuring that resources like naloxone (an opioid overdose reversal medication) are readily available.

Central to this initiative is the destigmatization of substance use within older adult communities, fostering open dialogue and support mechanisms. Overdose safety planning should be offered to all individuals at risk of overdose, including older adults receiving a prescription for opioids. By equipping healthcare providers, caregivers, and community leaders with essential training and resources, Zero Overdose empowers primary providers and frontline responders to partner with their patients on overdose risk mitigation, recognize early signs of opioid misuse, understand the unique risks faced by older adults, and implement effective prevention strategies.

The effectiveness of overdose safety planning hinges on its comprehensive nature—it not only equips individuals with the tools and knowledge to handle potential overdoses but also engages them in managing their own health more actively. This may include regular monitoring for signs of increased overdose risk, such as changes in tolerance, periods of abstinence or reduced use, and use of multiple substances. By involving healthcare providers, family members, or friends in the planning process, the approach fosters a supportive environment that can significantly enhance the safety and well-being of individuals at risk.

The work of Zero Overdose highlights a crucial and growing need within public health responses—tailored interventions that address the specific challenges faced by older adults struggling with substance use disorders. By fostering community engagement, enhancing healthcare provider education, and implementing strategic overdose prevention initiatives, Zero Overdose is not only mitigating the immediate crisis but also paving the way for more resilient urban communities. As this group continues to grow, the need for such specialized and compassionate approaches will only increase, underscoring the importance of sustained effort and innovation in tackling the overdose epidemic among the elderly.

Looking ahead, Zero Overdose remains committed to expanding its impact through innovative partnerships and program enhancements. By continually adapting to the evolving needs of older adults in the opioid crisis, Zero Overdose not only saves lives but also cultivates a more informed and resilient community.

Thomas McCarry, LMHC, is CEO/Co-Founder and can be reached at tmccarry@zerooverdose.org; Julian Mitton, MD/MPH, is Medical Director and can be reached at jmitton@zerooverdose.org; Jorge Petit, MD, is Strategy and Development Advisor at Zero Overdose and can be reached at jpetit@zerooverdose.org.

For more information about our Overdose Safety Planning Specialist Training or how to support or get involved with Zero Overdose, please visit zerooverdose.org or reach out to us at info@zerooverdose.org and help make a difference in the lives of many.

Caring for Older Adults With Depression

By Jordan Baker
Content Marketing Manager
Relias

The population of older adults in the United States is growing at an unprecedented rate. From 2010-2020, the number of Americans aged 65 or older grew by 34%, with no signs of slowing down (United States Census Bureau, 2020). This large aging population presents several challenges for the healthcare industry, from housing to pharmacological complications to behavioral health issues. In recent years, research has begun to examine how all of these factors contribute to a rather high incidence of mental health conditions. In fact, 1-in-5 adults over the age of 55 experience some kind of mental health concern (National Council on Aging). One of the more prevalent of these conditions for older Americans is depression.

Risk Factors for Depression in Older Adults

As we go through life, we inevitably live through periods where life is unkind. From losing loved ones to slowing down physically, among other things, we'll all face times when feelings of sadness are unavoidable. For older adults, this process can be amplified, putting them at risk of depression.

Depression, however, does not just mean feeling appropriately sad as the result of an adverse event. Depression is a treatable medical condition, which, according to the DSM-5, presents as having five (or more) symptoms for a 2-week period, which represents a change from previous functioning (Florida Behavioral Health Center). These symptoms include (National Institute on Aging):

- A mood that is constantly low, anxious, or numb
- Feelings of despair, guilt, worthlessness, or helplessness
- Getting easily annoyed, restless, or fidgety
- Losing interest in activities that used to be enjoyable, including sex
- Having trouble focusing, remembering, or making decisions
- Having problems with sleeping, either too much or too little
- Feeling tired or drained of energy
- Slowing down in movement or speech
- Changing appetite or weight, either eating more or less than usual
- Having thoughts of death or suicide or attempting suicide

While depression can occur among anyone, it's especially prevalent among older adults living with Alzheimer's or dementia. When depression surfaces as a comorbidity to these other conditions, it can prove to be acute. In fact, researchers have noted that individuals with dementia and depression are at an increased risk of dying by suicide (National Institute on Aging).

Though these statistics are sobering, there are concrete steps your organization can take to improve the mental health of the older adults in your community.

How Your Organization Can Help

A great first place to start is to work with primary healthcare providers in your area and ensure they are properly conducting mental assessments of their patients. This could be as simple as asking how their patients are feeling and then taking that conversation more in-depth if they notice

see Depression on page 40

Improvement from page 20

These researchers administered comprehensive health assessments of participants beginning at birth and repeated at periodic increments thereafter. Final assessments were administered to participants upon their 45th birthday. Thus, this study yielded robust data sets that illuminated interrelationships among participants' health conditions, living habits, and life circumstances from which meaningful conclusions could be drawn. The study's longitudinal design permitted investigators to account for other variables to which the premature onset of physical illnesses commonly associated with the aging process might be attributed. Participants who developed a serious mental health condition during childhood or adolescence were significantly more likely to experience a subsequent onset of one or more chronic medical conditions than participants who did not develop a mental illness or corresponding diagnosis. These findings held even after certain factors known to cause or exacerbate certain medical conditions were eliminated. That is, they could not be attributed to poor childhood health, socioeconomic stressors, Body Mass Index (BMI), smoking, or the use of antipsychotic medications (medications commonly associated with metabolic dysfunction and other physical ailments) (Wertz et al., 2021). Moreover, the prevalence of physical ailments among individuals with mental illness was not limited to a specific manifestation of mental illness or select diagnostic classifications. Those with thought and mood disorders were similarly disposed to comorbidities and associated complications.

Ashley Brody, MPA, CPRP

The foregoing study suggests individuals with SMI are predisposed to the premature development of various physical illnesses commonly associated with aging, but it does not discount the role of protective factors and evidenced-based interventions in ameliorating dysfunction. In an exhaustive survey of current and emerging best practices in health care for older adults with SMI, Reynolds et al. (2022) highlight the role of certain clinical approaches in the restoration of individuals' functional capacities and alleviation of chronic or debilitating symptoms. For instance, proven pharmacotherapeutic and psychosocial interventions for older adults with schizophrenia include the selective use of antipsychotic medications coupled with such manualized treatments as Cognitive-Behavioral Social Skills Training (CBSST). CBSST aids participants in developing cognitive behavioral strategies, identifying precursors to relapse, cultivating social networks, and improving engagement and communication with healthcare and social welfare providers. Randomized controlled trials of CBSST demonstrated significant improvement in participants' social activities, cognitive insight, and mastery of problem-solving skills (Granholm et al., 2013). CBSST is one of several interventions that underscore the importance of holistic and integrated approaches to treatment for older adults with chronic and comorbid health conditions. Other researchers have affirmed what is largely self-evident to current providers of healthcare and social welfare services. Optimal care must entail multidisciplinary approaches that include clinical, rehabilitative, preventive, and supportive services (Palinkas et al., 2007).

To this end, stakeholders in the plight of older individuals with chronic and comorbid health conditions must address enduring structural impediments to the provision of optimal care. An acute shortage of safe, affordable, and supportive housing opportunities for these individuals is a leading impediment to progress. Older individuals are also more likely than their younger cohorts to experience poverty and its attendant economic stressors (e.g., food insecurity, limited access to transportation, etc.). Clinically-focused service interventions, however promising, may falter if offered to individuals who are unstably housed, homeless, or deprived of other resources essential for lasting health and wellbeing. Stressors associated with housing and economic instability are known to exacerbate an array of health conditions, and their effects may be especially grievous for physically and psychologically frail individuals. Current trends in homelessness affirm the scope of a crisis visited upon the most vulnerable members of our community. Older adults are the fastest-growing age group of those experiencing homelessness. They constitute nearly half the homeless population, and their ranks are expected to triple by 2030 (Henderson et al., 2023). To the extent affordable and supportive housing is available for this population, its operators often lack the resources or operational capacities to satisfy tenants' needs. A survey administered to supportive housing providers revealed rising concern among its respondents, 75% of whom reported they are unable to provide adequate care for older tenants with chronic and comorbid health conditions (Corporation for Supportive Housing, 2024).

Older adults, particularly those who experience comorbid behavioral and physical health conditions, require an integrated array of healthcare and social welfare services to achieve optimal health and stability. Isolated or siloed approaches to care and interventions that fail to address foundational components of health and wellbeing are bound to fail or, at best, produce suboptimal outcomes. Nothing short of a comprehensive restoration of the societal safety net will fulfill our obligation to the most vulnerable among us.

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Community Mental Health Promotion and Support Team Helps Older Adults Thrive

By John Javis
and Jeanne Morrison, LMSW
CEC Health Care

CEC Health Care operates a Community Mental Health Promotion and Support (COMHPS) team that provides emotional support, wellness activities, screenings, and referrals to treatment in Western Nassau County. A multi-disciplinary team of licensed mental health professionals and paraprofessionals seeks to engage the general public in mental health wellness activities by providing information and resource tables, conducting small groups and classes, and having individual meetings in person or by phone to discuss mental health concerns and available resources.

COMHPS is the successor program to Project Hope. During COVID, CEC Health Care participated in Project Hope, a FEMA-funded program that provided crisis counseling and referrals to mental health treatment to assist the general public in managing the stress of the pandemic. The CEC Project Hope Team was present at a COVID vaccination site, conducted both virtual and in person wellness groups, and provided a high volume of individual sessions by phone to provide crisis counseling and support.

Older persons struggled during the pandemic, with isolation being the prominent issue. Family members feared becoming ill themselves or feared transmitting COVID to the older members of their family. Due to the lack of healthy outlets during the COVID lockdowns, family members became less patient with each other, and tensions arose. Seniors contacted the Project Hope staff, expressing feelings of anxiety, vulnerability, and helplessness. The team also provided grief counseling when loved ones were lost to COVID.

At the end of 2022, as the COVID pandemic dissipated, FEMA ended the funding for Project Hope. The New York State Office of Mental Health then decided to use the lessons learned from Project Hope to develop a new program model called Community Mental Health Promotion and Support (COMHPS). COMHPS retained the community engagement model of Project Hope but changed the focus from pandemic-related crisis counseling to promoting mental health wellness and resiliency. COMHPS also utilizes concepts from the substance use "Prevention" programs operated by NYS OASAS.

Based on its success with Project Hope, CEC Health Care was awarded a COMHPS team for Western Nassau County. Several of the former CEC Project Hope staff, including the leadership, were retained by the agency to work in the new COMHPS program.

The team regularly attends health fairs, community festivals, senior centers, assisted living, nursing homes, libraries, food pantries, soup kitchens, farmers markets, veterans' organizations, and schools. The teams will provide information and resource tables, conduct small groups and workshops, and provide individual support via phone and text. Staff are also trained to recognize and respond to severe emotional distress and suicidality and to take appropriate action as needed.

Pictured Left to Right: COMHPS Team Members Carolyn Tynan, Debra Soon and Team Leader Jeanne Morrison

The COMHPS team has also been trained to utilize a standardized screening tool. The tool helps shape the conversation when an individual is seeking assistance. Frequently, individuals initially approach the COMHPS team with questions about concrete issues (i.e., benefits, housing, insurance, etc.), but if a behavioral health concern is discovered later in the encounter, the team uses the tool to screen for various mental health issues (including suicidality); the team will also assist the individual in being referred and accessing the appropriate service.

In 2023, the CEC COMHPS team encountered over 7,200 individuals at tabling events, provided in person classes and individual support to over 9,100 individuals, and served over 1,900 persons via phone or text.

The CEC COMHPS team has successfully encountered and engaged older adults in senior centers, nursing homes, assisted living, and libraries. Seniors served by the COMHPS team often experience isolation because younger family members have moved away or are reluctant to share their feelings with their families.

Some seniors struggle with how much the world has changed since they were younger, especially regarding technology. One concerning theme is that seniors are becoming more and more fearful about being the victim of violence. Another theme is that seniors fear a loss of control, such as being unable to drive, not being able to shop for themselves, and an inability to care for their personal needs. Questions and concerns about developing Alzheimer's and Dementia are also frequently raised.

Staff report that older persons seek conversations surrounding grief and loss; COMHPS often utilizes the "stages of grief" in groups conducted at senior centers. Anniversaries, particularly the anniversary of the death of a spouse, are particularly painful.

Older persons welcome the opportunity to express themselves and receive support in group and individual settings. They report that contact with others by phone or video is not as satisfying as in person contact. One activity conducted by the COMHPS team involves groups where older persons share "life lessons" with younger individuals. This fosters a greater sense of community.

An inflection point for many older persons is when they first retire from the workforce. One's identity is often tied to their work, and the ending of their career can result in a loss of that identity. The COMHPS team seeks to assist seniors to stay active and to develop a new sense of purpose.

The COMHPS team uses a variety of modalities to engage seniors and the general public. Crafts, art activities, and memory games serve as icebreakers and conversation starters for group activities. One activity utilized by the COMHPS team with seniors involves "reconciling the past," where seniors come to grips with it and learn to "let go" of past hurts.

The Western section of Nassau County is becoming increasingly diverse with a growing Hispanic population. Many COMHPS staff are bilingual in Spanish and try engaging Spanish-speaking seniors in various settings.

As part of serving older persons, the CEC COMHPS team has also successfully engaged older veterans, particularly Vietnam veterans in their mid to late 70's. COMHPS has one staff member who is an Iraq veteran and another who directed the Nassau County VET Center; both are highly skilled in assisting veterans.

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Understanding Teenage Self-Harm: Strategies for Prevention and Support

By Scott Bloom, LCSW
Director of Special Projects
New York Psychotherapy and Counseling Center (NYPCC)

I needed to cut, the way your lungs scream for air when you swim the length of the pool underwater in one breath. It was a craving so organic it seemed to have risen from my skin itself (Kettlewell, 2000). This striking yet genuine comment reflects how many teenagers feel when engaging in self-harm. Although this destructive behavior can be treated, it is crucial to understand the underlying emotional distress adolescents experience, the reasons behind their actions, and the practices that can reduce feelings of depression, anxiety, and low self-worth to prevent further self-harm.

Understanding Self-Harm

Self-harm, also known as non-suicidal self-injury (NSSI), involves the deliberate, non-accidental injury to one's own body tissue without suicidal intent (Favazza, 1999). This behavior often arises from unwanted emotions such as depression, anxiety, or anger, leading to an intense focus on self-injury and frequent thoughts of harming oneself. Self-harm can take various forms, including cutting, burning, scratching, hitting, or picking at the skin. It has been shown to include engaging in such behaviors on five or more days over the past year and using it to relieve unwanted feelings, resolve relationship conflicts, or create a desired emotional state (Young Minds, 2021).

Most mental health surveys completed by teens do not include specific questions about self-harm; however, there are mental health factors and issues that can lead to this behavior one must look out for (Adrain, 2018). These would include feelings of depression, hopelessness, and sadness for two or more weeks. In a recent study, the percentage of NYC public high school students reporting feelings of sadness or hopelessness increased from 27% in 2011 to 38% in 2021(Hamwey, 2024). Among teens identified with depressive symptoms, 48% had minimal symptoms, 27% had mild symptoms, 14% had moderate symptoms, and 11% had severe symptoms. Other risk factors include experiencing a mental health disorder, being a young person who is not under the care of their parents, or young people who have left a care home, and being part of the LGBT community (Recovery Village, 2024). It is important to remember that although these are risk factors that can make someone more likely to self-harm, having any of these does not mean someone will self-harm.

One of the most common stereotypes is that self-harm is merely 'attention-seeking.' This is inaccurate. Many individuals who self-harm do not disclose their struggles for a long time, and it can be extremely difficult for them to find the courage to ask for help. It is important to understand that self-harm is distinct from suicide: a person attempting suicide seeks to end all feelings, whereas a person who self-harms seeks to feel better (Favazza, 1999). Clinicians should recognize that self-harm is typically a carefully controlled behavior intended not to end life but to cope with it.

"I felt like I was isolated from the world, dead, with no emotions at all. The blood told me I was alive, that I could feel…Also I couldn't cry, and bleeding was a different form of crying" (Strong, 1999). There is no single clear cause for self-harm. However, young people who engage in this behavior often experience overwhelming emotional pain. Some report feelings of loneliness, worthlessness, or emptiness and will do anything to alleviate these feelings, even temporarily. Others feel overstimulated, misunderstood, or fearful of close relationships. Additionally, some individuals feel overwhelmed by school and family responsibilities or seek to punish themselves for perceived wrongdoings.

Factors Contributing to Teenage Self-Harm

Adolescents experiencing intense emotions may resort to self-harm as a coping mechanism. For example, individuals who cut may not view it as an intense *problem* but rather as a *solution* to their emotional turmoil, which can be challenging for parents to comprehend. This creates a *push-pull* dynamic: teens seek to end their suffering, and self-harm provides a quick, albeit temporary, relief. Research indicates that self-harm, such as cutting, triggers the brain to release chemicals similar to opiates, reducing amygdala activity and offering a momentary escape from emotional distress. However, the rapid burst of endorphins only produces short-term effects and does not address the underlying issues (Young Minds, 2021). This behavior aligns with Freud's *pleasure principle*, which posits that the mind seeks to achieve pleasure and avoid discomfort, aiming to eliminate tension and attain satisfaction (Freud, 1961).

Several factors may contribute to the development of self-harm behaviors in teenagers (Foye, 2023):

- **Mental Health Issues:** Teenagers struggling with mental health conditions are at a higher risk of engaging in self-harm as a maladaptive coping mechanism.
- **Peer Pressure and Bullying:** Social dynamics, including bullying, peer pressure, and social isolation, can significantly impact a teenager's self-esteem and sense of belonging, driving them toward self-harm to cope with emotional pain.
- **Family Dynamics:** Family conflicts, dysfunctional relationships, or a lack of emotional support at home can exacerbate feelings of loneliness and alienation in teenagers, increasing their vulnerability to self-harm.
- **Academic Pressure:** Academic expectations and performance-related stress can overwhelm teenagers, leading to feelings of inadequacy and failure, which may trigger self-harm as a coping mechanism.

Prevention and Intervention

Teenage self-harm is a complex issue that necessitates a multifaceted approach encompassing prevention, education, support, and intervention. There is no single

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Supporting Socially Isolated Seniors

By Judy Fink, LCSW
Director of Senior Services
Westchester Jewish Community Services

For many seniors, especially those who live alone, life can become progressively more challenging and isolating, compromising their ability to age well and safely in place. According to a report from the National Academies of Science, Engineering, and Medicine, nearly one-quarter of adults age 65 and older are considered to be socially isolated, and 43% of adults age 60 and older report feeling lonely. Social isolation is described in the *U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community* (Murthy, 2023) as "having few social relationships, social roles, group memberships, and infrequent social interaction" (Badcock et al., 2022; Holt-Lunstad & Steptoe, 2021) and loneliness is defined as "a subjective distressing experience that results from perceived isolation or inadequate meaningful connections," (Prohaska et al., 2020; NASEM, 2020), both can be harmful to one's emotional and physical health. Social isolation is associated with an increased risk of dementia, heart disease, stroke, and death. Loneliness is associated with higher rates of depression, which may impact motivation to maintain one's physical and mental health.

Addressing issues faced by the elderly is increasingly important in Westchester County, New York, where people 65+ compose the fastest-growing age group and represent 18.4% of the population in 2022.

Seniors living on limited incomes in Westchester often face insecurity, with 8% of seniors 65+ living in poverty and more than 39% of people 65+ living alone.

Westchester Jewish Community Services (WJCS), one of the largest human service agencies in Westchester County, New York, serving people of all ages and backgrounds, is dedicated to helping seniors age in place safely and with dignity. We recognize that seniors often experience health challenges that make shopping, driving to medical and dental appointments, and socializing difficult. Being involved in the community becomes a struggle. The death of a spouse or friend, the demands of being a caregiver, and the difficulty of traveling to see friends can all create a sense of social isolation. Those who enjoy and are no longer working often lack a sense of purpose and vitality.

WJCS offers a wide range of programs, services, and activities to help seniors maintain a sense of safety, identity, self-esteem, and self-worth.

Our senior programs are aimed at supporting low-income seniors in Westchester County, so they have the opportunity to age safely and well in their homes or communities with dignity and give peace of mind to their family members and caregivers. Programs are offered at no charge or on an income-based sliding scale and extend beyond health and wellness for seniors to include support for their loved ones, including dementia support, end-of-life care, and bereavement services.

WJCS services for seniors and their families include:

Geriatric Care Management: WJCS offers comprehensive services, including in-home assessments, personalized care planning, ongoing case management, guidance about senior living options, referrals for home health care, and legal and financial advice. Our experienced staff members are adept at working with out-of-town families to oversee and coordinate long-distance care.

Isolation to Connection: Through this free program, caring professionals work with isolated older adults to assess their needs and connect them to an array of community-based services, including home-delivered meals, transportation, vaccine appointments, ongoing case-management programs, home-based medical services, telephone or in-person counseling, home care, and social programming.

Respite for Caregivers: *Project Time-Out* is our respite services program that gives caregivers the opportunity to attend to medical, social, recreational, or business matters while providing stimulating companionship, supervision, and socialization for their loved ones. Program coordinators offer free assessments of a family's respite needs and referrals to home health care and legal and financial experts. Carefully screened, experienced, and trained consultants are matched with families to offer relief from caregiving responsibilities on a flexible basis. The cost for families requesting an in-home companion and who are caring for an older dependent adult is based on the Westchester County Department of Senior Programs and Services EISEP sliding scale, determined by the income and expenses of the older adult or married couple. WJCS also offers caregivers of older adults an *Escort Program* that enables caregivers to enlist an escort to accompany their senior loved one to a doctor's visit, shopping trip, errand, movie, or restaurant. The escort service itself is free. Users are responsible for arranging transportation and any costs associated with the outing.

Livable Community Connection Project: This program encourages people to work proactively at the grassroots level to create communities where older people can remain at home, stay healthy and connected to friends and family, and be actively engaged in their communities. *Livable Community Connections* services include health, wellness, educational, and cultural programs along with support services, such as accessible transportation, personal safety, and advocacy for affordable housing, safe sidewalks, and roads.

Northeast Yonkers NNORC (Neighborhood Naturally Occurring Retirement Community): In partnership with the City of Yonkers Office for the Aging, WJCS provides a wide range of activities, services, and resources to seniors 60+ in Northeast Yonkers to help them maintain their quality of life and independence as they remain connected to their neighborhoods. With 17% of its population being age 65+, Yonkers is the oldest city in New York State. WJCS is employing a preventative, early intervention, cost-effective approach to deliver services to this type of densely populated naturally occurring senior community – a model that can be duplicated in similar communities.

Assistance to Individuals with Dementia and Their Caregivers: WJCS provides professional assistance to individuals and families caring for a loved one with Alzheimer's or other forms of dementia (through the New York State Department of Health Alzheimer's Disease Caregiver Support Initiative). Our compassionate and specially trained staff offer care consultation and clinical assessments, individualized care planning, resource referrals, individual and group counseling, discussion and completion of advanced directives, as well as specialized home care and respite services.

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Total Wellness at Urban Pathways: Focusing on the Needs of Older Adults

**By Romi Avin, LMSW, MS, HS-BCP,
Jose Cotto, LCSW,
Anne Handford, MPH, CHES,
and Mardoche Sidor, MD
Urban Pathways**

Founded in 1975, Urban Pathways has long been a beacon of hope for those in need of supportive housing and comprehensive care. Today, under the leadership of CEO Frederick Shack, Urban Pathways serves over 3,900 people across a variety of 20+ services and programs in NYC. UP operates outreach teams, drop-in centers, safe havens, apartment treatment, supported housing, affordable apartments, and specialized programs to address employment and health needs.

As many nonprofit agencies have noticed over recent years, the number of people aging in place has significantly increased despite care models remaining the same. In the past year alone, UP has served 1088 unique individuals who are 55 years of age or older. People's lives have become more complex (comorbidities, impact of the pandemic, increased needs), while staffing patterns and funding have become a bit antiquated. This has led to a more assertive, creative approach by agencies like UP to address a growing need, especially among older adults.

In 2015, the Total Wellness Program was created in response to an increase in medically related 911 calls and ER visits. It emphasizes holistic care, addressing the physical, mental, emotional, and spiritual needs of the people being served. This program is particularly vital for the growing population of older adults within their supportive housing community. It began with one program and now collaborates closely with about ten programs, including safe havens, permanent Supported Housing, NYCHA apartments, and affordable housing. In 2023, 417 people were served by this initiative. Of those, 65% were 51 years of age and older. Folks benefiting from the Total Wellness Program often carry multiple diagnoses, with at least 50% struggling with three or more chronic diagnoses. Diagnoses include endocrine, nutritional, metabolic, and circulatory diagnoses, infectious diseases, cancer, and substance use disorders. The approach of the program is aligned with New York's triple aim, which is to improve care, improve health, and reduce costs.

The Total Wellness Program consists of a Medical Director, Project Coordinator, Wellness Social Worker, Peer Specialist, Case Managers, Licensed Practical Nurses, and Medical Assistants. All other Urban Pathways staff receive relevant training and consultations from the TWP. Consultation sessions, facilitated by Dr. Sidor, take place every Thursday from 3-5 pm.

Romi Avin, the Program Director at Ivan Shapiro House, has been a pivotal figure in recognizing and addressing the needs of the aging population within supportive housing. Observing a significant increase in older adults, Romi spearheaded efforts to integrate a specialized focus on geriatric care within the Total Wellness Program. This initiative aims to ensure that every person receives comprehensive care tailored to their unique needs, promoting healthy aging and enhancing quality of life.

Each program site maintains a community partnership with a Federally Qualified Health Center that provides primary and specialty care in their respective community. The Total Wellness Project Coordinator, Anne Handford, Program Nurses, and Case Managers work to connect all residents to physical and mental health care, with linkages to specialty care and substance use services as needed. Program Nurses and the Project Coordinator provide group and one-on-one health education and work to increase residents' knowledge of how their lifestyle and health behaviors impact both risk factors and protective factors for chronic and infectious diseases. All staff members aim to support people in building self-efficacy for appointment and medication adherence and to promote a culture of health and wellness.

Health education workshops and wellness events are held at 6 of our sites a year. Topics range from hypertension, diabetes, self-esteem, intimacy, sexual health, employment, healthy aging brains, and budgeting. These workshops help to address all aspects of one's overall total health. It's an approach Urban Pathways takes to help expedite a person's recovery so they can achieve and sustain their life goals and age in place.

As we delve into the stories of several folks, we see the profound impact of this program and the dedicated work of one of our Program Directors, Romi Avin, LMSW, and the Total Wellness Program Coordinator, Anne Handford, MPH.

The Challenge of Aging and Alcohol Use Disorder

A 66-year-old man is facing significant hurdles due to his alcohol use. Despite his desire to transition into assisted living, his use has led to repeated denials. Romi and Anne have been instrumental in providing comprehensive support, helping him navigate the complex web of healthcare, social services, and personal recovery. Through motivational interviewing and consistent medical accompaniment, the program aims to foster a healthier relationship with alcohol and support him in reaching his goal of moving into assisted living. The teamwork goes beyond traditional case management.

Addressing Hoarding Behaviors in Social Isolation

The pandemic-induced social isolation has led to unintended consequences for many, including a person in her 60s who developed hoarding behaviors. This behavior has caused challenges in apartment upkeep and has exacerbated her mental health conditions. The program is providing targeted interventions that address the root causes of her hoarding behavior. By fostering social connections and offering mental health support, the program aims to improve her living conditions and overall well-being (BMC Public Health). Safeguards are also being put in place to support this person better as they reduce their hoarding. Opportunities for socialization are explored and normalized through community resources (spiritual centers, places of special interest, etc.), social media, and gatherings/events facilitated by the TWP and dedicated program site operations and social service staff.

The Invisible Struggle with Dementia

A 67-year-old man presents a poignant example of the challenges faced by older adults in supportive housing. He appears much older than his age, often wanders, and struggles with memory issues, likely exacerbated by undiagnosed dementia. The team is stepping in to provide the necessary support for dementia care, ensuring he receives the medical attention and social support required to manage his condition. This also includes providing different options for him, such as life alerts, home attendant services, visiting nurses, appliances that reduce risks of fire, a reliable and consistent check-in system, and so on.

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Addressing Social Isolation and Loneliness in Older Adults

By Sasha-Marie Robinson, EdD, LCSW, MA
Senior Vice President of Recover and Treatment Services
Services for the UnderServed (S:US)

Social isolation and loneliness are health risks that affect a quarter of Americans 65 and older (National Academies of Sciences, Engineering, and Medicine, 2020). Social isolation is defined as the objective state of having few social relationships or infrequent social contact with others, and loneliness is defined as a subjective feeling of being isolated (Cudjoe et al., 2020). Studies have shown that social isolation and loneliness have negative effects on a person's physical and mental health (De Jong, van Tilburg, & Dykstra, 2016). As the behavioral health population ages, their health challenges increase and have been shown to create feelings of loneliness (Domènech-Abella et al., 2019).

Most recently, due to COVID-19, there has been a period of increased isolation across the world. The pandemic called for unprecedented seclusion to prevent transmission of the virus. The risk of infection was higher for specific populations, namely older adults over the age of 60 (US CDC, 2020). While employing these public health measures assisted in the reduction of the transmission of the virus, we experienced an increase in isolation and loneliness among older adults (Hwang, Rabheru, Peisah, Reichman, & Ikeda, 2020). Older adults with a mental health diagnosis also experienced higher levels of loneliness and isolation (Donizzetti, 2022).

As a behavioral health provider, the impact of social support on the overall health of an individual is well known. Cohen, Underwood & Gottlieb (2000) state that social support is important for retaining or improving an individual's health and well-being when living with health challenges.

At Services for the UnderServed (S:US), we provide support to approximately 37,000 individuals with co-occurring health conditions on an annual basis; of those served, about 15% are 65 and older. S:US trains staff at all levels to provide client-centered care with a focus on providing care based on the specific needs of each individual, taking into account their environment and current resources. Our interconnected programs aim to serve the "whole person" by providing holistic care that focuses on identifying not just health needs but social needs as well. This was our goal before COVID-19 and continues to be a key focus, as providing support related to socialization and recreational activities has been shown to be beneficial for individuals who have a mental health diagnosis (Forrester-Jones et al., 2012).

S:US operates several programs on its own and collaboratively works to support each person served with health needs as well as socialization. Our Certified Community Behavioral Health Clinics (CCBHC), Clubhouse, and Street Engagement teams are a few programs that also serve as the entry point into our system of care. CCBHCs are an outpatient model which utilizes a multidisciplinary team to apply evidence-based treatment, psychiatric rehabilitation, case management, and peer support services both on-site and within the community. At our CCBHC, an individual can spend the day receiving services from different providers while joining groups that are geared towards their behavioral health and social needs. All services are available on-site, in the person's home, and through telehealth. These different modes of services allow persons served to readily access care no matter their circumstances. As a result of the services provided, many are connected to needed support in their homes and community, such as home health care, transportation, and connections to our Clubhouse or any other programs they can attend during the day.

Clubhouses are community-based and are aimed at supporting people living with mental illness (referred to as members). Clubhouse offers a community where members have access to opportunities for socialization and skill development. An individual who joins and attends our Clubhouse as a member spends the day working in "units" specific to different skill-developing tasks. Currently, we have units that focus on the development of skills such as outreach, newsletter production, and other activities that can be used in the operation of the Clubhouse. Another unit focuses on culinary skills, allowing members to participate in the preparation and creation of meals, a skill that is transferable to their own home environment. The members also have the opportunity to socialize while they work and at mealtimes with other members, which has been found to boost their sense of community.

Our Street Engagement teams engage individuals and older adults based on specific needs such as substance use or homelessness. Individuals are able to get one-on-one services in the community from the team to assist with specific needs as well as support the individual with socialization. Currently, the teams we operate serve communities in Brooklyn, Harlem, and the Bronx. They provide support and engagement opportunities and connect individuals to our outpatient and housing programs.

Our CCBHCs, Clubhouse, and Street Engagement teams are all staffed with licensed practitioners, case management, and certified peer staff. Specifically, peer support has been shown as an intervention that can positively address social skills and support, thereby promoting recovery in mental health and related services. Peers are individuals who have lived experience with mental health and/or substance use; they are trained to use their experience to support others with similar conditions. In all of the program types mentioned, peer staff often share their lived experience when dealing with isolation and loneliness during their own recovery. In addition, a peer supports the individual by providing resources for services while also accompanying them to aid with understanding and integration.

Social isolation and loneliness were well-noted risk factors among the aging population before the pandemic, and they have increased since then. There is evidence that social connection is a protective factor for those at risk of experiencing social isolation and loneliness. To fully address the health needs of the people served, organizations need to be intentional in the integration of social connectedness across the continuum of care (Holt-Lunstad, 2021).

Programs that support the whole person through many different service modalities, including peer support, assist us in not only addressing the health needs of the aging population but also providing them with support to reduce the likelihood of social isolation and loneliness, thus improving their overall health outcomes (Fortuna et al., 2020).

Sasha-Marie Robinson, EdD, LCSW, MA, is Senior Vice President of Recovery & Treatment Services at Services for the UnderServed (S:US). To learn more about Services for the Underserved's approaches to care, visit sus.org, call 877-583-5336, or email services@sus.org.

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SPOP
SERVICE PROGRAM FOR OLDER PEOPLE

HEALTHY AGING

Behavioral Healthcare for Older Adults: It's All About Resiliency

By Catherine Thurston, LCSW
Chief Executive Officer
Service Program for Older People (SPOP)

It is with great excitement that I step into the role of CEO of Service Program for Older People (SPOP), a position I assumed on July 1 following the retirement of our long-time CEO, Nancy Harvey. It is a tremendous honor to be entrusted with the leadership of an agency that has transformed the lives of older New Yorkers for nearly 40 years.

I entered the field of aging and behavioral health when I was 19, working as a member of one of the only mobile behavioral health teams for older adults in New York City. I loved the work and never really strayed far from it, as I gained my MSW from Hunter College School of Social Work and pursued opportunities in various settings, including hospitals, long-term care administration, and aging services providers. I have served as Chief Program Officer at SPOP since 2016, and I look forward to sharing my thoughts on aging and behavioral health in this column.

Located in New York City, SPOP is one of only a handful of agencies in the country entirely dedicated to community-based behavioral healthcare for older adults. I view SPOP as a true pioneer in the field and a model for how other cities and communities can support the well-being and independence of older adults. We serve some 1,000 older New Yorkers each year, and our Clinic and PROS program (the only one for older adults in New York State) offer individual and group therapy, psychiatry, medication management, assessments, psychiatric rehabilitation group support, and linkages to other agencies and organizations that provide services to support aging in place. Much of our work is now done by telehealth, which has been a valuable tool for clients who are managing transportation challenges, frail health, or mobility impairment.

Throughout my career, one of the most profound lessons I have learned – and continue to learn every day – is that there is nothing "generic" about aging. Our client population spans at least four decades and reflects the economic, ethnic, racial, and gender diversity of New York City. Each client brings a long and complicated history to the process, and we aspire to listen without any preconceptions about aging, race, ethnicity, sexual orientation, gender expression, or financial status.

The most common diagnoses that we see in our clinic are depression and anxiety, though we also treat clients for a multitude of other presenting issues. Social isolation, economic insecurity, caregiver distress, chronic illness, and alcohol or substance misuse have always been contributing factors to our clients' well-being, and all of these became much more acute during the pandemic.

Our team of mental and behavioral health professionals all have deep expertise working with adults over age 55, and many identify as LGBTQA+, people of color/multiracial, bilingual, or having lived experience as an older person or mental health consumer. To a person, they bring an extraordinary dedication to their work, which translates to a 97% satisfaction rate among our clients.

Resilience is the word that comes to mind when I think about the SPOP community. Yes, each client becomes older while they are at SPOP (as have I!), but they also learn, grow, and change during treatment. We strive to create an environment that is free of negative stereotypes about aging as we encourage clients to focus on their strengths, not on their chronological age, and work toward new goals.

Each year, I see our clients – some well into their 90s – achieve sobriety after decades of alcohol or substance misuse, learn to understand and resolve grief after the loss of a partner or acquire self-regulation skills to manage symptoms of anxiety or depression. Others have resolved deep-seated emotions rooted in trauma or abuse, found ways to define and celebrate holidays in meaningful and joyous ways, or learned how to acknowledge the challenges of chronic illness and how to accept assistance from others. Our clients – and our therapists, psychiatrists, schedulers, receptionists, and intake staff – are an unending inspiration for me.

Older adults are the fastest-growing population segment in much of the country. We know that behavioral healthcare can play a role in improving their overall well-being, reducing social isolation, and increasing their independence. We also know that greater independence can translate into reduced expenses for everyone.

I hope that we can expand this conversation about aging and behavioral health and work together to eliminate negative stereotypes and increase access to services and treatment for all ages. Please reach out to me at cthurston@spop.org with your ideas about how to support the resilience and well-being of our older friends, neighbors, and family members.

Visit www.spop.org to learn more about Service Program for Older People (SPOP) and its work as a community-based behavioral healthcare provider for older adults in New York City.

Catherine Thurston, LCSW, was appointed Chief Executive Officer of Service Program for Older People (SPOP) in July 2024, having previously served as Chief Program Officer for eight years. She has over 35 years of experience in gerontological social work, including serving as Chief Services Officer at SAGE/Service &

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Elder Abuse and Mental Health: Victims, Perpetrators, and Potential for Change

By Katherine O'Malley, MPH
Policy Analyst
Boston University School of Public Health

Elder abuse is increasing in the United States (US) as more Americans age and become vulnerable to various forms of mistreatment (Chang & Levy, 2021). This kind of abuse can have significant effects on mental health, not only for older victims but for perpetrators of abuse, too.

Identifying elder abuse, who it impacts, and how it intertwines with mental health can be challenging. However, it is the first step in addressing the problem and guiding interventions.

Elder Abuse: A Snapshot

Elder abuse affects about 10 percent of adults over 70 in the US annually, though this is likely an underestimate (Rosay & Mulford, 2017).

Elder abuse can be difficult to recognize and comes in different forms, including physical abuse, emotional or psychological abuse, neglect (including self-neglect), abandonment, sexual abuse, and financial exploitation. Obvious signs that abuse may be occurring include unexplained injuries or bruises, unusual weight loss, or unclean living conditions. However, there can also be more discrete signs, such as unusual changes in sleep and behavior, increased anxiety, or unpaid bills (National Council on Aging (NCOA), 2021).

While elder abuse can be committed by anyone, family members are often the main perpetrators. Researchers at the University of Southern California found that, among callers to the National Center on Elder Abuse's resource hotline, nearly 50 percent reported abuse at the hands of a family member (Weissberger et al., 2020).

The Link Between Elder Abuse and Mental Health

Some older adults may be more vulnerable to elder abuse than others, such as those with cognitive impairment, those experiencing social isolation and depression, and those with small or no social networks (NCOA, 2021; Koga et al., 2020).

Though depression may put older adults at greater risk for abuse, the relationship between mental health and abuse isn't so simple. In fact, research suggests that depression is both a risk factor *and* an outcome of elder abuse.

In one study, older adults with existing depression were about two times more likely to experience elder abuse than counterparts without depression. Concurrently, older adults without mental health concerns who then experienced elder abuse were about two times more likely to experience depression in the following three years (Koga et al., 2020).

Suicidal ideation can also result from elder abuse. Researchers in China found that older adults who experienced elder abuse were much more likely to experience suicidal ideation than those who were not abused (almost 18 percent versus two percent) (Wu et al., 2013).

Perpetrators of Elder Abuse Face Their Own Mental Health Challenges

It's no surprise that victims' poor mental health outcomes and elder abuse are related.

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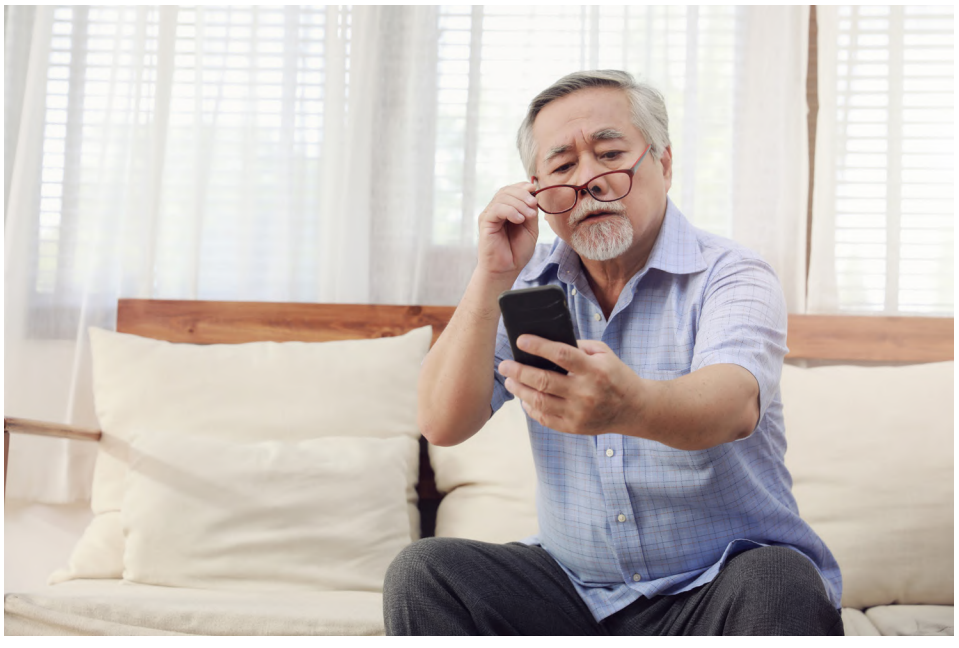
Aging Vision: How Social Workers Can Help Address Vision Loss

By Lisa Beth Miller, LCSW-R, BCD
Outreach and Referral Coordinator
Lighthouse Guild



What happens to someone who wakes up one morning and can no longer see? It could happen to any of us at any time - clinician or client. Stoic wisdom might suggest that one prepares for loss by imagining it has already happened and resolving to accept the change, to embrace life fully, whatever happens. How do we prepare?

Vision changes are an expected part of aging. The need for reading glasses may be the initial sign of losing elasticity in the eyes when changing focus near or far, adjusting between light and dark, outdoors and indoors, or day and night. With the expanding aging population, many wonder whether their vision changes are within the range of normal eye aging or a serious eye condition that may significantly worsen vision, possibly requiring medical treatment. Only an eye doctor can determine the difference; early detection and treatment may help maintain vision.

Vision loss often triggers or worsens depression and anxiety, and depression and anxiety may worsen vision. This bi-directionality of physical and mental illness suggests that the approach to wellness and recovery benefits from addressing vision function and emotional function concurrently, when possible.

What Else Do You Need To Know About Vision Loss?

Regular comprehensive eye exams are crucial for the early detection of eye disease. During COVID, non-urgent doctor visits were paused. If you or your clients haven't recently had an annual eye exam, now is a good time to set one up. Healthy eating and exercise habits support eye health, too. When regular glasses, contact lenses, medication, or surgery can no longer correct vision problems, a referral is made to a low-vision optometrist, who prescribes specialized glasses or a magnifier and recommends tools and exercises to help people read, work, socialize, and enjoy other activities. Even those who are totally blind may benefit from a low vision exam and may be prescribed protective sunglasses.

Eye drops or injections may prevent or reduce the progression of vision loss from some common eye conditions, such as glaucoma and macular degeneration. In February 2023, the first FDA-approved drug treatment for dry macular degeneration was announced and other treatments are in the pipeline, awaiting approval. Clinical trials provide access to participation in promising new research and can be located online at the National Eye Institute and clinicaltrials.gov. Only an eye doctor can prescribe treatment.

Medical conditions affecting vision include stroke, traumatic brain injury, cataracts, diabetic retinopathy, detached retina, Retinitis Pigmentosa, Usher Syndrome, optic nerve atrophy, albinism, Stargardt Disease, and Charles Bonnet Syndrome. Magnifiers and task lighting are low-tech tools for increasing functional vision. Adding lamps that are easy to turn on and changing to LED bulbs may help. Clearing any clutter and cords on the floor at home reduces fall risks. High-tech devices include electronic readers, CCTVs, and handheld readers, which enlarge text. Some devices audibly narrate text and describe individuals in the room. Many free phone apps magnify text and read aloud. Computerized sight canes aid with navigation.

Who Helps?

For direction and guidance, social workers can help sort through negative emotional reactions to the loss of vision and learn about the resources available. As knowledgeable, supportive listeners and thought partners, social workers can plant seeds

see Aging Vision on page 47

Enhancing Geriatric Behavioral Health: Best-Practices and Technology-Assisted Care Solutions

By Jorge R Petit, MD
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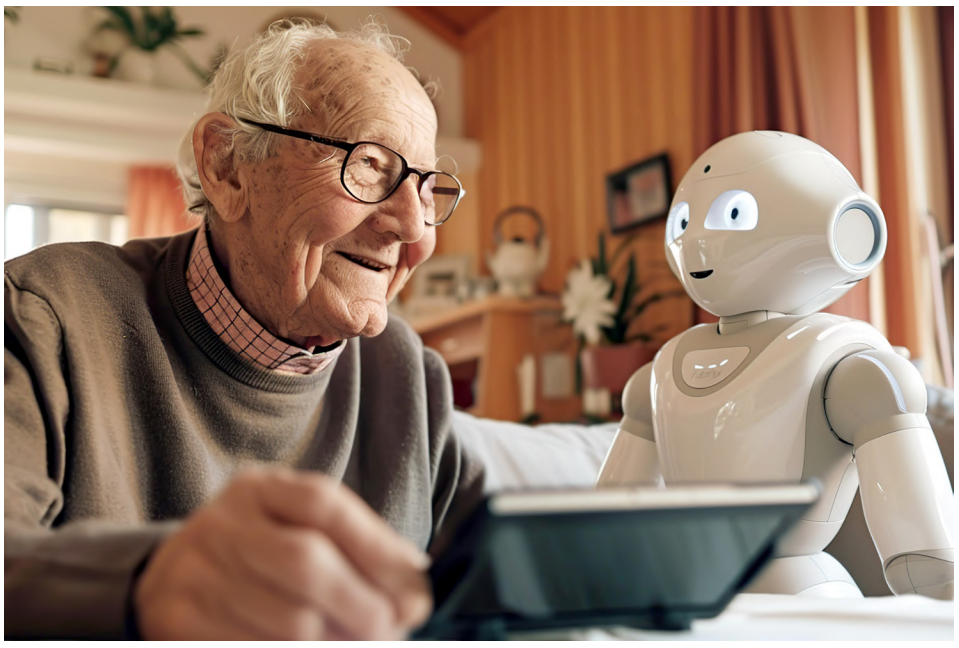

As the United States grapples with the realities of an aging population, the importance of adapting our health and social service system of care to meet the needs of older adults has never been more critical. In 2020, approximately one in six people in the U.S. were aged 65 or over, highlighting a significant demographic shift. This group has now reached 55.8 million or 17% of the total population, which is a 38.6% increase over the previous decade.

The older population not only requires more healthcare resources but also needs tailored behavioral health services that are sensitive to the complexities of aging. America's Health Rankings Senior Report points out a number of health disparities among older adults that impact overall healthcare and calls out the required changes needed in the healthcare system in order to innovate and expand services that cater specifically to this age group.

A recent SAMHSA report [2021 and 2022 National Surveys on Drug Use and Health (NSDUH)] provides critical insights into the behavioral health trends among older adults, focusing on substance use, mental health, and treatment needs within this demographic.

Listed below are a few of the relevant findings from this report:

- An estimated 12.5% of older adults had any mental illness (AMI) in the past year, with a smaller subset (1.9%) experiencing serious mental illness (SMI).

- About 16% of older adults received some form of mental health treatment in the past year, but there is a large perceived unmet need for mental health services among those who recognize their issues but do not seek help.

- Around 9% of older adults had a substance use disorder in the past year, but fewer than one-third of those who needed substance use treatment actually received it.

- Perceptions regarding the need for treatment were also skewed, with a significant majority of those needing treatment not recognizing the need.

- Approximately 12% of older adults reported using illicit drugs in the past year, with older adult males more likely than females to use these substances.

Additionally, other studies [1][2] consistently show very low rates of mental health treatment utilization among older adults, with the majority (60-70%) not receiving services despite having clinically diagnosed mood, anxiety, or substance use disorders.

In order to address these findings and the disparities in access to needed services, supports, and treatments, there are a number of recommendations in the report that must be systematically implemented. All of these underscore the importance of developing targeted strategies to support the mental health and substance use challenges faced by an older population, emphasizing the need for policy adjustments, specifically tailored interventions, and more strategically focused resource allocation to meet these growing needs.

Best-Practices

Enhanced Screening and Access: We must improve routine screening, especially during primary care visits, for substance use and mental health disorders among older adults, using validated tools like the Alcohol Use Disorders Identification Test (AUDIT) and Geriatric Depression Scale. [3][4] Integrating screening into primary care settings, where older adults more frequently access services, can help identify those in need of intervention and referral to specialized treatment.[5] Enhanced screening must be paired with better access to treatment services, such as integrated care or collaborative care model, where there are significantly higher treatment engagement rates compared to referrals to separate clinics (71% vs 49% engagement).[6]

Addressing Gender Differences: We must develop and implement tailored interventions to address the distinct needs of older men and women, particularly as it relates to substance use and mental health treatment and services. SAMHSA's Treating Substance Use Disorder in Older Adults highlights several such programs, including:

- Women's Integrated Treatment (WIT) is a group-based intervention that integrates psychoeducational and cognitive-behavioral techniques to address substance misuse, trauma, and mental health issues common among older women.

- Men's Integrated Substance Abuse and Trauma Treatment (MINSATT) is a group therapy program tailored for older male veterans with PTSD and substance use disorders.

Integration of Services: Coordinated care approaches that integrate physical health, mental health, and substance use treatments have shown promising results in improving outcomes for older adults. One of the most successful integrated care approaches is the Collaborative Care Model, which involves multi-disciplinary teams – including primary care providers, care managers, and behavioral health specialists – working together to manage patients' care. Studies show that this model not only improves the quality of care but also enhances patient satisfaction and reduces healthcare costs by focusing on holistic treatment rather than separate treatment streams for mental and physical health.

Innovative care coordination and navigator programs have also been proven effective. For example, the Wellness Recovery Teams program involves navigators,

see Technology-Assisted on page 43

Expand Harm Reduction Services to Address Impact of Overdose Crisis on Older Adults

By Ramona Cummings
Chief Program Officer
Alliance for Positive Change

The devastating impact of the overdose crisis in the United States has been well-documented, affecting people from all backgrounds, demographics, and geographic regions. The data tells us that one age group in particular has been overlooked in this crisis – older adults.

The rate of fatal drug overdoses among people 65 years and older quadrupled between 2002 and 2021,[1] and older adults with opioid use disorder are at a higher risk of death compared to younger adults with the disorder.[2] More must be done to connect older adults with harm reduction resources and other services proven to reduce risk and save lives.

Older adults face unique and multifaceted challenges amid the overdose crisis that require tailored solutions. Many have chronic pain conditions – about 40 percent of older adults report pain, compared to 30 percent of the general population.[3] They may lack information about how to safely use prescribed opioid medications, or they may begin to use the substances to treat emotional pain in addition to their physical discomfort.

In addition to the aforementioned factors, the emergence of fentanyl and xylazine in the drug supply also poses a particular risk for older individuals who may be unaware of the dangers associated with these substances, such as increased risk of overdose.

Furthermore, many older adults who live alone and use drugs in isolation are at increased risk for overdose. Loneliness is also a big concern – nearly one-fourth of adults aged 65 and older are considered to be socially isolated,[4] which carries significant health risks, including higher rates of depression, anxiety, and suicide. Some may turn to substance use to cope. Finally, older adults can experience stigma and shame regarding engaging with help – they are less likely to seek support when experiencing challenges related to substance use[5] or mental health concerns.

There is good news: overdose deaths are down[6] overall for the first time in the past five years, in part due to the expansion of harm reduction services by community-based organizations like mine. Alliance for Positive Change provides low-income New Yorkers living with HIV and other chronic conditions with access to quality health care, housing, harm reduction, coaching, and peer training. Among our many services, we offer overdose reversal training, syringe exchange, fentanyl testing strips, group counseling, case management, and more.

In recent years, we have seen a local and national movement to normalize harm reduction as routine medical care. Now, we need to normalize these conversations for people of *all* ages as part of their routine screenings so that people who use drugs – both younger people and older adults – are having more conversations with professionals and their supportive networks about substance use and harm reduction. These interactions help remove stigmas and make people who use drugs more comfortable accessing preventative services. The worst thing to do is push people who use drugs into the shadows, away from helpful services, so I am proud that my organization helps people who use drugs come out into the open.

Many of the people we serve are over 65

see Overdose Crisis on page 47

Innovative Delivery of Therapy for Older Adults with Depression

**By Jo Anne Sirey, PhD,
Isabel Rollandi, PhD,
and Victoria Micha Weiss, BS
Weill Cornell Institute
for Geriatric Psychiatry**

There are many changes that take place as we age, but many people assume that depression is a normal part of aging. Instead, depression is best thought of as a response to losses and changes associated with aging, and most importantly – it is treatable! In our work with community-dwelling older adults, between 10-25% of individuals presented clinically significant depressive symptoms (Raue et al., 2019; Sirey et al., 2020). In New York City, these numbers are higher, with 25% of senior center members reporting clinically significant depression measured with the PHQ-9 (Sirey et al., 2023). Yet older adults are less likely to seek professional help, and often, depression goes untreated (Elshaikh et al., 2023). We have seen both concerns about medications offered by primary care physicians and stigma related to mental health keeping people from accessing care. Sometimes, older adults are concerned about the views of others (family, friends, communities) who they worry may think less of them if they seek care. This stigma and the lack of knowledge about easily accessible resources make it challenging to provide appropriate care (Sirey et al., 2014). To address these barriers, our group at Weill Cornell Medicine has focused on developing therapies that are easy to access, brief and focused, and, in the case of research – often free to individuals who meet the criteria.

Our team at Weill Cornell Medicine has been conducting research funded by the National Institute of Mental Health (NIMH) on community-based interventions since 1990. With a transdisciplinary scientific approach to therapies for depression among older adults, we create interventions, methods, and evaluation strategies to improve depression interventions for underserved and hard-to-reach older adults in community settings and promote intervention sustainability. For this purpose, we work closely with community providers to offer information about our services and facilitate referrals. In addition, all of our mental health programs include tracking of symptoms to ensure that the therapy is effective. This evidence-based framework is critical to all of the therapy programs we offer. In this article, we illustrate our approach to the delivery of care by describing a current research project to offer specialized and innovative care for older adults – "Do More, Feel Better."

Do More, Feel Better

With our colleagues in Seattle and Tampa, we developed "Do More Feel Better" to be offered to community-dwelling older adults who are depressed. This program offers a brief therapy called Behavioral Activation (BA), which is delivered by either a social worker or a trained lay volunteer to adults 60 years and older with sad moods or lack of enjoyment in usual activities. It is designed to expand the workforce of individuals who can offer care to older adults (Raue et al., 2022). BA therapy is a straightforward evidence-based intervention based on the principle that depression arises from a chronic reduction of positively reinforcing events that further leads to a withdrawal from usual and pleasurable activities, creating a downward spiral with fewer opportunities to experience positive events (Dimidjian et al., 2019; Raue et al., 2019). BA is easy to learn and easy for clients to follow and has shown effectiveness among older adults (Cernin & Lichtenberg,

see Delivery of Therapy on page 41

Supporting Seniors: Challenges and Solutions for Tomorrow

**By Temitope Fabayo, BA, MBA-HR
President
DMC Homecare**

As the United States undergoes a profound demographic transformation, the aging population poses unprecedented challenges and opportunities. The proportion of individuals over 65 is projected to swell from 18% today to 23% by 2054, with the number of centenarians set to quadruple.

This demographic shift strains healthcare systems and social structures, driving up care costs and exacerbating the shortage of care workers while increasing the risk of homelessness among the elderly, particularly those with dementia. Amidst these daunting prospects, there is a glimmer of hope: groundbreaking healthcare, technology, and housing advancements.

These innovations promise to enhance the quality of life for older adults, enabling them to age with dignity and support. However, realizing this promise demands thoughtful policy reforms to address caregiver shortages, the financial burden of long-term care, and the sustainability of Medicare funding.

Failure to act could undermine the strides made, but with strategic planning, the aging population could be a testament to human inventiveness and resilience.

Demographic Trends and Diversity

In 2018, 52.4 million Americans were 65 and older, representing 15.6% of the population. By 2030, this will rise to 20%. The aging population is increasingly diverse, with a 135% projected increase in racial and ethnic older adults from 2017 to 2040, compared to 36% for non-Hispanic Whites.

Challenges and Stereotypes

Stereotypes portray older adults as frail and disengaged, but many remain active and intelligent into advanced age. Implementing policies that ensure older adults receive equitable, person-centered, high-quality care is essential. Failure to act could undermine the strides made, but with strategic planning, the aging population could be a testament to human inventiveness and resilience.

Cultural Sensitivity and Diversity in Geriatric Mental Health Care

Cultural sensitivity is paramount in geriatric mental health care. Older adults come from diverse backgrounds, each with its cultural norms, values, and beliefs that significantly influence their mental health and well-being. Understanding and respecting these cultural differences is crucial for providing effective and compassionate care.

Understanding Cultural Backgrounds

Healthcare providers must educate themselves about the cultural backgrounds of their patients. This includes recognizing cultural attitudes towards aging, mental illness, and health care. For instance, some cultures may view mental health issues as stigmatizing, which can impact an older adult's willingness to seek help.

Language Barriers and Communication

Effective communication is essential for quality care. Language barriers can lead to misunderstandings and reduced quality of care. Providing translation services and employing bilingual staff can help bridge this gap.

Inclusion of Family and Community

Family plays a central role in caring for older adults in many cultures. Involving

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Nursing Home-Initiated Discharges of Residents a Critical Issue for Patients with Mental Health Disorders

By Kirti Vaidya Reddy, JD, and Theresa DeAngelis, JD, MHA
Quarles & Brady LLP

Nursing homes care for a growing number of adults with mental health disorders. In fact, mental health is sometimes a decisive factor that contributes to placement in a nursing home, causing nursing homes to become the de facto institution for persons with mental illness. Thus, there is increasing concern when nursing homes admit a resident with mental health disorders but then discharges that resident, often for allowable reasons, as that may impact the resident's health and safety.

As part of its responsibilities, the US Department of Health and Human Services Office of the Inspector General ("HHS OIG") identifies risks to the people they serve, evaluates issues, and provides reports of recommended necessary improvements. On March 29, 2024, HHS OIG issued two reports examining nursing home facility-initiated discharges of nursing home residents.[1,2]

HHS OIG issued these reports, recognizing that discharges that do not follow federal regulations can be unsafe and traumatic and lead to resident harm. Of particular note, HHS OIG reviewed 126 facility-initiated discharges and found that 72 of the discharges were due to a resident's endangering behavior, and 93% of these residents were discharged due to behavior resulting from mental health disorders. Ultimately, "[i]nsights from this data brief raise some concerns and questions about nursing homes' admission of and capacity to care for residents with mental health disorders."[1]

Background

Nursing home compliance with facility-initiated discharge requirements has been part of HHS OIG's work plan. As HHS OIG described:

Data from the National Ombudsman Reporting System show that from 2011 through 2016, the Long-Term Care Ombudsman Program, established to advocate for older Americans by the Older Americans Act of 1965, cited complaints related to "discharge/eviction" more frequently than any other concern. In addition, the media has highlighted the rise in nursing home evictions.[3]

CMS defines a facility-initiated discharge as a discharge that "the resident objects to, or did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences."[4]

Federal regulations allow nursing homes to initiate discharges of residents for six specific reasons.

1. The resident's welfare and the resident's needs cannot be met in the facility.
2. The resident's health has improved sufficiently, so the resident no longer needs the services provided by the facility.
3. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.
4. The health of individuals in the facility would otherwise be endangered.
5. The resident has failed, after reasonable and appropriate notice, to pay.

see Nursing Home on page 37

Addressing the Aging Crisis in New York's Mental Health Housing

By Sebrina Barrett
Executive Director
Association for Community Living

New York's mental health and supportive housing system is currently facing a significant challenge: an aging population among its residents. Forty years ago, when the original funding and housing models were developed by state leadership, the longevity of residents was not a primary concern. Today, more than 48,000 New Yorkers living with mental health challenges depend on mental health housing providers to find appropriate and necessary care.

The population among those 48,000 individuals in mental health housing is aging, and this demographic shift presents numerous challenges. Nursing homes are increasingly refusing to admit individuals with severe mental illness, leaving mental health housing providers to shoulder the responsibility of elder care. However, a recent poll revealed that 75% of these providers across the state admit that with the current state-funded housing models, they are not equipped to handle their residents' aging medical concerns. This lack of preparedness has significant implications for the well-being of residents and the sustainability of mental health housing providers.

It is important to understand that mental health conditions and comorbidities can cause individuals to age faster biologically than their peers. Mental health challenges, such as schizophrenia, bipolar disorder, and severe depression, often come with comorbidities like cardiovascular disease, diabetes, and chronic pain. These conditions can significantly reduce life expectancy and accelerate the aging process, making people in their 50s or 60s experience health issues typical of much older adults. Consequently, when we talk about elder care in the context of mental health housing, we are often referring to individuals well before the typical retirement age or "elderly" classification. This creates its own set of challenges in that many benefits for "older" adults are not redeemable until the individual has reached retirement age, leaving another gap in care that is currently unaddressed.

As residents age, their medical needs become more complex. Mental health housing providers are now faced with the task of managing chronic conditions such as diabetes, heart disease, and mobility issues, which require specialized care and resources. To address these needs, staff in mental health housing require additional support, including but not limited to:

- **Nurses and On-Site Health Aides:** Having medical professionals on-site is crucial for managing the health of aging residents. Nurses and health aides can provide necessary medical care, monitor chronic conditions, and respond to emergencies.
- **ADA-Compliant Spaces:** Many mental health housing facilities are not designed to accommodate residents with mobility issues. Making spaces ADA-compliant would ensure that aging residents can move around safely and comfortably.
- **Additional Staff Training:** Staff need specialized training to understand and manage the unique health concerns of aging residents with mental health issues. This training would equip them with the skills to provide better care and support.
- **Better Pay for Staff:** To attract and retain skilled workers, it is essential to offer competitive pay. Better compensation would also reduce staff burnout, a common issue in this demanding field.

Appropriate and necessary funding is crucial for addressing the needs of aging residents in mental health housing. Increased financial support is needed to hire

see Housing on page 46

How to Approach Treating Older Adults with Complex Mental and Physical Care Needs

By Marlene McDermott, LMFT, PhD, and Jennifer Comerford
Array Behavioral Care

Roughly 14% of adults over age 60 (WHO, 2023) live with a mental health condition. As the geriatric population continues to grow (Urban Institute, n.d.), so do its rates of mental distress, depression, and drug deaths (Wilson, 2024). The behavioral health industry must prepare to care for more older Americans with mental health issues, especially those with chronic comorbidities like diabetes, cancer, heart disease, and COPD, who often need a higher level of care.

Providing behavioral health care to older adults with complex health conditions presents a number of challenges for clinicians, including identifying the correct diagnosis and treating mental health issues in a way that doesn't negatively impact other care a patient might be receiving. The industry must adjust its approach to assessments, treatment pathways, bedside manner, medications, and more to properly support this population.

In our work with complex older adults across hospital, community, and home care settings, we've identified a number of techniques that help us better connect with and treat patients:

Separate Mental Health From Physical Health Symptoms

There are a number of medical conditions with symptoms that present similarly to mental health conditions. For example, an untreated urinary tract infection (UTI) can lead to episodes of delirium. Seeing delirium symptoms, a behavioral health professional might recommend a certain type of care when the best course of action is simply treating the UTI. Dementia and Alzheimer's may present similarly to schizophrenia but require completely different treatment pathways.

Before launching a therapy program or prescribing psychiatric drugs, clinicians must first rule out any medical issues causing distress. That way, a mental health professional is not treating an issue that doesn't actually exist. That means utilizing information from lab tests, which can illuminate an individual's physical health complexities in ways a therapist or psychiatrist cannot see during their assessments. Medical comorbid complexity makes accurate diagnosis a challenge, but having access to patient medical records and care team collaboration speeds the process and ensures all stakeholders are aligned.

Move Beyond the Diagnosis

Correctly diagnosing a mental health issue in a complex older adult is just the first step. Once their physiological issues are identified and addressed, mental health clinicians should begin treating their mental health symptoms. To mitigate potential issues, including side effects caused by contraindicated medications, it's imperative to involve the entire care team, sharing any setbacks or improvements along the way.

In the best-case scenario, getting a complex older adult to a point where all of their issues, both physical and mental, are being treated can take months. However, finding the right balance when treating every comorbidity and mental health condition can also last for the rest of the patient's life, requiring constant adjustments based on lab

see Treating Older Adults on page 45

We Can Break the Cycle of Preventable Emergency Room Visits and Improve Patients' Lives

By Nadeem Ramjan
Director of Data Strategy & Analytics
Advanced Health Network/Recovery Health Solutions (AHN|RHS)

In New York State, almost half (48%) of emergency room visits are for routine, non-emergency care offered by community health providers or are otherwise preventable. These visits disrupt patients' lives and strain limited hospital resources. Moreover, communication gaps between hospitals and community health providers mean that patients too often slip through the cracks and do not receive the care they need.

Patients like Winston*, who was in therapy three days per week but regularly visited the emergency room because he was lonely and seeking human connection. Or Angela*, who struggled with chronic asthma, sleep apnea, and depression and frequently went to the emergency room for respiratory concerns that a primary care provider could have addressed.

Advanced Health Network/Recovery Health Solutions (AHN|RHS), operating in affiliation – a behavioral health provider network serving New York City and Long Island – collaborated with the Bronx Regional Health Information Organization (Bronx RHIO) and our provider network to develop and implement actionable, data-driven solutions to this problem. We encourage provider networks nationwide to invest in similar collaborations and technical tools to support equitable, high-quality, patient-centered care delivery.

The data tools we created – Emergency Department Alerts, Emergency Department Patient Registry, and Emergency Department Follow-up Reports – are designed to close communication gaps, empower providers and patients, and connect patients with the routine care they need to avoid future emergency room visits. These tools help providers identify patterns, trends, and insights to inform care delivery interventions.

Good data is meaningless without trained staff and systems in place to make use of it. That's why we partnered with Primary Care Development Corporation (PCDC) to help our providers establish smart, sustainable workflows that actively utilize data to improve patient care. PCDC coaches considered the unique needs of each practice and leveraged data-driven insights to enhance patient-centered care delivery across the AHN|RHS provider network.

Our implementation of these data-driven tools has had clear and impactful results. One provider in our network reported a 62% increase in patient outreach from May to September 2023, and staff reported discussing patients' emergency room visits in follow-up appointments in 79% more cases than at baseline.

Another provider reported that their patients' 30-day readmit rate at the emergency room decreased from 66% in January 2021 to 42% in September 2023 following the implementation of the data analytical tools. The share of patients receiving a follow-up call from their behavioral health provider within 24 hours of an emergency room visit increased from 0% in January 2021 to 90% in September 2023.

As for Winston* and Angela*, the data collected from our new suite of tools empowered them and their providers to break the cycle of preventable emergency room visits. Winston and his behavioral health provider discussed the underlying cause of his emergency room visits – his loneliness – and decided that he should receive therapy five days per week to meet his need for

see Emergency Room on page 46

We're in a Mental Health Crisis. Why Do We Refuse to Help People with Treatment-Resistant Schizophrenia?

**By Matt Kudish,
Robert Laitman, MD,
Ann Mandel-Laitman, MD,
and Donna Taylor, MSN, RN**

90% of our country believes we are facing a mental health crisis.[1] And whenever there is a tragic incident in New York City, our City and State say that yet another person with schizophrenia has fallen through the cracks.[2] We have a solution staring us in the face which can help alleviate suffering, improve quality of life, and reduce the burden of disease for many who are suffering with persisting psychosis due to schizophrenia. We largely refuse to use it, leaving our city's most vulnerable at risk and in an endless cycle of psychiatric hospitalizations, homelessness, and incarceration.

According to a recent report, schizophrenia costs the US an estimated $281.6 billion annually.[3] Costs for patients with persisting psychosis, often referred to as treatment-resistant schizophrenia (TRS), are 3 to 11-fold higher.[4] Left untreated, psychosis – a collection of symptoms that affect the mind, where there has been some loss of contact with reality – poses severe debilitation.[5] However, with proper care, many individuals will thrive, with a significantly reduced risk of tragic premature death,[6] and go on to lead healthy, productive, and fulfilling lives.

At the forefront of treatment for persisting psychosis (TRS) stands clozapine, a medication renowned for its efficacy. It is the gold standard therapy, outperforming all other antipsychotics in symptom management, proven reduction in suicide, and quality of life improvement.[7,8] Despite its proven effectiveness, only a fraction of individuals who could potentially benefit from clozapine receive it – roughly 2-4% of all cases – a travesty that underscores systemic failures in mental health care.[9]

The history of clozapine dates to its initial use in the 1960s, when it emerged as a highly effective treatment option for all psychotic disorders. However, in 1975, sixteen elderly women in a small Finnish village on multiple medications, including clozapine, developed severe neutropenia. This resulted in clozapine's temporary withdrawal from the market. Clozapine was reintroduced in the US in 1989 after Gil Honigfeld and John Kane's study demonstrated clozapine's superiority to other antipsychotics in treatment-resistant schizophrenia.[10] It came back on the market with cumbersome strict monitoring protocols in place. Despite its remarkable efficacy, clozapine remained vastly underutilized.[11]

As it stands now, clozapine, the gold standard treatment for persisting psychosis, is offered as a last resort, often after years of multiple antipsychotics being tried and failed and frequently at the urging of desperate families and loved ones. The delay in offering clozapine is inexcusable. If symptoms persist after two adequate antipsychotic drug trials, there is an insignificant chance of a meaningful recovery with any other medication except clozapine.[12,13] Inadequate and delayed treatment of psychosis narrows the window of recovery. This is a huge risk to take, to put someone's life on the line. To put this in perspective, imagine if the gold standard treatment for cancer was withheld for such a duration. No surgery to remove malignant tumors, no chemotherapy. The outrage would be

see Schizophrenia on page 44

Time to Confront the Challenges of an Aging America

**By Michael B. Friedman, LMSW
Mental Health Policy Advocate**

America is aging rapidly.[1] Over the next few decades, the proportion of adults 65 and older will come to exceed the proportion of children under 18 – an historic first.[2] And as the number of older adults grows from approximately 56 million at the beginning of this decade to 85 million in 2050,[3] so will the number of older adults with cognitive impairment, mental and/or substance use disorders, and autism or other developmental disabilities.* Unless there are long hoped for breakthroughs in treatment and prevention, the number of older people with diagnosable mental disorders in the United States will grow from about 11 million in 2020 to about 17 million in 2050.[4] The number of older people who misuse alcohol and other drugs will grow from a bit over 2 million to 3.5 million.[5] And the number of older people with dementia will grow from about 7 million today to 13 million in 2050,[6] most of whom will have co-occurring behavioral health conditions during the time that they have dementia.[7]

Despite decades of demographic and epidemiological warnings and some efforts to respond, America is still not adequately prepared to meet the challenges of supporting mental well-being in older adults. Current services are dysfunctionally fragmented. Many older people are not able to live where they would like to live, whether in a family home or a retirement community. People with cognitive impairment living in the community have a range of unmet needs, including "neuropsychiatric behavior management and caregiver support.[8] Those living in nursing homes and assisted living facilities often get inadequate treatment for cognitive and behavioral health disorders.[9] Fewer than half of older adults with mental or substance use disorders get any treatment at all[10] because of limited-service capacity and access. As a result, treatment for mental illnesses is too often provided by primary care physicians without adequate training or by mental health professionals without geriatric expertise.[11] Only about 1 in 3 people who get treatment get even "minimally adequate treatment."[12]

And very importantly, our systems of care are plagued by racial and economic disparities.

Some Basic Facts

- About 1 in 10 people 65 and older have some form of dementia, most likely Alzheimer's disease. At 90 and over, it's approaching about 35%.[13]
- Virtually all people with dementia develop behavioral health conditions (aka "neuro-psychiatric symptoms"), such as depression, anxiety, psychosis, etc., at some point while living with dementia.[14]
- About 1 in 7[15] (the NIMH estimate) or perhaps 1 in 5[16] (the CDC estimate) of older adults have mental illnesses such as anxiety disorders, mood disorders, or psychosis.
- About 1 in 25 suffer from addiction,[17] and as many as 1 in 5 dangerously misuse alcohol and medications.[18]
- Many older adults experience emotional distress in response to challenging life circumstances such as the pandemic, social isolation, economic instability, racism, disasters, poor health, and the changes that are part and parcel of aging.

For example, emotional distress - including grief, loneliness, hopelessness, anxiety, and more - unquestionably increased during the pandemic for older as well as

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AI and Home Care: Navigating Challenges and Embracing Innovation to Meet Growing Needs

By Josh Klein
CEO, Emerest

We are on the brink of a significant transformation in healthcare, driven by two converging crises: an aging population and an overburdened workforce. As the number of elderly individuals requiring care continues to grow, the home care sector faces unprecedented challenges due to high staff burnout and turnover rates. According to AARP, the population of those aged 80 and above is expected to increase by 79% by 2030, while the primary caregiving age group (45 to 64) will only increase by 1%. This demographic shift, coupled with a median caregiver turnover rate that has surged from 65% to 77% since 2021, underscores the urgent need for innovative solutions to address these challenges. This imbalance threatens to overwhelm our healthcare systems, leaving many without the necessary support and care. However, emerging technologies, particularly artificial intelligence (AI), offer a beacon of hope, promising to bridge the gap and revolutionize care delivery.

AI as a Solution for Enhancing Home Care Delivery

In response to this impending crisis, AI and other advanced technologies are being used to support and enhance the capabilities of doctors, nurses, and caregivers for the homebound. Initially, these technologies have been utilized for administrative and routine tasks, such as scheduling, documentation, and basic patient monitoring; however, the potential of AI extends far beyond these functions. In behavioral and social health, AI is a powerful tool for creating highly efficient grouping models that foster virtual communities of patients with similar needs, social contexts, and health conditions.

One of the most promising applications of AI in-home care is its ability to analyze large amounts of data to identify patterns and predict outcomes. By analyzing various clinical and non-clinical factors, such as social determinants of health, AI can identify commonalities among patients that might not be immediately apparent to under-resourced healthcare workers. This allows for creating virtual support groups and communities where patients can share experiences, offer mutual support, and receive targeted interventions.

Transforming Home Care Through Virtual Communities

These virtual communities can transform home care by providing a platform for continuous engagement and support. For instance, patients with chronic conditions such as diabetes or heart disease can benefit from being part of a community where they can share tips on managing their conditions, receive encouragement, and access educational resources. This not only improves patient outcomes but also alleviates some of the burden on home care professionals by enabling patients to take a more active role in managing their health.

Moreover, AI-driven grouping models can help home care providers tailor interventions to the specific needs of different patient groups. For example, patients with similar socioeconomic backgrounds and health conditions may face common challenges that require specific interventions. By identifying these groups, home care providers can develop targeted programs that address the unique needs of each

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family members in the care process and respecting their input can enhance the patient's comfort and compliance with treatment plans.

Creating Age-Friendly Environments for Mental Wellness

An age-friendly environment significantly contributes to the mental wellness of older adults. These environments are designed to be accessible, safe, and supportive, promoting physical and mental health.

Accessibility and Mobility

Ensuring that physical spaces are accessible to those with mobility issues is crucial. This includes installing ramps, handrails, and elevators. Safe, easy-to-navigate environments reduce the risk of falls and promote independence.

Social Engagement Opportunities

Isolation and loneliness are major risk factors for depression in older adults. Creating spaces for social interaction, such as community centers and organized group activities, can enhance mental well-being.

Mental Health Services

Easy access to mental health services, including counseling and support groups, is essential. Integrating these services within community centers and primary care settings can reduce stigma and increase utilization.

Temitope Fabayo, BA, MBA-HR

Holistic Approaches to Senior Mental Health

Holistic approaches to mental health consider the whole person, including physical, emotional, social, and spiritual well-being. This comprehensive approach can lead to more effective and personalized care for older adults.

Integrative Therapies

Techniques such as mindfulness, meditation, and yoga can reduce stress and improve mental health. These practices promote relaxation and can be adapted to suit the physical abilities of older adults.

Art and Music Therapy

Engaging in creative activities can enhance cognitive function and provide emotional expression. Art and music therapy have been shown to reduce symptoms of anxiety and depression in older adults.

Spiritual Care

For many older adults, spirituality is vital to their identity and well-being. Providing opportunities for spiritual practice, whether through religious services or meditation, can support mental health.

The Role of Nutrition and Exercise in Supporting Mental Health in Aging Population

Proper nutrition and regular exercise are foundational to mental health, particularly in the aging population. They contribute not only to physical health but also to cognitive and emotional well-being.

Nutrition

A balanced diet rich in essential nutrients supports brain health and reduces the risk of mental health issues. Omega-3 fatty acids, antioxidants, and vitamins such as B12 and D are important for cognitive function. Encouraging older adults to maintain a healthy diet can significantly impact their mental health.

Exercise

Physical activity improves mood, reduces anxiety, and enhances cognitive function. Regular exercise, such as walking, swimming, or gentle yoga, can alleviate symptoms of depression and anxiety. Exercise also promotes social interaction, further enhancing mental well-being.

Hydration and Sleep

Adequate hydration and quality sleep are often overlooked but critical components of mental health. Encouraging proper hydration and healthy sleep habits can improve cognitive function and mood stability.

Conclusion

Caring for older patients requires a multifaceted approach that integrates cultural sensitivity, diversity, and holistic care. By creating age-friendly environments and emphasizing the importance of nutrition and exercise, healthcare providers can significantly enhance the aging population's mental health and overall well-being. By understanding and addressing the unique needs of older adults, we can ensure they receive the compassionate, comprehensive care they deserve.

Temitope Fabayo, BA, MBA-HR, is President at DMC Homecare.

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Blockbuster Movies and Mental Health: Exploring New Narratives in Summer Films

By Simcha Weinstein
Founder
Jewish Autism Network

Movie blockbusters have always been a staple of summer entertainment, providing thrilling escapism with larger-than-life characters and spectacular action sequences. However, recent films like "Inside Out 2" and, even more surprisingly, "Bad Boys: Ride or Die" have added a new dimension to the genre by addressing mental health issues in a manner previously unseen in popcorn escapism.

Image credit: Disney

Inside Out 2: Navigating Puberty with a New Cast of Emotions

"Inside Out 2," the highly anticipated sequel to the beloved animated film, tackles the complex emotional landscape of adolescence. As Riley enters puberty, she is joined by a new set of emotions, including Embarrassment, Envy, Ennui, and Anxiety. Anxiety, voiced by Maya Hawke, plays a central role in Riley's journey. The film portrays how anxiety, with its well-meaning but misguided attempts to prepare Riley for the future, can lead to new anxiety-based beliefs and a reshaped sense of self.

As a father of four children in various stages of puberty, I find the depiction of anxiety in "Inside Out 2" to be incredibly relatable. Anxiety often dictates how we operate and determines our sense of worth. The film's portrayal of a panic attack at its climax is especially harrowing, offering a poignant representation of a struggle that many viewers prone to anxiety will find all too familiar.

This depiction hits close to home for me, as I have wrestled with anxiety silently since puberty. Like the movie, I have experienced moments when anxiety completely takes over, dictating my actions and affecting my self-worth. I have learned to navigate it, and I believe this portrayal will resonate deeply with anyone who has faced similar struggles.

Bad Boys: Ride or Die: Challenging Stigmas in an Action-Packed Sequel

In a surprising turn, the latest installment in the "Bad Boys" franchise, "Bad Boys: Ride or Die," delves into the mental health struggles of its iconic characters, Mike Lowrey (Will Smith) and Marcus Burnett (Martin Lawrence). The film, which sees the aging detectives grappling with grief, anxiety, and the toll of their long careers, provides a refreshingly honest departure from the traditional action formula.

Will Smith and Martin Lawrence, now in their late 50s, bring depth to their roles beyond the usual bravado. Mike Lowrey's panic attacks during gun battles and Marcus Burnett's near-death heart attack and subsequent spiritual awakening offer a nuanced exploration of vulnerability and redemption. These elements allow viewers to see the characters in a more human and relatable light, breaking down the stigma surrounding mental health issues.

The inclusion of these themes in a mainstream action movie is significant. Traditionally, society has positioned men as strong and stoic, discouraging expressions of vulnerability. This film challenges that

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The Mental Health Association of Westchester and The Mental Health Association of Rockland Merge and Rebrand as Greater Mental Health of New York

By Greater Mental Health of New York, Inc.

The Mental Health Association of Westchester and The Mental Health Association of Rockland announced the completion of their merger and the new name of their combined organization: Greater Mental Health of New York, Inc. The merger increases the size and scope of integrated, person-centered services delivered by the community-based non-profit and strengthens the new entity's ability to reduce barriers to quality mental health care in the Lower Hudson Valley region.

"On behalf of the Board of Directors of Greater Mental Health of New York and our dedicated staff, I am pleased to introduce our expanded and enhanced organization to our partners, supporters, and clients," said Honorable Mary F. Foster, President of the Board of Directors. "Together, we have a greater menu of integrated services, a greater number of highly trained and compassionate staff, and a greater ability to support the most vulnerable people in our community."

Greater Mental Health of New York will serve more than 15,000 people across the region through a wide array of services, including therapy, care management, peer services, employment services, residential services, medication management, substance use recovery, and more - as well as community education and advocacy efforts. Certified Community Behavioral Health Clinics in Mount Kisco, White Plains, Yonkers, and Upper Nyack complement a variety of community-based, mobile services for all ages. Greater Mental Health of New York also offers a suite of services in its Valley Cottage location, in addition to a large portfolio of residential programs throughout the region. Greater Mental Health of New York will have an operating budget of approximately $50 million and a staff of 500 employees.

"The merger between The Mental Health Association of Westchester and The Mental Health Association of Rockland is an exciting evolution of our two organizations, each of which has been deeply committed to meeting the evolving needs of our community for nearly 80 years," said Greater Mental Health of New York Chief Executive Officer Stacey Roberts, LCSW. "With our many decades of experience creating and delivering compassionate, evidence-based mental health care, we are strongly equipped to meet the demands of the future. As one organization, our combined expertise and values enable us to enhance our mission of promoting mental health through advocacy, community education, and direct services. During my nearly 25 years at The Mental Health Association of Westchester, I have had the distinct pleasure of experiencing the tremendous growth and transformation of the agency. It is with great pride that I join my colleagues in taking this new step in our journey, which promises to be the most transformative yet for our community."

"We are excited to mark this new chapter in our combined history with a full rebranding of our organization," said newly appointed Chief Advancement and Marketing Officer Stephanie Madison, LMSW. "Throughout this process, we have worked behind the scenes, creating and honing a new brand identity that captures our mission, values, and innovative, person-centered work. Our new brand reflects the unique mental health journey each person navigates in their life and the many points of connection at which Greater Mental Health can offer support and care. After working for The Mental Health Association of Rockland for 27 years, 12 of which I served as President and CEO, I am heartened to work alongside Stacey Roberts and our combined Board of Directors as we forge a new path in mental health and substance use recovery services."

Stacey Roberts, LCSW, formerly CEO of The Mental Health Association of Westchester, serves as CEO of Greater Mental Health of New York. Stephanie Madison, LMSW, formerly President/CEO of The MHA of Rockland, serves as Chief Advancement and Marketing Officer of the combined organization. Honorable Mary F. Foster serves as the President of the new Board of Directors, which combines members of both agencies' respective Boards. The administrative headquarters of the new agency is located at 580 White Plains Road, Suite 510, Tarrytown, NY 10591.

The Mental Health Association of Westchester and The Mental Health Association of Rockland have joined forces to become Greater Mental Health of New York. Promoting mental health through advocacy, community education, and direct services, Greater Mental Health of New York offers a range of person-centered and trauma-responsive mental health and substance use treatment services to foster resilience, wellness, and recovery. To learn more, visit greatermentalhealth.org.

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The Geriatric Mental Health Act also mandated funding to establish the Geriatric Service Demonstration Project, which funds community-based programs that support older adults by focusing on:

- community integration,
- improved quality of treatment in the community;
- integration of aging services and behavioral health services;
- workforce development programs and the use of Peer Support;
- family and caregiver support;
- cultural minorities and Veterans as specialized populations; and
- ongoing staff training initiatives.

Since OMH began awarding Geriatric Service Demonstration grants, organizations throughout the state have developed integrated models of care for older adults with mental health, substance use, and aging-related needs. The grants are helping to expand access to services that integrate behavioral health treatment as well as aging services, with an emphasis on reaching older adults who are residing in community living situations who may be unconnected or inconsistently connected to services, may have diagnosed, undiagnosed or subacute behavioral health needs, or have chronic medical conditions.

The Geriatric Demonstrations have been very effective at breaking down siloed service systems by establishing local triple partnerships between mental health, substance use, and aging providers. Some of the clients who have benefited from these programs have graciously agreed to share their success stories below. (Details have been changed to protect their identities and personal information.)

Addressing Wholistic Wellness of Caregivers

One client is an 85-year-old woman living in senior housing and experiencing multiple emergency room visits for physical and mental health concerns. She was also a caregiver for her husband, who was experiencing early-onset dementia. She suffered from anxiety, depression, caregiver burnout, and a lack of community resources.

A Geriatric Service Demonstration Grant Program funded by the Office of Mental Health helped her connect with a Health Home Care Coordinator, a therapist from a community-based clinic, and a home care aide, all of whom helped her manage her chronic health conditions. The program's Registered Nurse and Social Work Intern provided her with information about her anxiety and the importance

Ann Sullivan, MD

of taking her medication with daily phone call reminders.

When her case was first opened, she was visiting the Emergency Room 4-5 times a week due to her anxiety and caregiver stress. After receiving person-centered support in connecting with ongoing services to support her holistic wellness, her visits were reduced to 1-2 times a month to receive critically needed treatment for her chronic physical health condition.

Building Coping Skills and Resiliency During COVID-19 Pandemic Lockdown

Another older adult benefited from a local Geriatric Service Demonstration program. She was actively suicidal after placing her husband in an Assisted Living Facility. When her husband was placed on Covid restrictions, her condition worsened because she was unable to see him. She was hospitalized for suicidal ideation; however, staff from a local community provider supported by the Geriatric Service Demonstration program were able to meet with her weekly and provide phone support between visits. She learned coping skills to manage her depression symptoms and created a safety plan and a list of supports.

After six months of participation in this program, she is no longer suicidal, is active in the community, successfully caring for her home independently, and meets with her husband on a weekly basis. She said thanks to the services she received, she "now feels hopeful and happy again."

Benefits Navigation Addresses Social Determinants of Health in Rural Communities

A third client resides in a very rural area. He lives in his own home, which is quite a distance from any stores or shopping centers. He was identified because neighbors noticed him looking for food in their garbage cans. When program staff met him, they learned it had been several years since he was able to afford oil for his furnace, electricity, food, or medical care. The team quickly began providing him with services and helped him enroll in HEAP, SNAP, Medicaid, and an electricity payment plan. Thanks to their person-centered intervention and support, Andrew is living a far healthier and self-sufficient life.

Strengthening the Continuum of Care for all New Yorkers

Governor Kathy Hochul has initiated the first State Master Plan for Aging, which is designed to ensure that older adults can live healthy, fulfilling lives while aging with dignity and independence. The plan was first announced in the Governor's State of the State Address and Fiscal Year 2023 State Budget and is helping state agencies coordinate existing and new policies and programs for older adults and their families. The Master Plan for Aging is expected to be finalized in early 2025 and will provide guidance for building healthy, livable communities that offer opportunities for older adults and improve access to the health and mental health care services they need.

Additionally, as part of her comprehensive $1 billion multi-year plan to overhaul the continuum of mental health care throughout the state, Governor Hochul initiated investments into programs to help older New Yorkers live healthy, fulfilling lives while aging successfully in the communities of their choice. Her plan included funding for new residential units, increased inpatient capacity, and expanded outpatient services for all New Yorkers, including older adults.

In response to the Governor's unprecedented support for the expansion of mental health services, OMH modified two existing, successful programs to specifically target and support older adults: the Assertive Community Treatment (ACT) program and the Safe Option Support (SOS) program.

Assertive Community Treatment for Older Adults

Assertive Community Treatment (ACT) is a multidisciplinary, evidence-based, team approach to providing comprehensive and flexible treatment, support, and rehabilitation services to people of all ages. ACT teams have a low individual-to-staff ratio with professional staff, including members from the fields of psychiatry, nursing, psychology, social work, substance use, employment/education, and peers. Many services are provided by ACT staff directly and in the community where the individual lives. Recipients of ACT services often have high continuous needs that are not met in traditional site-based services.

Thanks to the Governor's historic investment into mental health services, OMH is supporting the development of an Older Adult Assertive Community Treatment team in the Bronx. The ACT team will serve older adults who have Serious Mental Illness and have not been successfully engaged by the traditional mental health treatment and rehabilitation system in NYS. These individuals may also be high utilizers of emergency and/or crisis services, have co-occurring substance use disorders, are isolated from community supports, are in danger of losing their housing, are homeless, and/or have histories of involvement with the criminal justice system.

Safe Options Support Program: Older Adult and Medically Fragile Support Team NYC

Unfortunately, older adults are the fastest-growing group of homeless individuals. According to the U.S. Department of Housing and Urban Development, there were 13,635 adults aged 55 and older in NYS experiencing homelessness in 2023. In response to the homeless crisis, OMH is supporting the development of Safe Option Support (SOS) teams, which provide intensive outreach, engagement, and care coordination services to individuals, including older adults experiencing street homelessness and those in temporary shelter settings.

And because approximately 42 percent of current SOS clients are over the age of 50, OMH has also issued a Request for Proposals to develop an SOS Older Adult & Medically Fragile Support Team in NYC. This team will provide specialized services and support to older adults and individuals with existing chronic medical conditions who are currently unsheltered or have recently transitioned from street homelessness to housing.

Addressing the Growing Loneliness Epidemic

The ACT and SOS teams are having great success in helping older adults living with serious mental illness. However, many older New Yorkers are living with a condition that is not as easy to diagnose. Social isolation and loneliness can have a severe impact on our physical and mental health. They are associated with multiple physical and mental health issues, including cognitive decline, anxiety, depression, cardiovascular disorders, weakened immunity, Alzheimer's Disease, and premature death.

A recent study by the National Academies of Sciences, Engineering, and Medicine found that more than a third of adults 45 or older experience loneliness, and nearly a quarter of adults 65 or older are living in social isolation.

While the aging process does bring with it certain challenges that can impact our health, it is important to remember that effective treatment options are available that draw from the strengths of older adults and help them manage their mental health, improve their quality of life, and navigate multiple service systems to build a personalized system of support. Fortunately, this is especially true here in New York State.

Ann Sullivan, MD, is Commissioner of the NYS Office of Mental Health (OMH).

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Treatment Services from page 12

women aged 55 and over struggling with addiction.

Over two decades ago, with seed money from the Mary and Milton B. Rosenback Foundation, a family foundation steered by our late Board Chair, George Rosenfeld, we developed a discrete service for older adults based on what we saw as their critical need for specialized treatment.

What began with a small cohort of similar-aged clients grouped on a floor of a treatment center is now a standalone 100-bed residential and outpatient program supported with ongoing funding from the New York State Office of Addiction Services and Supports (NYS OASAS).

Our comprehensive services include:

- Individualized treatment plans and lengths of stay
- Mature staff experienced in senior care
- Evidence-based therapies like CBT and trauma-informed care
- Medication-assisted treatment and on-site medical/dental clinics
- Age-appropriate physical fitness, art and recreational activities, education, job training
- Housing assistance and ongoing outpatient support.

Importantly, group therapy provides a stigma-free environment with a strong community focus. Many older adults have lived with addiction for decades while trying to hide it from family, friends, and co-workers. Having a supportive peer network is crucial for accountability and lasting recovery.

As the aging population continues to grow, so too will the need for specialized substance use treatment tailored to their unique circumstances. Odyssey House remains committed to innovative, evidence-based care that meets our clients where they are and helps them rebuild lives of purpose and dignity.

With increased awareness, training, and access to proper resources, we can ensure that no one is left behind on the road to recovery.

Peter Provet, PhD, is President of Odyssey House.

Peter Provet, PhD

Nursing Home from page 31

6. The facility ceases to operate.[5]

Nursing homes must provide residents and their representatives with written notice if discharged for one of the aforementioned reasons. In addition, CMS requires nursing homes to document the basis and justification for such discharges.[5]

HHS OIG's Findings

In HHS OIG's review, nursing homes most frequently initiated discharge because the resident's behavior endangered the resident or others in the facility. "Endangering behavior" includes the safety of individuals in the facility being endangered due to the clinical or behavioral status of the resident, the health of the individuals in the facility being endangered, and the inability of the facility to meet the resident's welfare and needs (e.g., the facility could not keep a resident safe from wandering, elopement, suicide or self-harm).[1] Physical and/or verbal aggression was the most common endangering behavior observed.

After endangering behavior, failure to pay was the second most frequent reason for discharge. In 16 discharges, no reason was documented, though 6 had indications in the medication records that these discharges were due to endangering behaviors. Finally, improved health was the least frequent reason for discharge.[1]

Nursing homes tried interventions prior to discharging the residents due to endangering behavior, including medication changes, counseling, one-on-one staff monitoring, room changes, and using wearable bracelets to alert nursing staff if the resident was wandering near a monitored door.

A discharge may resolve a nursing home's issues, but it may have a significant impact on the health and safety of the improperly discharged resident. Most residents were discharged to an acute care residence. The next most frequent destinations were private residences, followed by another nursing home. Five residents were discharged to unknown locations, two to nonspecific locations, and three to a hotel. For these patients, discharge summaries were not provided for or reflected in medical records. HHS OIG concluded that in these cases, it was impossible to know whether the nursing home ensured a safe transition for the residents. Some cases raised safety concerns. In one example cited, a nursing home discharged a resident to a hotel for failure to pay when the patient was on dialysis.

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Theresa DeAngelis, JD, MHA

The report indicates that "[m]ore research is needed into how to provide safe and effective long-term care for residents with mental health disorders and behaviors," – particularly in light of the increasing demand for such care.[1] HHS OIG indicates that the new Center for Excellence for Behavioral Health in Nursing Facilities, established by the Substance Abuse and Mental Health Services Administration in partnership with CMS, may offer promising contributions in this space. According to HHS OIG, "[t]he center aims to provide technical support, resources, and training to nursing homes to care for residents with mental health needs and substance use disorders."[1]

Takeaways

From both a quality of care and financial perspective, the Government is focused on the care provided by nursing homes.

With regard to care, OIG concluded that there were concerns about "nursing homes' understanding of and compliance with notice and documentation requirements for facility-initiated changes."[3] Specifically, OIG noted that (1) there were instances where nursing homes failed to provide required documentation, such as documentation that the receiving facility could provide the services that meet residents' needs; (2) nursing homes often failed to notify residents of their discharges and frequently omitted required information in notices, potentially compromising residents' rights and abilities to plan for safe transitions; and (3) even when nursing homes provided the resident with a facility-initiated discharge notice, they often failed to provide a copy of the notice to the Ombudsman, as required, potentially impeding on the Ombudsman's ability to effectively advocate for residents.[3]

These reports follow the US Department of Justice's 2020 launch of a national nursing home initiative to coordinate and enhance civil and criminal efforts to pursue nursing homes that provide grossly substandard care to their residents and a 2022 White House announcement of CMS initiatives to ensure residents receive quality care.[6,7]

From a financial perspective, in light of the gross reimbursements by federal payors, as well as the Provider Relief Funds distributed to nursing homes during the COVID-19 pandemic, nursing homes remain in an era of heightened government scrutiny. DOJ has demonstrated an appetite for enforcing the False Claims Act, 31 USC §§ 3729-3733, imposing steep civil penalties against nursing homes based on various issues such as substandard quality of care, inadequate staffing, false certifications, and misuse of Paycheck Protection Program funds. Thus, in the wake of HHS OIG's reports, nursing homes must stay vigilant in ensuring compliance with facility-initiated discharge and other requirements.

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hospice care will be explored in the later stages of illness. Having these conversations ahead of time with the person, family members, and caregivers makes the process much easier and less stressful to put in place when the time comes. It is challenging for loved ones to make those types of decisions without much notice, and when there is an opportunity to avoid that, we should. It can be easiest to address these issues regularly and when an urgent decision is not required.

Staff Training

Caring for individuals with IDD across the lifespan requires compassionate caregivers and dedicated professionals. Collaborating with experts in healthcare, physical therapy, occupational therapy, speech-language pathology, and palliative care/hospice is necessary to maximize each individual's goals for aging well, maintaining a high quality of life, and dying with dignity. As changes occur to an individual's functional status, caregivers should have access to robust training and education. Trainings, including practice, discussion, and follow-up, allows the caregiver to best support an individual to age with dignity and respect. Caregivers can then recognize future changes in status and reach out for support. Areas of training needs often include topics such as how to provide care due to changes in functional status, which can include mobility changes, ability to eat independently, diet texture changes, and communication changes. Throughout this process, there is a continued need for interdisciplinary collaboration from all therapists and practitioners involved in the person's care. Training should be developed by these team members and then trained by the person's primary caregivers. Often, in residential settings, direct support professionals carry out complex care plans daily that require frequent follow-up, training, and revisions.

Supporting Family Needs

An important aspect of end of life care includes having available support and familiar people, such as families and friends, who continue to be part of the individuals' lives. When End of Life Care begins, the teams should continue to encourage visitation and communication with their loved ones. Depending on the current care needs of the individual, this may be in the home visits or visits to their family's home if the environment supports this. Alternative communication methods for families that live further away include phone calls or video conference calls to be able to see and support their loved ones during this time of transition. Some family members may not know what will comfort the individual at this time. The National Institute on Aging (2018) has recommendations that can be shared with families, including providing physical contact, setting a comfortable mood, asking the person receiving end of life care if they have any preferences, and also just being present during the time together.

As the needs of the individual change, open and frequent communication helps the families understand the progression while also preparing them for any changes that may be seen during their visits. Care needs can change in a short period of time, and even families that visit daily could see a difference from one day to the next. Education on the progression of illness, while also being transparent that each person experiences this progression differently, can equip the family with the understanding of these changes. Families that do not live within a proximity that allows them to visit frequently during this time may value frequent communication from the care team.

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Maximizing Quality of Life

When an individual is diagnosed with a terminal illness or begins end of life care, the care team should evaluate how the quality of life can be increased through their daily interactions and ensure that meaningful opportunities are provided. Through open communication with the individual's medical care team, these options can be assessed for appropriateness and decided with the best interest of the individual in mind. For those that have the skills to communicate, these wishes may be explicitly shared with the care team. For others, considerations may be made based on the knowledge of likes and interests prior to end of life care, beginning with speaking with those who know the individual the best, such as family or friends.

Supporting Peers and Staff

Individuals who live in provider residential settings create bonds with those they have lived with or participated in various activities during the time they were together. Providing education to their peers about changes and the progression of life can assist with understanding how age and illness can impact someone. This sensitive topic should be discussed at a level that can be understood and evaluated by the individual's care team on the benefits of seeing someone who is at the end of life stage. If appropriate, a visit to see their peers during this end of life stage can provide an opportunity to share memories they had together. It may also help the individual to create some memory books or other concrete reminders of the shared time and memorable experiences.

Support Post-Passing

When End of Life care ends due to the passing of an individual, there are various steps teams can take to continue their support. Team members who have been involved with communicating with the family members may consider the family's wishes for continued communication. Many individuals' family members are involved throughout the overall time spent in a long-term living setting and grow relationships with those who provide this care. Communication with the family post-life will vary based on the wishes of the family. Sharing with the family the impact that the individual made on the team, as well as the memories made, provides a sense of comfort. When the family shares the details of services or gatherings to remember the individual, the team should make every effort to be there to continue to support the family during this difficult time. This may include members of the team who managed the care and support staff who provided care to the individual.

Once the services are arranged, communication with the family will also include conversations about their wishes regarding the individual's belongings. This communication will assist the family and team to arrange a time to come together and ensure that all items the family would like to have to remember their loved ones can be available. This time may vary depending on the setting, but sharing the available time with the family can provide an opportunity for family members to discuss how to best arrange this process.

Case Review

Jackson, an individual with Downs Syndrome, began to show some differences in his typical everyday behaviors and was observed to be forgetting common people or skills he previously knew. When these changes were identified by the team, they completed an assessment that showed signs of dementia. Through medical follow-up with his primary care doctor and neurologist, Jackson was diagnosed with dementia. At this time, Jackson had been living in a home that had multiple flights of stairs and a large layout. Due to the perceived risk of his progressing dementia, the team met and was able to identify a home that had a layout that better suited the long-term needs for Jackson. Communication with the individual's external team and family occurred to share the proposed change early on to ensure that all questions could be answered before any major changes were observed for the individual. This early transition to a new home allowed Jackson to learn the layout and bond with staff who worked in this new setting.

As Jackson's dementia progressed, there was a decrease in cognition, memory, and ambulatory needs. Family and friends were no longer easily recognized. The setting of the home was arranged for open movement, without obstructions, to ensure that it was familiar to Jackson early on during his diagnosis. Jackson began to sleep through much of his day, leading to retirement from his day program setting. Frequent changes to his care were communicated to his family, as well as the staff. Some of these changes occurred quickly, while others were maintained for longer periods of time. As his care needs increased, his diagnosis and current health status now required hospice care.

The team met to review some opportunities to provide an increased quality of life during this time of change for him. Jackson was an avid Philadelphia sports fan. His favorite hockey team was having an upcoming game near his home. The team reviewed this opportunity to see a game with his family, as well as the medical personnel overseeing Hospice Care recommendations. After all considerations were reviewed, his support staff were able to bring him to see one last game from box seats. Although there were times when Jackson was not able to express himself as he had in the past, there were multiple instances of large grins and celebratory motions. He was able to experience this with peers he had grown to know over the years, and it appeared to have had a positive impact on his life. Photos of this experience were shared with his family so they could share the joy it brought to their loved ones.

As time progressed, Jackson's diagnoses increased, and his care needs increased. This individual, once independent in most aspects of his life, now depended on full physical care throughout his day. As this transition occurred, the bond between him and his care staff continued to grow. His family increased their visits to see him as often as time would allow. The team continued to share the care needs changes with the family to keep them informed of changes, and this communication continued until the individual passed peacefully with staff by his side.

After Jackson's passing, many members of his team joined the family at a local service. Memories of time spent together were shared by all who grew a bond with Jackson over the years. After the service, the Director of the Jackson's Residential home spoke with the family about their wishes for his belongings. Since the family had traveled from different areas, they decided to come the next day to see which items they would like to remember him by. The family wanted to donate the medical equipment that could be passed to others who needed it, as their own lives changed as they aged.

see Residential on page 40

Silver Center from page 16

benefits. Eager beavers help run the clubhouse as part of the wellness, culinary, garden, communications, and research units.

Because "creativity" is essential for recovery, our art gallery and studio offer first-class exhibits and classes. And on our NJ farm, contrary to the notion that digging in the dirt is a reversion to childhood, learning to help plants grow is one of the best ways to recover from what may seem like personal dead ends. As for continuity of care, Fountain House partners with a nearby health home and community health center.

"At Fountain House, a third of our [1200 active] members are 55 and older, many of whom have been a vibrant part of our community for decades. In 2018, we opened the Silver Center to keep our older members supported and connected as they age and to address the ongoing concerns of isolation, physical illness and decline, inadequate housing, and poverty.

One of the more unique – and valuable – aspects of the clubhouse model for older adults is that they're able to make meaningful social connections, not just with people their own age, but with younger adults. These intergenerational relationships can lead to powerful healing benefits. Numerous studies show that these kinds of relationships can improve physical health, quality of life, and cognitive function for older adults, while also providing young adults mentorship and greater self-esteem."[2]

In other words, Fountain House, as a voluntary, intentional, intergenerational community with a sense of belonging and mutual support, appears to be a key to the well-being of our older members. With the support of staff, members care for each other and dare each other to do and be better.

Susan Lieblich, who has been a staffer on and off since 1980 and was the first program director of the Silver Center, credits Norman Feldman, a Fountain House member, with initiating "senior services" in the education unit. Said Lieblich, "Norman believed that being older was a time to grow and give back." Out of his inspiration, the center was born!

Sadly, Norman died of COVID, but he would have been proud of the way the center rose to the challenge of the pandemic with online programming and continues to promote a robust digital presence by a third of its members who are unable to attend in person. Of the 164 Fountain House members who used the center in 2023, 100 participated at least once a month.

In addition to all the activities offered, members meet with staff twice a day to decide on the administrative work needed to sustain the center. The enthusiasm generated powers a cooperation that was evident in several members' responses to this reporter's questions:

Interviewee Judy's Zoom self-portrait

Carl: How long have you been a Fountain House/Silver Center member? Has your participation changed over that time?

Judy (age 68): Member since 2019. Was inactive until pandemic when I got Slack and Zoom. Became very active, attending daily virtually.

Jerry (63): 2018. Online during the pandemic was better than isolation. Now I come here five days a week to reach out to members in nursing homes or alone at home. Feel productive.

Carmen (65): 13 years. Every day for 4-5 years. Recently too much trauma. Only twice a week.

Carl: How's your recovery? What part is due to Fountain House/Silver Center and what to other factors?

Judy: Doing well and love my time virtually with Zoom meetings. Silver scene, standards study. Used to like current events. Love the go-around [check-in]. Have friends.

Jerry: Not being stuck at home and doing fun things. Music, books on tape, and helping my older sister.

Carl: What activities and services at Fountain House/Silver Center are most helpful for your wellness?

Judy: Art and training and advocacy. Love it all. And technology.

Jerry: Board games and writing stories with prompts. When we had a sports club, going bowling and softball batting.

Carmen: I became a peer specialist during my Fountain House years. Then took over the Double Trouble in Recovery group. Many of our older members died or relapsed during COVID. I got a Zoom room so people wouldn't feel isolated and could talk about their substance abuse recovery. While in the Silver Center, I organize mailings, enter data, make get-well cards, call members, and help run the chair exercise group.

Carl: What do you like best/least about Fountain House/Silver Center?

Judy: Love virtual. Don't like to miss out if in-person only. Miss current events.

Jerry: Reach Out and heart healthy food, but the portions are too small and often cold.

Carmen: How the community works together. Fountain House lets you do what you want and gives you lots of choices. Doesn't force you. Some members don't realize how much Fountain House offers.

Carl: How has Fountain House/Silver Center changed during your time here?

Judy: Improved especially virtually

Jerry: Not at all. Always very nice people.

Carmen: Had to be young adult to be admitted. Now open to all ages.

Carl: How does Fountain House/Silver Center compare to other mental health and/or substance use programs you (have) participate(d) in?

Judy: Great that it's combination mental health advocacy and senior love

Jerry: The place I went to on Long Island before Fountain House shut during COVID.

Carmen: When I got out of the hospital 30 years ago, the Post-Graduate Center and Fountain House were considered the two best programs for housing. Unfortunately, Fountain House was only accepting people up to age 35 and I was 42, so I went to PostGrad. I really wanted to go to Fountain House. I kept applying until they accepted me about 13 years ago.

Carl: How does the Silver Center compare to other older adult programs you (have) participate(d) in?

Judy: Hybrid and virtual interaction and karaoke is better than senior center with no virtual, no mental health. I am welcome. No stigma. Informative. Helpful. Advocacy.

Jerry: No other place like it. Where I went before, mental illness and aging made people worse.

Carmen: Haven't tried others.

Carl: How would you like the center to improve?

Judy: More virtual. Improve virtual.

Jerry: Bring back the sports club and expand the center.

Carmen: Need more room for big events. More senior housing and job opportunities for seniors to earn money taking care of our seniors who are less able.

Carl: Anything else you would like to share about your Fountain House/Silver Center experiences?

Judy: My art is on artsy.com.

Jerry: No

Carmen: I have a lot to give.

Carl A. Blumenthal, MS, MA, NYCPS

A 73-year-old CORE peer specialist at Fountain House and journalist for 50 years, Carl Blumenthal can be contacted at carl.blumenthal@fountainhouse.org or (929) 715-2700.

Footnotes

1. M. Usman, PhD and Joshua Seidman, PhD, "Beyond Treatment: How Clubhouses for People Living with Serious Mental Illness Transform Lives and Save Money," Fountain House, February 2024 (www.fountainhouse.org/reports/beyond-treatment)

2. www.fountainhouse.org/news/being-around-younger-people-can-feel-rejuvenating-fountain-house-members-discuss-the-healing-benefits-of-intergenerational-relationships, April 13, 2023

Resiliency from page 26

Advocacy for GLBT Elders and as Director of Alzheimer's Programs at the Cobble Hill Health Center. Catherine has published in the areas of Dementia and Long-term care and LGBT Aging and has sat on the New York State Caregiving Coalition, AARP's Caregiving Committee, and the American Society on Aging's LGBT Aging Network. She has served as Adjunct Faculty at the Silberman School of Social Work at Hunter College since 2016. She received her Master of Social Work from Hunter College School of Social Work.

COMHPS from page 21

The COMHPS team meets with veterans at the Nassau County Veteran Service Agency, in libraries, at Veterans Food Pantries, and at various veterans' events.

Older veterans express a fear of being forgotten, and the low attendance at veterans' parades and events is particularly upsetting. They also express concerns that the newer generation of veterans will not receive their due recognition. Seeing scenes of wars in the Ukraine and Gaza is also triggering for these veterans. The COMHPS team allows veterans to express their feelings and encourages them to look out for each other through peer support.

The CEC COMHPS team recently participated in a Veterans Conference on Long Island. At the conference, COMHPS assisted one of their clients, a 102-year-old female veteran who was a nurse in World War II, in speaking on a conference panel about her experiences. She spoke about how her hospital unit followed the front lines as it traveled throughout Sicily and Italy, and she spoke lovingly of the care she provided to young and wounded soldiers.

It should also be mentioned that in addition to their work with seniors and veterans, the CEC COMHPS team has done a tremendous amount of work in school districts to increase mental health awareness among youth. The team has also been heavily engaged in providing workshops to migrant youth who may have experienced trauma in their home country and during their journey. These workshops are conducted in Spanish. During these sessions, one of the COMHPS team members, who had immigrated to the US himself, shared his journey as an inspiration.

The COMHPS model has been successful in reaching out to individuals with various levels of mental health issues by being present in natural community settings. The program helps enrich the lives of seniors, veterans, and young migrants. As the program grows and develops, the requests for such services have increased.

John Javis is Operation Director and Jeanne Morrison, LMSW, is COMHPS Team Leader at CEC Health Care. For more information on the CEC Health Care COMHPS Team, you may call (516) 622-8888 ext. 4110 or email Jeanne Morrison at morrisonj@charlesevanscenter.org. The agency's website is www.charlesevanscenter.org.

Pictured Left to Right: COMHPS Team Members Carolyn Tynan, Debra Soon and Team Leader Jeanne Morrison

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Depression from page 19

any of the signs of depression listed above. Tactics like this will allow healthcare providers to notice if their patients need help from a behavioral or mental health professional before depressive episodes lead to suicidal ideation or even attempts. To that end, research has shown this approach to be highly effective in reducing suicide rates among older adults (National Institute on Aging).

Once an individual enters your organization for depression treatment, something to keep in mind beyond the normal standard of care is offering culturally competent assessments and care. Depression presents differently across cultural boundaries. For example, one study found that hopelessness more often presents as a symptom of depression among white Americans than it did Black Americans (Assari S & Lankarani MM, 2016). This tendency for cultural norms to dictate one's displays of emotions related to depression has led one researcher to describe depression as "a chameleon, changing its stripes as it presents differently across racial and ethnic boundaries"

Jordan Baker

(Bailey, Rahn, Kennedy et al., 2019).

To offer the best care possible to clients living with depression, it's important to talk with them to get a sense of their cultural identity and how this influences their perception of their depressive symptoms. Once you understand how emotionality presents within their culture and how this could be affecting their response to their mental health condition, you can develop a culturally competent method of care.

Jordan Baker is passionate about e-learning and helping learners achieve their goals. At Relias, he works with subject matter experts across disciplines to shape healthcare content designed to improve clinical practice, staff expertise, and patient outcomes. Relias provides lifelong workforce enablement solutions for more than 11,000 healthcare and human services organizations and 4.5 million caregivers to drive measurable outcomes. Customers use Relias solutions to attract and retain talent, elevate care quality, and reduce risk with our technology, services, community, and expertise.

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Residential from page 38

Summary

Planning for end-of-life care is never easy and is always fraught with anticipated grief. Yet, these realities must be faced for all lives, including those of individuals with disabilities. Much can be done to ease the transition to the end of life by ensuring that the individual, their family members, their peers, and their caregivers are helped throughout the process. It is important to prioritize quality of life and comfort at all stages of an individual's life and, increasingly, when age and medical conditions warrant changes in care. Contact with the individual who is approaching the end of life can enhance coping for the individual and for family members, caregivers, and peers. Sharing memories and mementos of times together can be important in the later stages of life and after the individual's passing. Acknowledging the loss is important, as is the preservation of the memory of the individual and their impact on others.

Maggie Haag, MEd, BCBA, LSW CDE®, is Executive Director, Heather Hirst, PT, DPT, is Senior Director of Rehabilitation Services, and Aaron Emmons, MS, is Director of 6400 Residential Programs at Melmark PA.

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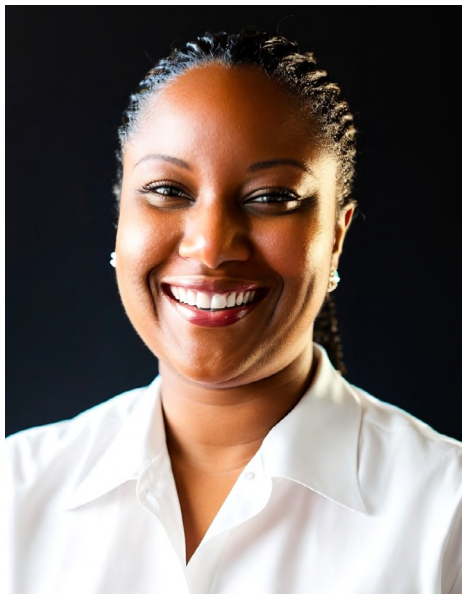

Romi Avin, LMSW, MS, HS-BCP

Jose Cotto, LCSW

Anne Handford, MPH, CHES

Mardoche Sidor, MD

Total Wellness from page 24

The Road Ahead

The need for comprehensive, age-specific care in supportive housing is backed by compelling statistics. According to the National Institute on Drug Abuse, older adults are at increased risk of substance use disorders, and the pandemic has only heightened these vulnerabilities. Programs like Total Wellness are vital in bridging the gap, offering a lifeline to those in need (SAMHSA).

Urban Pathways is making significant strides in transforming the lives of its older adults. By addressing the multifaceted needs of each individual, our Total Wellness Program not only improves health outcomes but also fosters a sense of community and support. As we continue to navigate the complexities of providing care in a post-pandemic world, the stories of resilience and recovery at Urban Pathways serve as a testament to the power of holistic, compassionate care. As we continue to expand and refine our Total Wellness Program, we owe immense gratitude to the generous funders who make this work possible. The Altman Foundation, the Robin Hood Foundation, and the Mother Cabrini Health Foundation have been instrumental in supporting our mission to provide holistic care to our folks, especially those aging in place. Their contributions enable us to address the myriad needs of people in our care, ensuring they receive comprehensive physical, mental, emotional, and spiritual support.

Romi Avin, LMSW, MS, HS-BCP, is Program Director of Housing; Jose Cotto, LCSW, is Chief Program Officer; Anne Handford, MPH CHES is Project Coordinator of the Total Wellness Program; and Mardoche Sidor, MD, is Medical Director at Urban Pathways.

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Delivery of Therapy from page 30

2009; Chartier & Provencher, 2013). During nine weekly individual meetings, clients work with their providers to identify and plan pleasurable activities, reducing their depressive symptoms. All services are delivered remotely, allowing for maximum flexibility.

Lay volunteers have traditionally been a resource for community agencies and senior centers and have been shown to successfully deliver brief mental health interventions (Choi et al., 2020; Raue et al., 2019). “Do More Feel Better” was designed to tap into the large resource of older adults who serve as volunteers across the national aging network (Aging, 2023) and contribute to the access and sustainability of mental health programs for older adults (Raue et al., 2022). In “Do More, Feel Better,” we use a simplified BA treatment and train lay volunteers who are 60 years or older from the community to become “peer coaches” and deliver nine weeks of treatment to depressed older adults. Lay volunteers go through a rigorous certification process that involves four training sessions as well as weekly clinical supervision to help maintain fidelity to the intervention.

Given the large number of monolingual Spanish-speaking older adults in the US, we expanded our “Do More, Feel Better” project to serve this population. Spanish is the primary language for 21% of older adults living in New York City, and almost 14% have Limited English Proficiency (LEP) (Aging, 2023). Further, Hispanic older Americans have been shown to experience depressive symptoms at higher rates compared to non-Hispanic white American older adults (Hooker et al., 2019). Recognizing the need for and lack of care as well as potential limitations posed by language barriers, we expanded our program to give older Spanish speakers the opportunity to participate in research and receive BA therapy in Spanish. We have worked with multiple senior and community centers in the New York City area serving the Hispanic population to bring awareness of mental health needs, contribute to destigmatizing late-life depression, and present our project as an available resource.

Jo Anne Sirey, PhD

Striving to develop a workforce of non-traditional providers, “Do More Feel Better” has high potential for sustainability by making use of the existing national volunteer resources: according to a recent New York State Aging report, there are nearly one million volunteers aged 55 and older in New York State providing over 495 million hours of service at an economic value of $13.8 billion annually (NYSOFA, 2023). As the next step, we will be launching a program to sustain the “Do More, Feel Better” at senior centers. Senior centers will take over the training of volunteer coaches and oversight of the program.

Since the launching of the program in 2020, all participants, from the peer coaches to the clinicians and especially the clients, have reported positive experiences. Across three cities, New York City, Tampa, Florida, and Seattle, Washington, 52 peer coaches have been trained, and more than 244 participants served. Fidelity to treatment from peer coaches and clinicians has been maintained, and participants have reported an increase in their daily activities and enjoyment of the program (Gum & Raue, 2023).

Final Remarks

Older adults are at risk of experiencing mental health distress that can lead to poor health outcomes and a significant reduction in quality of life (Jia & Lubetkin, 2017). Stressful life events such as exposure to crime and increasing social isolation and loneliness among older adults have been shown to have dramatic effects on their mental well-being (HHS, 2023). “Do More, Feel Better” seeks to address the mental health needs of community-dwelling older adults by implementing a community-based approach to the delivery of BA Therapy and increasing the potential for sustainability by utilizing the existing older adult volunteer network. “Do More, Feel Better” participants have reported positive experiences in the program, including trained lay volunteers who further experience reward from learning to deliver an evidence-based intervention and help their peers (Gum et al., 2023). The lack of available and scalable evidence-based interventions for this population led our teams’ efforts to develop innovative programs to address the unmet needs of depressed older adults. Collaboration with National and Federal agencies is fundamental to continue to address this mental health concern.

If you want to learn more about our community-based research and mental health programs for older adults, please visit sireylab.weill.cornell.edu. You can email us at SireyLab@med.cornell.edu or call at 914-682-5453. Interested in learning more about “Do More, Feel Better”? Contact us at 914-507-7672.

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View the full reference list here.

Elder Abuse from page 27

But mental health plays a role for perpetrators of elder abuse, too.

Chronic physical or mental health conditions, substance or alcohol misuse, and high stress and burnout are risk factors for perpetrators of elder abuse (World Health Organization (WHO), 2022).

The COVID-19 pandemic produced a perfect storm for elder abuse that reverberates today, as both older adults and perpetrators experienced social isolation, stress, and health problems. One survey of community-based caregivers shows that, post-COVID, they are drinking more alcohol, feeling significantly more socially isolated and lonely, and are more worried about their finances than before the pandemic (Makaroun et al., 2021).

These stressors also impact paid staff in long-term care settings. Self-reports from these staff suggest that the risk of elder abuse is greater when they experience stress from staff shortages and emotional exhaustion, both of which have been exacerbated by the COVID-19 pandemic (Yon et al., 2019).

We Can't Reduce Elder Abuse Without Awareness

While addressing stressors is important, it's also crucial to equip our communities to identify elder abuse and normalize talking about it. Most experts agree that elder abuse is underreported, mainly due to fear of retaliation or shame (RAINN, n.d.).

Research shows that victims of elder abuse seek help from law enforcement only 15 percent of the time. Older adults are least likely to report abuse to authorities when they depend upon their abuser and when their abuser is well-connected to the community (Burnes et al., 2018).

Older adults often don't feel empowered or equipped to seek help, and professionals are undertrained to identify abuse or help older victims access care and services they may need.

So, What Can We Do?

To better identify elder abuse and give older adults a voice, we can look to critical access points in our healthcare system where providers often interact with older adults. One example is the emergency department (ED).

Older adults account for 23 million ED visits each year, yet ED providers say they do not commonly screen for elder abuse and feel that they often miss it (Sheber et al., 2023; Rosen et al., 2018). Reasons

Katherine O'Malley, MPH

for this include time constraints, a lack of training, and a positive screen for elder abuse requiring additional work.

Implementing a multidisciplinary team (MDT) in the ED that specializes in elder abuse is one way to help providers better identify elder abuse and link patients with resources. Hospital MDTs are made up of social workers, legal experts, and patient services staff, among others. They augment clinical provider care by conducting a comprehensive evaluation of an older patient with suspected elder abuse and then connecting that patient with necessary services and support.

MDTs are also used outside of hospital settings in towns and districts, staffed by a mix of civic and health professionals, including law enforcement, mental health clinicians, and attorneys. These community-based teams link elder abuse victims to services and resources, provide counseling, and engage in crisis intervention (Office for Victims of Crime, 2023). They also deliver training to government officials, healthcare providers, and courts to identify elder abuse.

MDTs are valuable for victims, but we also need prevention for perpetrators, too.

The American Psychological Association (2022) suggests that education is key to preventing elder abuse for perpetrators. If perpetrators know what risk factors lead to abuse, how abuse impacts an older adult's mental health, and what resources are available, they may be less likely to commit abuse and get help.

Digging deeper into societal-level stressors that may lead to elder abuse is another avenue for change. Experts say that providing financial relief in the form of tax credits and other similar policies that can help reduce stress, burnout, and strain on caregivers would reduce elder abuse (Marshall et al., 2020).

These interventions are springboards for change, but we have much more research and work to do to prevent elder abuse and empower older adults. Importantly, interventions to address elder abuse must incorporate mental health for both victims and perpetrators. With a growing proportion of older adults in America, the time to tackle elder abuse is now.

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an integral piece of the intricate interplay between serving an aging population and empowering individuals to optimize their health, wellness, and ability to thrive in later life.

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registered nurses, and behavioral health professionals who work together to provide comprehensive care for adults with serious mental illness (SMI) who also have chronic medical conditions. This program has been linked to a reduction in emergency department visits and inpatient admissions while also improving patients' engagement with primary care and specialist services.

Public Awareness and Education: Increasing awareness about the signs of substance misuse and mental health disorders in older adults can help in reducing stigma and increasing early identification and intervention. Initiatives like Screening, Brief Intervention, and Referral to Treatment (SBIRT) train primary care providers to screen, provide brief interventions, and refer to treatment as needed. Raising public and provider awareness through campaigns, training healthcare professionals, integrating screening into routine care, and developing specialized programs for older adults can improve early identification and access to appropriate treatment services for this underserved population.

Technology-Assisted Care Solutions

Today, technology is an integral part of our daily lives, regardless of age, gender, or socioeconomic background, and the healthcare sector has embraced technology-assisted care solutions as important tools in improving outcomes. According to the 2024 Behavioral Health Industry Trends Report, many behavioral health organizations still lag in innovating with technology, but there's a growing push to integrate technology-assisted care solutions to improve service delivery and outcomes.

The integration of new technology-assisted care solutions into geriatric healthcare represents a paradigm shift in how geriatric care will be delivered, potentially making it more proactive, personalized, and accessible. The use of advanced technologies such as telemedicine, artificial intelligence (AI), and wearable devices can not only improve access to healthcare but also facilitate treatments and interventions that are tailored to the individual needs of older adults. As technology continues to evolve, the focus must remain on personalizing care to meet the complex health needs of older adults with precision and compassion, ensuring better health outcomes and improved quality of life.

Emerging best practices in the use of technology-assisted care solutions in geriatric care should include the development of comprehensive care models that combine telehealth, AI, and wearable technologies to provide more holistic care solutions.

Jorge R Petit, MD

1. **Telehealth:** Multiple studies have shown the transformation in healthcare delivery through telehealth, most notably during the COVID-19 pandemic. The utilization of telehealth has continued to surge, proving particularly valuable in geriatric care. Telehealth platforms facilitate real-time video consultations, which are critical not only for routine health assessments but also for mental health evaluations where the physical presence of a healthcare provider may not be necessary. These virtual visits have been shown to reduce the stigma or reluctance associated with visiting mental health settings, a significant barrier among older adults. These technologies offer enhanced accessibility, efficiency, and responsiveness to patient needs. For geriatric care, telehealth has been vital in providing continued access to healthcare services for older adults, particularly in remote and underserved areas.

2. **Advanced Analytics and Personalized Care:** Leveraging big data and advanced analytics, healthcare providers have the potential to offer more personalized care to older adults. By analyzing vast amounts of health data, including prior medical history and even real-time data from wearable devices, AI will eventually be able to better predict health deterioration and assist the provider in adjusting medications and customizing treatment plans to meet the individual's unique needs.

3. **Artificial intelligence (AI):** The use of AI is growing in diagnosing and managing cognitive health issues prevalent among older adults, such as dementia and Alzheimer's disease. AI algorithms can analyze speech patterns and physical movements to detect early signs of cognitive decline. Many companies are pioneering AI projects that can sort through complex clinical data to assist in developing personalized treatment plans that adjust to the cognitive abilities of the patient.

4. **Robotics in Elder Care:** Robotic technology, while still not mainstream yet, is finding its way into geriatric care, providing physical assistance and companionship to older adults. Robots like Mabu and PARO can help manage daily activities and improve mental health by reducing feelings of loneliness and social isolation.

5. **Wearable Technology:** These are increasingly being used to monitor the health of older adults. Devices equipped with sensors can track vital signs, detect falls, and monitor physical activity levels, providing real-time data to healthcare providers. The use of such technology, currently being supported by the National Institute on Aging, can assist in managing chronic conditions and preventing emergencies by allowing timely medical interventions.

While the integration of technology-assisted care solutions in geriatric care offers certain benefits, especially in managing certain mental health and substance use challenges, the vetting, purchasing, implementation, integration, and monitoring of these technologies is not without its obstacles. If these obstacles are not systematically considered and addressed from inception, the implementation and ultimate effectiveness of these technology-assisted care solutions in geriatric care may be hindered.

A major hurdle is the digital divide that affects many older adults, characterized by limited access to the internet and the necessary devices. This gap is more pronounced in rural and underserved areas where broadband infrastructure is often inadequate. Additionally, the high cost of implementing cutting-edge technologies can be prohibitive for many healthcare organizations or facilities, particularly those operating under tight budget constraints or serving economically disadvantaged populations. Beyond the costs, there are issues of data security, data sharing, and system(s) integration and interoperability that are critical to consider.

Another significant challenge is the need for comprehensive training for healthcare providers. The effective use of advanced technologies requires not only initial training but also ongoing education to keep up with evolving tools and applications. This training must be tailored to include practical skills in operating the technology and understanding how to integrate digital solutions into existing care protocols effectively.

The reality is that patients and healthcare providers may have reservations about the shift from traditional face-to-face interactions to digital platforms. For many older adults, personal interaction is a crucial element of trust and comfort in their healthcare experience. Overcoming skepticism and building confidence in using these technology-assisted solutions is essential, requiring ongoing efforts to demonstrate the safety, efficacy, and personal benefits of these tools.

Addressing these challenges will require a multi-faceted approach. Infrastructure improvements, particularly in rural and underserved areas, are crucial for ensuring access to telehealth and other digital health services. Funding initiatives, possibly through public-private partnerships or state and federal grants, could alleviate the financial pressures associated with technology adoption. Educational programs designed to enhance digital literacy among older adults and training for healthcare providers can help mitigate some of the cultural and operational barriers. Encouraging the development of user-friendly technology that considers the unique needs of older adults – such as simplified interfaces and enhanced accessibility features – will go a long way to increase acceptance and usage.

What is needed is an organized effort to address the policy, programmatic, structural, technical, financial, and cultural barriers to implementing these tailored best practices in geriatric care, and we must start paving the way for more widespread adoption of these emerging technology-assisted care solutions in our healthcare system…with the goal of ultimately leading to better health outcomes for older adults.

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Monthly Support Groups for Family

Caregivers: Emotional and practical support, both individual and in groups, helps caregivers who are often overwhelmed with stress and added responsibilities navigate their challenges and feel less isolated and alone. Emotional support, care management guidance, and resources play an important role in helping caregivers deliver the best care for their loved ones and themselves.

Addressing the Challenges of Serious Illness: Our *Pathways to Care* program offers an array of services to people and their caregivers impacted by chronic or life-limiting illnesses at locations throughout Westchester County. Services include needs assessments; home, office, and hospital visits; supportive individual, family, and group counseling beginning on the day of diagnosis; referrals to resources; discussion and assistance completing advance directives; insurance, financial, and legal advocacy; assistance navigating complex medical systems; emotional support at the end of life; bereavement counseling for individuals, families, and groups; on-site grief counseling; and chronic illness support group.

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notion, showing that even the most formidable heroes can struggle with mental health. By portraying these struggles, "Bad Boys: Ride or Die" opens the door for meaningful conversations about mental health, especially among men who may feel pressured to conform to outdated notions of masculinity. Action aficionados need not worry—the movie climaxes with a wild shootout in an abandoned alligator theme park!

A Personal Reflection

As someone who has experienced anxiety since adolescence, I find these portrayals both validating and hopeful. They reflect a growing awareness and acceptance of mental health issues in our society, encouraging more people to seek help and support. Moreover, these films highlight the importance of addressing mental wellness in a way that feels natural and necessary rather than sensationalized.

Simcha Weinstein

Moving Forward: Reducing Stigmas and Supporting Mental Health

Incorporating mental health themes in blockbuster films like "Inside Out 2" and "Bad Boys: Ride or Die" is a step in the right direction. To continue this progress, we must educate people about mental wellness, reshape perceptions of manhood, and provide better training for medical professionals and first responders, including our clergy members. As a member of Mayor Eric Adams' newly established Faith-Based Mental Health Working Group, I am committed to equipping clergy who often unknowingly serve as first responders to better support their communities in times of need.

I commend the mayor for discussing mental health in New York. Additionally, I applaud Governor Hochul for her commitment to youth mental health and the recent passing of regulations to support this effort. The struggle is accurate, and these steps are crucial in addressing it.

By reducing stigmas and promoting open discussions about mental health, we can create a more inclusive and supportive society. By smashing stereotypes and tackling mental health head-on, films like "Inside Out 2" and "Bad Boys: Ride or Die" are shaking up the blockbuster formula in the best way possible. They remind us that even our most beloved heroes aren't immune to life's challenges. So next time you're munching on popcorn, remember that behind every explosive car chase, there's a deeper story waiting to be told. And who knows? It'll inspire you to be a hero in your mental health journey.

June is Men's Mental Health Awareness Month. Some tips for addressing mental health include:

- Speak to someone you trust
- Reach out to your doctor
- Seek a licensed therapist

Simcha Weinstein is a renowned author and advocate, dubbed "New York's Hippest Rabbi" by PBS. He is the DEI and community engagement coordinator at Families Together in NYS, founder of the Jewish Autism Network, and co-lead member of NYADD (New York Alliance for Developmental Disabilities).

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palpable. So, why is it acceptable for people with serious mental illness?

Various barriers hinder access to clozapine. Physicians, Psychiatrists, and Nurse Practitioners are reluctant to prescribe clozapine for several reasons. These include special monitoring requirements, administrative burden, a lack of prescriber knowledge and confidence, negative prescriber attitudes, unprepared health systems, and inadequate appreciation of clozapine's unique efficacy by policymakers and payers.[14]

The primary barrier is the FDA Risk Evaluation and Mitigation Strategies (REMS) for clozapine. Clozapine's REMS program places a tremendous administrative burden on patients and providers. The program for clozapine is the most restrictive of any other FDA-mandated REMS. The clozapine REMS mandates weekly blood draws for 26 weeks, followed by a mandatory blood draw every two weeks for an additional 26 weeks, after which blood draws are required every four weeks for life. This leads to tragic outcomes as patients face no drug because of no blood scenarios.

The weekly blood monitoring aims to detect the risk of severe neutropenia (agranulocytosis: absolute neutrophil count less than 500). The true risk of severe agranulocytosis in this population is less than 0.5%, and the mortality rate is 2.7-3.1%.[15] In this same population, the risk of suicide is 5-10%, and clozapine, compared to other antipsychotics, reduces this risk by greater than 70%.[16] Suicidal behavior in patients with psychotic disorders represents a seriously undertreated, life-threatening condition – and clozapine is the only FDA-approved medication for TRS and for suicidal behavior.[17]

There are numerous tragedies resulting from the inadequate treatment of psychosis, highlighting the devastating impact of clozapine underutilization and abrupt withdrawal. After years of meaningful recovery, a Texas man's clozapine was discontinued because of a REMS snafu. His rebound psychosis led him to draw a wooden gun on a police officer, resulting in his fatal shooting. One young man's clozapine ran out on a Friday after the laboratory failed to report his test results, and his clinic was closed all weekend. By Monday morning, his rebound psychosis was so severe he drove disoriented on a freeway and crashed into a wall. While hospitalized for internal bleeding, his psychosis caused him to assault a nurse, and he was arrested shortly after discharge. Why do we allow needless suffering for people with schizophrenia, particularly young adults and their loved ones?

Even the road to recovery can be an almost impossible journey. The torturous five-and-a-half-year struggle of one young man from New York and his family included attempted suicide, nine hospitalizations, and 13 antipsychotics. Once on clozapine, his psychosis resolved. He graduated with honors from a prestigious university and is working at a high level in a career of his choosing. Another young man was subjected to five antipsychotics and, at one point, three simultaneously. He remained paranoid, delusional, and, at times, suicidal. After clozapine, he was able to thrive. He finished college with honors and is now a successful standup comedian in New York City.

There needs to be an investment in educating physicians on the timely, safe, and effective use of clozapine and compensation for diligent patient care and monitoring. And it's more than time to ease the clozapine REMS requirements to ensure that people with treatment-resistant schizophrenia have access to life-saving treatment. It is inhumane to deny a cancer patient chemotherapy, a diabetes patient insulin, and patients with TRS clozapine.

Not another person should be subjected to these draconian requirements. We urge you to contact the FDA to ease the REMS requirements and invest in physician education. Visit www.naminyc.org/clozapine.

Matt Kudish is CEO of NAMI-NYC, a non-profit helping individuals and families affected by mental illness for over 40 years. Robert Laitman, MD and Ann Mandel-Laitman, MD, are Mental Illness Psychiatric Internists with special expertise in clozapine; Team Daniel: Running for Recovery from Mental Illness. Donna Taylor MSN, RN, Team Daniel Running for Recovery from Mental Illness; Advocate for Caregivers and their loved ones with SMI.

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therapeutic method effective for all adolescents, given the diverse underlying causes of this behavior. Clinicians should aim to manage acute symptoms with behavioral therapies and/or medication, allowing teens to explore the deeper issues contributing to self-harm and offering alternative strategies to address underlying risk factors, such as trauma history, abuse, substance misuse, or family conflicts (Kilburn, 2009). Clinicians can normalize feelings of despair and encourage open communication about self-injury and relevant aspects of the teen's life. By exploring themes of guilt and shame, clinicians can help reduce the reliance on self-harm as a primary coping mechanism. Developing alternative coping skills is essential for managing stress, regulating emotions, and building resilience.

Effective coping strategies include (Kilburn, 2009):

- **Acknowledgment:** Recognize and acknowledge that cutting is currently a coping mechanism. Avoid immediate attempts to eliminate it, as it serves as a defense mechanism for the adolescent.
- **Grounding Techniques:** Assist teens in gaining control over dissociative states through grounding techniques.
- **Anxiety Reduction:** Use relaxation and stress management techniques to decondition anxiety.
- **Social Support:** Help develop a social support network.
- **Healing Process:** Emphasize that healing is a gradual process of increasing awareness of environmental impacts, allowing teens to expand their perspectives and options for making choices. Encourage them to direct their own healing process.
- **Patience:** Understand that this process takes time and that relapses may occur.

Scott Bloom, LCSW

By employing these strategies, clinicians can provide comprehensive support to adolescents struggling with self-harm.

Nearly one in four NYC teens (24%) reported needing or wanting mental health care in the past 12 months but did not receive it (Hamwey, 2024). Outpatient mental health clinics, such as the New York Psychotherapy and Counseling Center, are uniquely positioned to address these needs promptly. Trained clinicians begin with an assessment of the severity of self-harm and offer clients clinical interventions and coping skills for distress tolerance, interpersonal effectiveness, emotion regulation, problem-solving, assertiveness, mindfulness, and alternatives to self-harm.

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data, mental health assessments, and more. Clinicians must expect the unexpected and be prepared to get creative with the entire care team to address as many conditions as possible to improve a patient's overall wellbeing.

Understand How Past Events Might Cause Current Behavior

It's not just grief, isolation, loneliness, and substance use disorder that can spark behavioral health changes in older adults. Past trauma is also a significant factor, and issues stemming from either recent or early childhood events can have reverberating effects on someone's current mental state, especially if that trauma has not been resolved.

Adults aged 75 and older have the highest suicide rates in the country (American Foundation for Suicide Prevention, 2024). By uncovering past trauma, clinicians can better treat the root cause of present-day issues, customizing treatment in hopes of making a lasting impact on patients. It's also the first step towards decreasing the likelihood of self-harm.

Rely on Family and Friends for Additional Context and Support

While a medical team working together can help diagnose a patient, friends, and family are a foundational part of that care team. They're doing most of the day-to-day work and have background information that a patient may have forgotten. They can also share their observations about behavioral changes and any relevant insights about the patient.

Marlene McDermott, LMFT, PhD

For example, someone suffering from dementia or Alzheimer's may not remember certain relevant details, but a friend or family member can fill in the clinician. Someone with diabetes and depression can be lethargic and lack motivation, but those symptoms are similar for those who don't take their insulin or their antidepressants. A caretaker may be able to shine a light on what is actually happening, especially if medication is not taken regularly. Involving the patient's support system is necessary for effective care and can be invaluable for arriving at an accurate diagnosis and deploying the correct treatment.

Jennifer Comerford

Complex older adults deserve high-quality treatment just like the rest of us. With a little advanced preparation and an open mind, mental health clinicians, no matter their professional focus, can be a lifeline to these individuals, who greatly benefit from customized care in the later stages of their lives.

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Housing from page 31

additional medical and support staff, renovate facilities to meet ADA standards, provide ongoing training for staff, and, most importantly, ensure fair wages and reduce staff turnover. Unfortunately, funding has been a contentious issue. While Governor Hochul has historically demonstrated support for mental health, and specifically mental health housing, it isn't enough to combat the decades of underfunding this field has endured. The age of our housing models and the lack of resources to meet residents' modern needs require ongoing and sustained investments. This includes a need for an adequate and consistent annual cost of living adjustment (COLA), which helps providers cover mandated operation costs and pay their staff a living wage.

Addressing this time-sensitive issue facing aging New Yorkers in mental health housing and those who support them requires collaboration between various stakeholders, including state leadership, mental health housing providers, and advocacy organizations. Yet, twice (2021-2022: A.10139/S.9041, 2023-2024: A.5119/S.5178), Governor Hochul has vetoed a bill, which passed in both the Senate and Assembly, that would have organized a task force to make suggestions on how

Sebrina Barrett

to handle the crisis among mental health housing communities. This lack of progress exacerbates the crisis, as time is lost and residents continue to age without adequate support.

To remove barriers to the care of older adults living with mental health challenges, several solutions should be considered:

- Establishing a dedicated task force, as in the proposed legislation, could provide expert recommendations on addressing the needs of aging residents. This group could identify best practices, propose funding mechanisms, and suggest policy changes to improve care.

- Developing integrated care models that combine mental health services with elder care could provide comprehensive support for aging residents. These models would ensure that residents receive holistic care tailored to their unique needs.

- Implementing enhanced training programs for staff would equip them with the skills needed to care for aging residents. These programs should focus on both medical and mental health aspects to provide well-rounded support.

- Securing increased state funding is essential for implementing these changes. Advocates and providers must continue to push for financial support to ensure that facilities can meet the needs of their residents and the growing costs of operations.

- Raising public awareness about the challenges faced by aging residents in mental health housing could garner broader support for necessary changes. Highlighting the stories of affected individuals could humanize the issue and drive advocacy efforts.

The aging population in New York's mental health housing presents a significant challenge that requires immediate attention. By addressing the needs of aging residents through increased funding, enhanced training, and comprehensive care models, we can ensure that these individuals receive the support they deserve. Collaboration among state leadership, advocacy organizations, and providers is crucial for creating a sustainable solution. As we move forward, it is imperative to remember that the well-being of our most vulnerable residents is at stake, and we must act with urgency and compassion to address their needs.

Sebrina Barrett is the Executive Director of the Association for Community Living, which advocates on behalf of more than 48,000 New Yorkers living with mental health challenges to find appropriate and necessary care among the mental health housing providers across the state. She can be reached at sebrina@aclnys.org. More information about their advocacy and mission can be found on their website. To reach ACL staff, call (518) 688-1682.

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human connection.

Angela's care team worked with her to find a more effective medication dosage to treat her depressive symptoms. They provided her with additional education and reminders about the importance of regularly using her sleep apnea machine, nebulizer, and asthma pump. The care team also helped Angela set up appointments with a primary care provider and pulmonologist, as well as Medicaid transportation to get to those appointments.

The behavioral health providers in our network have seen significant improvements in provider-patient communication, health outcomes, and patient quality of life because of our investment in tools that provide actionable, measurable data. Effectively implemented, these tools empower us to provide care that centers on each patient's needs. And helping people

Nadeem Ramjan

access the services they need also helps the community by enabling hospitals to reserve their limited resources for true emergencies.

Community health provider networks across the United States can replicate and enhance the success of this initiative by investing in collaborative relationships between hospitals and outpatient behavioral health providers. Policymakers and other decision makers must also invest in resources, including technological solutions like the data tools we've developed, dedicated staff and training, redesigned workflows, and enhanced payment to support staff in implementing new processes.

The data analytical tools and processes we've developed are improving outcomes and decreasing costs for patients, providers, and the community. The positive impact of this initiative is a testament to the power of collaborative efforts to efficiently utilize community-based resources and improve patients' lives.

* Pseudonym to protect patient confidentiality

Nadeem Ramjan is a data strategy, governance, and management leader who supports actionable and measurable data solutions. He is Director of Data Strategy & Analytics at Advanced Health Network/ Recovery Health Solutions (AHN|RHS), a comprehensive behavioral health provider network. AHN|RHS provides integrated behavioral health services in an autonomous and cohesive program throughout the five boroughs of NYC, Nassau, Suffolk, and upstate New York. Partnering with insurance plans, medical practices, hospitals and health systems, and other strategic partners, AHN|RHS is dedicated to improving immediate access to quality care and empowering individuals to better manage their health and healthcare needs. AHN|RHS supports a person-centered, integrated healthcare model that focuses on early detection, prevention, and treatment with the goal of avoiding unnecessary emergency room visits and hospital admissions.

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group, leading to more effective and efficient care delivery.

AI's Broader Impact on Health Systems

In addition to creating virtual communities, AI can continue transforming entire home care systems. One area where this is particularly evident is in the realm of predictive analytics. By analyzing historical data, AI can predict future healthcare needs and identify potential gaps in care delivery. This enables home care providers to proactively address these gaps, ensuring that resources are allocated where they are needed most. For instance, predictive analytics can help identify regions with a high prevalence of certain conditions, allowing for the deployment of targeted interventions and resources to those areas.

Furthermore, AI can make care delivery more efficient by taking over routine tasks and simplifying workflows. This frees up home care professionals to concentrate on more complex and important tasks, ultimately improving the quality of care. For example, AI-powered chatbots can answer common patient questions, allowing nurses and doctors to spend more time on direct patient care. AI can also help with clinical decision-making by offering real-time insights and recommendations based on the latest medical information.

Addressing Challenges and Embracing Opportunities

Introducing AI and new technologies into home care comes with challenges. There are concerns about data privacy, AI bias, and the need for significant investments in tech. However, these challenges can be addressed. AI can greatly benefit home care with the right regulations, protections, and investments.

Now is the time to embrace AI. Instead of fearing the unknown, AI-driven tools should be harnessed to advance the healthcare system. This approach will help build a more efficient infrastructure that benefits both patients and caregivers. Machine learning will shape the next decade, making home care an even better option for patients. It will transform patient care, making the industry more effective and ensuring better care for clients and a sustainable future for caregivers.

Josh Klein is founder and CEO of Emerest, an innovative agency focused on specialized healthcare and home care solutions that service thousands in multiple states across the United States. Under the Emerest brand, Klein also leads Royal Care, a leading home care provider in the New York City area. Klein is a certified paramedic and volunteers for Hatzolah, the local community's foremost emergency response organization. You can follow Josh on his LinkedIn page.

Josh Klein

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and have long histories of substance use. However, many older adults who don't have a history of substance use are also at risk of overdosing on prescription opioids. Having frank conversations with prescribers, family, and friends about the potency and dependence-building nature of these prescription opioids is essential to protecting older adults.

Harm reduction saves lives and must be made more accessible to older adults. This includes increasing the distribution of naloxone, a life-saving medication that can reverse opioid overdoses, and ensuring that older adults and their caregivers know how to use it. Additionally, providing education about new batches of drugs and other harm reduction services such as syringe exchange, drug checking, and overdose prevention centers will help reduce fatal overdoses.

The loneliness epidemic can be best addressed by providing access to increased social connectedness. At Alliance, we offer unique programming for people impacted by chronic health conditions to express themselves creatively and to connect with a community. For example, our Creative Writing Workshop offers an opportunity for participants to write poetry, which supports self-expression and helps people process trauma. It is open to all ages, but programs such as these are particularly helpful for older adults who may benefit from more structure and purpose in their day-to-day lives.

Reducing the stigma associated with substance use and mental health challenges in older adults is crucial. Public health campaigns and community initiatives should aim to change the narrative around substance use in older populations through targeted outreach. Support groups and counseling services tailored to older adults can provide safe spaces for them to discuss their experiences and seek help without fear of judgment.

The overdose crisis requires a nuanced and comprehensive approach that is tailored to different communities and their needs. By focusing on the unique challenges of older adults and implementing targeted harm reduction strategies, we can begin to address the gaps in our current response and work towards a future where fewer lives are lost to overdose. It is imperative that we recognize and act on the urgent needs of older adults to mitigate the impact of this ongoing crisis.

Ramona Cummings is Chief Program Officer of Alliance for Positive Change. Learn more about the work of Alliance at www.alliance.nyc.

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for adjustment – de-escalating despair and depression, evaluating overall needs and strengths, and connecting people to the path of learning.

Optimally, an individual's needs, goals, and priorities are considered, which helps cultivate emotional access to specific, timely support services and inspires hope for improved quality of life. Those struggling with multiple crises benefit from both information and compassion to help re-direct their focus from loss to learning.

Since Covid, health insurance coverage has expanded to video calls and phone sessions, increasing access to individual psychotherapy, especially benefiting those with visual impairment. Outreach presentations about programs, services, and resources shifted from in-person to virtual, spreading a wide online information-sharing network to providers at medical centers and to community liaisons at senior centers, community boards, religious centers, and social service organizations.

Free, internationally available virtual support groups for coping with vision loss are available by phone or Zoom. In-person and virtual trainings provide demonstrations of accessibility features on phones and computers, phone apps, and high-tech vision aids. Additional support and enrichment opportunities include free case management services (NY Connects: 800-342-9871), free audiobook access (Andrew Heiskell Braille and Talking Book Library), escorted running (Achilles Club), InTandem Cycling, Blind Baseball, low-cost refurbished computers (Computers for the Blind), educational videos (YouTube), research participation and clinical trials (NEI and clinicaltrials.gov).

Vision rehabilitation specialists enable individuals with vision loss to attain their goals, training them in skills for navigating their home and community, shopping, going to school, and returning to work. They help people with low vision learn how to best use assistive technology and other tools that help them maintain their independence.

For those deemed "legally blind" by an eye doctor, the New York State Commission for the Blind provides, for eligible participants, access to independent living skills training – training in performing household tasks, orientation, and mobility skills, and a low vision examination. Also, vocational rehabilitation is provided for those interested in work, school, or career skills training. In New York City, three vision agencies provide Commission services – Helen Keller Services for the Blind, Visions, and Lighthouse Guild. Every state has its own commission for the blind.

Where to Start?

If you or someone you know has a concern or question about vision changes, now is the time to learn more. Asking for help opens the door to learning. With the help of social workers, people coping with vision loss can learn to take steps towards new ways of functioning, connecting to programs, resources, and individuals that help them emotionally adjust and functionally adapt.

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younger people.[19]

All of this contributes to personal and familial dysfunction, premature disability and death, avoidable institutionalization, high rates of suicide, and very high costs of care.

- Dementia was the 7th leading cause of death in the United States in 2022.[20]
- Behavioral health conditions, i.e., mental and substance use disorders, contribute to premature death. For example, people with serious mental illness die 10-25 years younger than the general population.[21] And people with co-occurring depression and cardiac conditions are far more likely to experience premature disability and death.[22]
- Depression contributes to high suicide rates among older adults, and in 2021, suicide was the 11th leading cause of death in the United States.[23] Suicide rates are especially high among older adults.[24]
- Anxiety disorders contribute to social isolation and rejection of help.
- "Neuropsychiatric" disorders are the leading cause of disability in the United States, accounting for nearly 20% of all years of life lost to disability and premature mortality.[25]
- Misuse of alcohol often leads to illnesses and accidental injuries, especially falls and automobile accidents, which can result in premature disability or death. Between 2015 and 2019, there were about 140,000 alcohol-related deaths per year in the United States.[26]
- Misuse of illegal substances contributes to overdose deaths (over 100,000 in the US in the last year), homelessness, the over-population of prisons, the spread of contagious diseases, disruption of work and family life, and violence in the home and in the community – especially in poor communities of color – and more.
- In addition, cognitive and behavioral health conditions are major drivers of high healthcare costs in America. This includes the costs of long stays in hospitals, the high use of emergency rooms, and long-term residential care.

It is important to note that while the risks to mental health are great in old age, the opportunities to experience mental well-being are also great.

For all of these reasons, it is very important to address the needs of those people who experience mental problems in old age.

Currently, for example, many states are developing "master plans" to address aging. They have various names, such as "multi-sector plans," "longevity-ready plans," etc.

Michael B. Friedman, LMSW

What should these plans include regarding cognitive and behavioral health? Here are 15 key goals:

1. Enable older adults with cognitive or behavioral health conditions to live where they prefer, generally not in institutions.
2. Improve long-term care, including nursing homes, assisted living, and home and community-based services.
3. Enhance support for family caregivers.
4. Increase cognitive and behavioral health service capacity to keep pace with the growth of the older population and to address current shortfalls.
5. Enhance access to care, particularly with extensive use of telehealth and increased outreach and engagement.
6. Improve quality of care and treatment, emphasizing clinical, cultural, and geriatric competence.
7. Increase and improve the professional and paraprofessional workforce in primary care, long-term care, behavioral health, and aging services. And develop alternatives to current service models using peers and others.
8. Enhance integration of care within and between service systems - dementia care, behavioral health care, primary care, long-term care, and aging social services. And enhance collaboration between service programs and community organizations, especially faith communities.
9. Address social "drivers" of behavioral health, such as racism, poverty, and social isolation.
10. Address racial and economic disparities.
11. Increase "preventive" interventions so as to reduce the incidence of cognitive and behavioral disorders, relapse, institutionalization, and suicide.
12. Promote mental well-being in old age.
13. Improve public and professional education.
14. Increase and redesign funding to meet the needs of older adults.
15. Compile epidemiological, services, and financial data and create a publicly accessible data dashboard.

A daunting agenda, no doubt. However, it is well past time to address the consequences of the elder boom. We knew it was coming decades ago. Now, we are halfway through the boom and just beginning to confront the challenges. No More Delay!

* People with developmental disabilities, who used to have a life expectancy no greater than 40, now have a life expectancy just a bit lower than those without developmental disabilities.

Michael B. Friedman is the Honorary Chair of the Geriatric Mental Health Alliance of New York and Co-Chair of the Ad Hoc Group of Experts on Geriatric Cognitive and Behavioral Health of Maryland. He has published over 250 articles, op-eds, and book chapters, most of which can be found at www.michaelbfriedman.com. He welcomes comments at mbfriedman@aol.com.

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Spotlight Interview from page 1

sector and collaborated with the two prior organizations that recently merged to become InUnity Alliance. I'm really looking forward to what the newly appointed CEO is thinking and planning. So, first question:

Can you share with us your strategic vision and priorities for InUnity Alliance in your first year, especially as it relates to and how we're going to address this growing mental health and addiction crisis in New York?

Jihoon Kim: Thank you, Jorge. It's great to be here. First, I'll say that our strategic vision and our priorities in the first year, but also in the upcoming years, are always going to be rooted in the everyday experiences of our membership, the communities that they serve, and the people who are receiving services from the community-based organizations.

So, as David said in the intro, InUnity Alliance came about as the merger of two long-standing associations, and now we have a statewide association representing 250 community-based organizations that are providing addiction and mental health services. And I've been spending a lot of my recent weeks and months traveling the state and just completed a tour in Western New York, Finger Lakes, the North Country, and the Capital Region, and have plans to spend more time also in New York City, Long Island, and Central New York, and the Southern Tier. I think in my time in government, the most important thing was not to legislate or dictate or regulate from the Capitol and the halls of Albany. It was really to meet people where they are, including the people who are receiving services, as well as the people who deliver those services.

In my short time here, four months exactly to date, the main issues that I'm hearing over and over again are about inadequate reimbursement rates, the historic workforce challenges, especially in the human services and mental health sectors, and also stigma and the disparities that exist. When I talk about stigma, it's not just stigma about the people who receive services, but it also exists in the layers of bureaucracy between government organizations, insurance companies, and the like.

I think there's a disparity between how we look at the services and the providers that deliver the services in addiction and mental health care versus big age health care. One of the challenges that I experienced in government that I'm hearing a lot about from my members is about citing issues, citing OTPs, citing other clinics. I don't think you would actually have those same kinds of issues if you were going into a community and to legislators and talking about bringing an urgent care clinic or a hospital into a community.

So, why is there a disparity in how my members are being treated by government and others as it relates to their services? So those are some issues that impact the daily lives of New Yorkers who are trying to access addiction or mental health care services. And it's deeply rooted in stigma, that we've overcome a lot of it, but I do believe there's still a lot more work to do.

I think the other thing, Jorge, is that we have to define the problem and talk about it honestly. I think one of the things that I've been spending a lot of time doing in traveling the state is meeting with providers across the continuum of care as it relates to the overdose crisis. And I think what I'm hearing over and over again, regardless of what part of the state I am in, is that people are genuinely concerned, providers are genuinely concerned about a lot of government officials who seem to have taken their finger off the panic button as it relates to overdoses. I think the CDC came out with provisional overdose numbers not too long ago, and I have heard many leaders in healthcare talking about the policy changes and investments over the last couple of years that have worked.

I would argue the opposite because of the over 6,000 deaths in New York State two years in a row. One example is Western New York in the Buffalo area, which is on pace to exceed its overdose numbers from the last two years. They're projected to have over 400 overdoses this year.

Those are unacceptable numbers. Fentanyl is the leading cause of death amongst any category right now, any category. And you layer that on top of the overdose rates in New York at a statewide level have ticked down very, very little, according to the latest CDC numbers. It still is like the sixth leading cause of death in the top 10 leading causes of death historically. Just behind strokes, I believe. So, I think those overdose numbers are unacceptable, especially as it relates to people of color, particularly men, especially black men, and those over the age of 55. Those numbers are rising sharply. I think you have to always look at the data in full context, not just the top lines.

And those are the realities. You can also make the same argument as it relates to suicide numbers suicide rates and analyzing those rates that have been around for a long, long time. We are seeing suicide numbers not being abated by all of the investments that are being made at a national and state level.

And we have to ask the question, why is that the case? I think it's because, ultimately, we have to be honest about the facts on the ground so that government officials will not continue to use their facts or their sets of facts to deprioritize addiction and mental health services under the guise of tight budgets. I think one of the most important things is that we're using data honestly to say there is an existing system of care within addiction and mental health where you have a continuum of services offered by community-based providers who have been talking about underfunding for quite a long time, actually since deinstitutionalization. They have been arguing about the need for more investments into community-based providers. And I certainly think that when I talk about traveling the state and starting where my members are and the people that they serve, that connects directly to the information that we're sharing with people in positions of power who can actually make policy changes and the right strategic investments into the providers who are doing the really difficult work day in and day out.

And I have a couple of other points on this topic because I have a lot to say about this. Third, I think one of the strategies that I'm really grateful for is the work that both John Coppola, formerly of ASAP, and Amy Dorin, formerly of the Coalition for Behavioral Health, have done to merge the two organizations. Not everyone goes down this road of mergers because it's not easy, and I think everyone ultimately wants to ensure that the priorities of whatever agencies that are merging are both retained in the new organization, and they both have done tremendous work, including with the respective boards. And I appreciate all of what they have done and their guidance over the last four months.

They did actually end their terms as consultants at the beginning of July, and I'm excited to say that I'm building a strong team here. Sarah DuVall started as our policy director in early June, and we have Amanda Semidey coming in as our Chief Operating Officer next week. So that's part of my strategy is that we're going to build a dream team here at InUnity Alliance where we are not only providing expert services and technical assistance to our members, but we're thinking about how the work that we're doing with our membership relates to the kind of policy and advocacy we have to do in a statewide and national level.

And then finally, I will say, Jorge, for your audience that may not be familiar with my most recent background, is in government. I had the privilege of serving Governor Kathy Hoch was the Deputy Secretary, overseeing all of the mental hygiene and human services agencies, including OMH and OASAS, OPWDD, and others.

I believe that my lengthy history in government and the most recent position I had directly overseeing the states investments and policy decisions on addiction and mental health services can really empower InUnity Alliance where I can advise and empower the entire InUnity Alliance membership based on deep understanding of the players and politics that inform decisions in Albany and also in City Hall here in New York City. So that's my long-winded answer.

Jorge: Great. Thank you for that. It's super exciting. Congratulations on your four-month anniversary and your recent hires. I do think this does fill me with a lot of excitement and hope because the leveraging the power that each of these organizations had in their own right and coming together, but also, with your experience in government, I do think there is this opportunity where at the inflection point in really being able to enhance the advocacy and the steering some of those public dollars in a more data-driven way. I love that you're talking about data and really trying to hone in our capability to be able to address these issues, not in this global fashion where I think historically we've done a little bit of everything everywhere, but really focusing in on those communities that are most impacted, whether it's targeting issues brought up around older Black men and overdose deaths or some of the rising rates of suicidality among LGBT and all these other sort of disparities that exist.

How do you plan on advocating for a more commonsense approach to funding and procurement based on data, rather than relying on the existing mechanisms?

Jihoon: Yeah, I mean, that's a great question. I think it's interesting and I think you can kind of go either way with the strategy here. I think ultimately, when you're thinking about just focusing on New York State government and state investments, there are always more priorities that a governor and their fiscal people will inherit and have to manage and deal with than there are dollars to go around.

That's just the reality. I think it really boils down to helping to reprioritize how government should be looking at the broader behavioral health sector, given what we know is happening on the ground as it relates to overdose rates, as it relates to suicidality, and suicide completion, especially as it pertains to particular groups. I think there's always this risk, and I saw this, and I admit, I think my time in government, there's always this desire or kind of a knee-jerk reaction that you want to announce something flashy, that you think everyone's going to be like great.

What I learned in my time in government, including being one of the main architects of the governor's $1 billion investment in mental health in two years ago, was that there's an existing infrastructure of providers. I can just pick out of a hat the membership of InUnity Alliance. Small, large, where there are experts who have been doing this work forever. I think really what it boils down to is listening to the voices of the people on the ground, not only from my perspective as the new CEO of InUnity Alliance, as I get to learn my membership and really what their priorities are, but also for government officials to say, "Hey, you really do need to listen to people on the ground."

I think this happened within the healthcare system during COVID, where you had a healthcare establishment saying, "Hey, you really need to listen to us. We're the experts. We know what works in our communities. You really need to help us figure out and organize around the fact that communities across New York State, with all of its beautiful diversity, have a lot of common ground in what we know works."

I think what we know works is community-based care that is very low threshold, meaning there are very little barriers, whether that's insurance barriers, payment barriers, whatever the barriers that exist, and really investing in those services. InUnity Alliance is made up of many member organizations that really deliver services where people are in their communities. What I've seen and what's beautiful about the community-based network is that you'll have an organization in the Bronx that says, hey, we started off providing medication-assisted treatment, and

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we have an article 31 mental health clinic. What we realize with a lot of the people coming through our doors is we have lots of rates of folks who don't have a place to live. We need to open a shelter, or we need to open some kind of other transitional living program. We also recognize that a lot of people have un-healthcare needs.

We have members that actually have FQHCs and other whole suites of services that really meet the people where they are. What I would say is we know what the data is showing, even with the governor's investments over the last two and a half years in mental health and the opioid settlement dollars actually going out the door over the last two years. We still see numbers that reflect that there's historic underinvestment in the existing infrastructure of community-based providers that actually better serve the needs of the average New Yorker who has unmet needs. Yes, there are people who are going to need to go inpatient for a period of time sometimes. There are people who may need an inpatient level of stay for addiction, but generally speaking, much as it is with broader health care services, people do not stay hospitalized inpatient in some of those more costly settings for the duration of their recovery. When we're talking about mental health, mental health disorders, and substance use disorders, we know that, for the most part, people will need some level of services for the rest of their lives. In that case, it makes the most sense to invest in the community-based system of care.

Jorge: I fully agree. As you were talking, I was thinking about a couple of follow-up questions. One of them, you talk about the voice of the community-based providers. Having been on that side, but also in government side, I do think sometimes we're not necessarily talking with each other. We're talking maybe at each other. I think that being able to bridge some of that between community-based providers and government is really critical. One thing that I have come to realize is it's really critical that we try to figure out how to elevate the voice of the individual we serve. I think that there are initiatives underway, and there are different organizations and different settings and where the voice of the individual we serve might have a larger valence. I do think that sitting in government, we sometimes don't really think about the impact of what we say or do, or even community-based providers coming up with their strategic plan for the next three years without really bringing into the conversation those individuals served, whether they're in a supportive housing unit, or in a CCBHC, or in a peer recovery program. I do think we have to figure out, and this is not a question. It's more a rhetorical framing, but I do think we need to figure out how do we elevate those voices differently.

I'm hoping that we'll think about that in the Alliance as it's moving forward in terms of how we embrace some of those voices. So, just a quick pivot then in terms of thinking about where we are today post-COVID and all of the issues that have come out of the lockdown and the workforce crisis. I think when I was at a large not-for-profit organization, our biggest issue was workforce, right? High turnover rates, low wages, recruitment, and retention were really complicated. The billion dollars that the governor put in the budget actually ultimately translates into programs that require individuals to be hired, whether it's a nurse, a social worker, or a doctor, and everyone is scrambling to find those resources.

From the perspective of InUnity Alliance, what are your thoughts about where and how you can mobilize the community-based providers around thinking about initiatives or programmatic ways of addressing some of those issues related to recruitment and retention of workers in our sector?

Jihoon: I always start with a conversation about the workforce that is also rooted in my own experiences. I worked as a direct care worker in a non-profit with men with both mental health disorders and intellectual and developmental disabilities, and this really feels like it was ages ago, but I still say to this day in any job interview I had because I've worked in this field for a while, including in government, is that it was my favorite job because there was a direct tangible impact in the lives of individuals that you can see every single day when you went to work. But I also say, as part of that story, I always had aspirations to go to graduate school. It ended up being in social work, and it was impossible for me to balance going to grad school, having to have another internship in grad school, and keeping that job.

I wish I could have done it all, but I couldn't. And I think about it in hindsight because if I were to stay at that organization or a similar organization, I probably would have had to work three or four different jobs. And what would have probably happened is I probably would have worked my way up through like an administrative kind of position within the organization.

And in many ways, I would have left the lower wages job behind in an interest to just be able to pay the bills. I think about this a lot, too, because as I was in government, there were lots of stakeholders coming to me asking for increased wages. And ultimately, the turnover rates in the workforce crisis are directly related to historic underinvesting in this field and recognizing that the nominal cost of living adjustments that, depending on the whims of that budget year, would either make it into the budget or not make it into the budget, that's not a reliable source of revenue for organizations that have to do multi-year planning as it relates to their services. So, the turnover rates are directly related to underpaid low-wage employees. It's not only about wages, but that is one of the main reasons why jobs that already lead to high burnout results in high turnover. The wages are just simply inadequate, Jorge. So, we need to raise the wages of the entire industry. People are literally leaving these jobs for higher-paying, low-wage jobs and working multiple of them. I mean, there are ideas such as developing like true career ladders for direct care staff, whether it be through mentorship or training programs, so that they can grow and promote within the organization.

But that also does lead to potentially the ranks of middle and upper management being taken care of while there will continue to be this challenge with the lower paid jobs, which is I think, the bulk of the jobs in most of these organizations and even low and forgiveness opportunities, those are, to a large extent is to help people on a career path within the organization and growing up the career ladder. I do think that there are some initiatives underway, right? There are some initiatives underway, whether it's in the IDD sector or other sectors where there are some incentives being offered to the nonprofit sector. There's currently a push for a bill to expand the existing government pension benefits to the nonprofit industry, particularly in this field. That's something that MHANYS has been leading the effort on, and it's something that in union line supports. Now that I am the CEO of my own nonprofit organization, I recognize that there are ways, even within a limited budget, for you to be able to take care of employees, keep them happy, keep them motivated, especially in these very high-stress jobs.

I think there are those kinds of incentives. I think one of the things that is also lost in the conversation about the workforce is what an organization can actually do internally to help the workforce. I think supervision is something that is not talked about that often. I'll give you an example of how recently I've been meeting with a lot of organizations that have begun to or try, have been trying to expand their use of peers.

The peer model is something that is not new but has been growing as of late, and I am proud that InUnity Alliance, one of the things that we continue to do as part of the merger and with the work that ASAP was doing, is continuing to expand upon the peer certification and recognizing that we have the certified recovery peer advocates, but we also have been developing other certifications, including a peer supervision professional credential, really with the goal of supervising and supporting this critical workforce. I think that's a good model and example of other types of support that employees in very high-stress jobs, where they probably would leave for another job that is paying similar or a little more that's not in the same kind of field to make sure that they're supported, especially with their high level of stress.

I think also related, providers do need to build in systems of care for their employees, including like enhanced and flexible pay time policies, as well as other management strategies to engage the employees, all things that we're also thinking about internally for InUnity Alliance staff. But I think there are internal strategies that can be employed that only go so far, to be quite honest. I think, ultimately, it comes back to what the InUnity Alliance is going to do with our membership in advocating with a very loud but also strategic voice as it relates to the sector. And when we're talking about the workforce, it's to help government officials reprioritize all their priorities. I know that with all the priorities that lay before any governor or any budget director, they're going to look at what remains after negotiating internally with all their other priorities.

I think that's unacceptable. I think we need to reframe the problem statement so that people understand, especially, and I know with this governor, she cares deeply about issues related to mental health and addiction, but it's really helping them to reprioritize how that should be in like the tier A level of investments that they're thinking about to make sure that the existing community-based system of care is robustly supported, not only with investments but any beneficial policy changes.

Jorge: Yeah, I know that's super important, but it's related. I was thinking as you were talking about how we shore up sort of just the foundational underpinning of how we're paying our staff, especially our direct service providers. And I keep on thinking about the fact that if you're trying to create career ladders and build in supervision, peer monitoring, supervision, and coaching to be able to ultimately help individuals stay within their trajectory and actually move on, those aren't reimbursable services.

How do we address the fact that we have so many healthcare plans? While parity around commercial rates has improved, it's still not ideal. From your perspective, how can we push managed care organizations to work more collaboratively and meaningfully with providers? This includes not just the providers themselves, but also independent practice associations, some of which are clinically integrated and seeking contracts with managed care on behalf of their members. How do we get them to start paying attention to these critical issues for the entire sector?

Jihoon: Yeah, that's a great question. One of the things I hear most about from members is about inadequate reimbursement rates, right? And I think that's directly related to your question about ensuring that there are these kinds of strategic partnerships where we're not just pointing the finger at each other, right? I mean, trust me, I'm very familiar with a lot of the finger-pointing that happens as it relates to insurance companies and then community-based organizations. And, I mean, Kudo goes to the New York State Council for their work, really elevating the issue of the inadequate rates on the commercial insurance side, right? I think what was passed and what was enacted in the recent budget, thanks to the work of our sister organization, the provider association, is that there is a requirement that commercial insurance companies pay at least Medicaid rate as a floor for the outpatient, OMA, no license services starting next year.

And that in and of itself is historic, right? I think when you couple that with, and this is where I don't know how much people understand, what network adequacy looks

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like within behavioral health outside of folks who work in behavioral health care. But the insurance companies understand what it looks like, right?

They do. They certainly understand what they fully acknowledge and recognize that there are inadequate networks as it relates to addiction and mental health clinics. The other thing that couples that are coupled with the Medicaid rate as a floor for commercial insurance is regulations regarding network adequacy requirements that will really help to ensure that insurance companies are negotiating in good faith with community-based organizations and like psychiatrists and others who are really like they look at the commercial reimbursement rates and why would they go in-network, right? Like they're, they can even just their going rate, which is reasonable to begin with, which is far above what commercial insurance reimburses.

So the question that I started asking in my time in government is why would a psychiatrist go into network? It's like deplorable the rate. So, what incentive can we provide? So, in addition to the Medicaid rate as a floor for a lot of these outpatient OMH and OHSLICS and services, there are going to be new network adequacy requirements where if an insured and enrollee cannot find an in-network provider within ten days, the insurance company has to actually pay, allow that person to go out of network and pay the in-network rate. I think when you think about the economics of it, what we hoped, from my time in government, what we had hoped that that would do, and we still have to see if it plays out this way, coupled with the better parity on the reimbursement rate, is that they will negotiate in good faith with these clinicians to try to get more of them in network so that they can have adequate networks where they're reimbursing at something that is at least on par with Medicaid. Jorge, I mean, I don't think it's lost on you as someone who's run an organization that delivers services. Honestly, talking about the Medicaid rate as the floor should shock people. When you talk to the person who says, hey, Jihoon, you were deputy secretary. My kid cannot find a psychiatrist. Can you help me?

What I always end up doing is feeling powerless in many of those conversations, and that's happening now as a CEO of InUnity Alliance, where ultimately, I have to go through the whole process with them. Who is your insurance carrier? What is your in-network benefit coverage for your plan?

Going through all of that, have you tried finding someone within your network? All of that, ultimately, what it amounts to is that there are these prohibitive floors established throughout any enrollee insurance coverage where, quite frankly, at the end of the day, when someone needs help, especially for mental health or addiction services, they're not going to find someone in network. That's just the reality. I think that's one important issue. We have a long-standing existing relationship, both through the coalition and ASAP, where we have a strategic partnership and a good relationship with the Health Plan Association.

I think ultimately, at the end of the day, we've had these conversations with them since I joined InUnity Alliance, where it's really continuing the conversation for me, for my time in government, where we need to better partner on these issues. I don't want to make a finger point here, but I want to make the reality very clear for New Yorkers who are trying to access services. When they have health insurance, they wonder why they still cannot find coverage. A lot of that is related to reimbursement rates. When providers are not being reimbursed adequate rates, then they're not going to be able to reduce those wait lists. It really is incumbent on both the community-based providers and the insurance companies to ensure that we're working in partnership so that we can really solve this problem for all New Yorkers.

Jorge: Yeah, it does resonate deeply with me in terms of the complexity of this and that. I do think we've got an incredibly inequitable system of care where access to services is not affordable, timely, or even meaningfully accessible in any reasonable way. I have similar issues where people will call me constantly about trying to find psychiatric care for their loved ones. It shouldn't be this complicated. It shouldn't require you, me, or some others to figure out where and how to connect people to services. But sticking with that idea in terms of equity, the 1115 waiver, we're working on it. We have the NOFA (notice of funding availability) going out for the social determinative care networks. The waiver is based on reading health equity.

Where and how do you think InUnity will fit into the thinking, planning, strategy, and implementation of initiatives aimed at making service access more equitable? What are your thoughts on this?

Jihoon: I appreciate that. The 1115 waiver is huge. It's a hot topic for many providers and experts serving different populations throughout New York. I worked on part of that in my time in government.

I didn't work directly on the healthcare side of things. I think there are opportunities with InUnity Alliance that we've already been providing for a lot of our members. We've provided free webinars and learning collaboratives for Unity Alliance members directly related to the 1115 waiver. We're going to continue to develop strategic partnerships. I know that the SCN announcement was delayed a little bit towards the end of the summer or early fall. We have been in contact with many different organizations that have applied for that so that we can actually leverage those relationships as well as the opportunities built into the SCN model. I think the other thing that is equally, if not more exciting, is all the workforce dollars that are available through the 1115 waiver. I think there's an opportunity there where we're going to continue to work in close partnership with a lot of organizations throughout New York State who have already reached out because there are many organizations that are very excited about what's happening with the merger to create InUnity Alliance and people have reached out to set up time to talk about 1115 and potentially partnering given InUnity's broad membership of addiction and mental health providers throughout New York State. I think one of the things that I will say is that there's always good news and bad news with anything. One of the things that I was very disappointed not to see in the 1115 waiver was the part that would provide Medicaid services to incarcerated individuals prior to their release. We understand that the state has developed a process in partnership with some community-based organizations and advocacy organizations to get this reprioritized InUnity Alliance. We are also thinking of other ways that we can keep the attention on this issue because we know for a fact that our jails and prisons for many New Yorkers, especially those living in poverty, especially those who have been part of marginalized groups historically, that they become the facto service delivery system, unfortunately. It's unconscionable that Medicaid has to turn off and then turn back on when we know that within 72 hours of release, especially for someone who is on medication-assisted treatment or recovery for an SUD, they're at the most vulnerable state.

That is no time to lose. I think we are hopeful, and we will continue to advocate for the state to actually include and submit that part of the waiver that was left out of the last waiver. There's some more news to come about that, Jorge, but we will save that for a future date.

I think the 1115 provides a lot of opportunities, and it's actually a good example of places where we can partner closely with folks outside of traditional mental health and addiction organizations where we're thinking about the whole system of care for an individual.

Jorge: That's great. Thank you for that response. As I'm thinking about the waiver and all these different sectors that we talked about and partnerships, I mean, you mentioned partnerships multiple times. I do think, again, so we're at this potentially unprecedented time where our ability to be able to really foster partnerships that are meaningful because I do think that not every one of your members can do everything for everyone in their community.

How do we bring together the different components of New York's rich and diverse healthcare ecosystem so that everyone is rowing in the same direction? From my experience, many are focused on just staying afloat rather than considering how to partner differently with community-based providers. Platforms like yours could bridge city and state government, various stakeholders, and non-traditional, non-medical providers as part of the waiver in thinking about the SCNs. Additionally, we need to include private entities in this conversation. Even though they are for-profit and compete with not-for-profits for workforce, they are an integral part of the ecosystem. So, How can we better integrate all these elements? Sometimes it feels like we're all just spinning our wheels. What are your thoughts on creating a comprehensive partnership to tackle these challenges effectively?

Jihoon: You raise a good point. I think this kind of goes back to when we're advocating, right? I think there are some kind of bread-and-butter policy advocacy issues, and they all boil down to the survival of the non-profit sector and the survival of community-based organizations. People put their heads down, and they work hard. Some have more of a cushion in their fiscal budget, in the fiscal year budget, so they can do some innovative things. Many are not even at a place where they can contemplate how AI and all these evolving and emerging technological advancements can even incorporate that because they're so worried day to day about their workforce, having enough people doing their care work and paying their bills and keeping their doors open, right? I think, ultimately, this all ties into advocacy because when you think about it, everyone is so worried about their piece of the pie, right?

And I understand why. This is normal when you're just used to not being prioritized by the government, right? And it's not even prioritizing the sense of giving us billions of dollars; don't ask questions, just give us money. That's not the case. I think sometimes that's how government looks at community-based organizations, but that's not what it is. Some of it is about policy flexibilities and regulatory relief, but I think ultimately we have an advocacy agenda where whether you are a not-for-profit, a for-profit, whether the issue we're advocating for is maybe 2% from your business perspective of concern to you, or if it's 80% of concern to you based on what your portfolio looks like, we have the opportunity as InUnity Alliance to advocate for everyone's needs as if all 250 organizations were all saying the same thing. That's the beauty of the advocacy world, and the association world is that not only do we allow somebody to not have to be the one having that difficult conversation with a state agency commissioner or their office or the governor's office or DOB for fear that there might be some kind of reprisal, not that people are vindictive and are going to do things like that, but there is always that fear.

We don't want to stick our necks out on this. We have an advocacy organization in the InUnity Alliance that can do that for you. I can give you one example of a way that this kind of concept really played out well with the restoration of some cuts that were in the enacted budget. We advocated strenuously throughout the budget negotiation process and then post-budget enactment, state budget enactment for the restoration of $11.4 million in vocational and educational services and programs that Oasis had that the governor's budget had included as cuts in the Oasis budget. I think from an InUnity Alliance membership perspective, I think it impacted maybe five to 10% of our members at most, but we as an association did a call for a letter-writing

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campaign, phone calls, and advocacy where ultimately the state did something unprecedented and they actually, with something that was in the enacted budget, $11.4 million in cuts, it was actually $8.4 because the legislature restored $3 million of it. They restored the entire program post-budget enactment, which honestly is unheard of. I think two things. One, that's a good example of where we had the entire membership get very motivated because I think everyone saw this could be us. This could be that program that's kind of on the margins of people even being aware of what it does and how it benefits people in recovery from an addiction, that we can be next. And I think we kind of hit on the nerve of people's concerns, which also leads to that, put your head down, work very hard, keep your business open, provide services, let someone else advocate for us.

We don't have time for that. Also, to give our members insight into what happens when you put all of your advocacy together under the umbrella of an advocacy organization to say, this is unacceptable; we're in the middle of an overdose epidemic, and you're cutting services that help people in recovery. So I think that's a good example. And I know that I didn't directly answer some other parts of that question, but you're right. I think we're in this part. We're at this critical moment where everyone recognizes, especially coming out of COVID, that there was this kind of sleeping pandemic of unmet mental health and SUD needs. It really emerged to the surface, where it felt like a lot of people were scrambling to try to throw spaghetti at the wall and see what sticks.

But it's not time for us to get competitive. I think it really boils down to starting where the person is. And what I will say is, whether it's InUnity Alliance, an association that serves people with IDD, or an association that serves people primarily in the foster care system, we're actually talking about the same people. And I think at the association level, we've recognized that. So we're going to partner very closely with a lot of our like our sister and peer advocacy organizations to really unite forces in this upcoming budget because we realize that what we cannot show is any kind of competitiveness in, amongst associations, because we're all talking about the same people that our members serve, regardless of what kind of license you have from the state.

Jorge: Yeah, that's super critical. And I'm glad to hear that because the number of stakeholder groups that are out there, associations that represent sort of different parts of the sector, make it really difficult for, let's say, larger organizations that have sort of very portfolios to be able to really figure out how do you meaningfully lean into, InUnity or supportive housing or whatever it may be, right? So, it's good to hear that you guys are thinking about partnering up. You're right. I think what it comes down to is we serve some of the hardest to engage and treat individuals with complex care, multiple diagnoses where development of disabilities, mental health substance use, and homelessness are all of the things that really make this population so vulnerable. Folks need to be very innovative and creative about where and how we're going to provide services in a very integrated, comprehensive, holistic manner.

You briefly mentioned AI, and I can't resist asking about the influx of technology-assisted care solutions. How do AI technologies like machine learning, natural language processing, and big data analytics come into play in your strategy? Where do you see InUnity having some level of influence with these technologies, if you've formulated your thinking around that?

Jihoon: It's a timely question, not only because everyone's talking about it, but because it's probably the one kind of group that has lobbied me for time on my calendar more in the last four months than any other group. And rightfully so. I think there are huge benefits. I think, even in my time in government, it was like just emerging over the time that I worked in the governor's office where you went from people questioning whether there were maybe like administrative efficiencies you can find for any organization, whether it was a community-based mental health provider or a for-profit company, there are, there are actually ways to leverage technology, emerging technology as including artificial intelligence with training of the workforce and providing other administrative efficiencies. I think there are a lot of benefits when it comes to these, those daily administrative tasks and tons of paperwork, where there are tremendous opportunities for not only cost savings for a nonprofit organization but also to perhaps eliminate a lot of human error as it relates to the administrative task. I think the trick, honestly, though, is that what more people are talking about is not necessarily the administrative, like the business side of things. It's really about how and what role AI plays in the actual delivery of services, right? That's a tricky one.

The tricky one is that I think telehealth was a good example of an efficiency that was necessary during COVID. And there are a lot of parallels that I think warrant being very intentional. And to some extent, I'm not saying like slow things down, but maybe some of it's slow things down. Because I think ultimately what I recognize with a lot of the organizations that make up InUnity is they're not even at a place where they can potentially be thinking about, do I leverage AI into my business model and into my service delivery? The existing technology, infrastructure, billing system needs, and data collection needs of the behavioral health system have been lacking for a long time, right? I think it was never fully included when EHR was being launched on a broader healthcare level by the feds.

So it's really, really lacking. As I consider the role of AI, I believe there may be members of the InUnity Alliance and professionals within the behavioral health sector who could benefit from early adoption. In a sense, they might serve as pioneers or 'guinea pigs,' exploring the potential advantages and applications of AI sooner rather than later. But I think there is huge potential. I do think that we should be very careful that we ensure it's person-centered, that we address any of the racial, ethnic, and cultural disparities that always exist within technology and healthcare, and that, ultimately, it will be for them in the best interests of the people that InUnity Alliance members serve. I think if we could answer all of those questions, then I think it's the kind of thing that, as an association, we would be trying to leverage and figure out how this benefits our members. But I have a lot of, I think a lot of people have more questions right now than answers, but I also know that there are some emerging technologies that have been around for a while but are emerging to behavioral health providers that you'll see more and more and more incorporated into the business model over the next couple of years. We're always looking to be kind of ahead of the curve, but on this one, I think it makes sense to be strategic as well as watch and see what comes of it in many ways.

Jorge: That's a reasonable approach, I think. There is just a lot out there, and it's important to be able to sift through that and figure out what might or might not be meaningfully relevant for providers and the people we serve. We've covered a lot of territory in this last hour, so again, thank you so much for joining us.

Before we wrap up, is there anything that I haven't asked you or anything that you wanted to share that we haven't covered?

Jihoon: Yeah, I mean, what I will say, Jorge, is I'm having a lot of fun, right? It feels weird to say that because anyone who knows me from my time in government it was one of the highlights of my career working for Governor Huckle as its deputy secretary, but it was also stressful in very, very different ways. I love the engagement with people on the ground providing services to people in need, right?

And I think ultimately, in any kind of government job, you just end up feeling detached from that reality, right? I thoroughly enjoyed the four months, learned a lot from Amy Dorn and John Capolla, and am grateful to them as InUnity Alliance continues to grow and plot out our strategic vision and plans for the next couple of years. And I really appreciate the time that you've given me this morning. You and David have given me this morning to chat a little bit about our vision and what I think people can expect in the coming years.

Jorge: Well, again, thank you so much for joining us. I wish you tremendous luck. I mean, InUnity Alliance is a critical piece of our healthcare ecosystem, so I'm really excited about all the things you're going to be doing with your team, and hopefully, we'll be able to check in again at some point down the road and see how things are going. But again, best of luck to you, and congratulations on the role!

David: I echo what Jorge said. It sounds like an amazing opportunity, and I'm really looking forward to seeing how things evolve. So, I'd like to thank you, Jihoon Kim, for sharing your time and expertise with us today and Dr. Jorge Petit for leading this enlightening discussion.

If you'd like to learn more about InUnity Alliance, please visit coalitionny.org and asapnys.org. If you found this conversation valuable, I encourage you to visit behavioralhealthnews.org, where you'll find a wealth of information on important mental health and substance use disorder topics, including in-depth articles, resources, and more interviews with leaders in the field. You can also subscribe to receive our quarterly issues and stay informed about the latest developments in behavioral health.

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