Making Sense of S.I.L.V.E.R. Research - Promoting Recovery Among Older Adults with Serious Mental Health Conditions: Strategies for Implementing Psychosocial Interventions in Community Mental Health Settings with Nathaniel Dell, PhD.

This call is being recorded.

Jane Burke-Miller:

And we're recording. Great. Thank you, Amanda. So, hello everyone. My name is Jane Burke Miller, and I'm a senior mental health training and implementation associate at the Center for Psychiatric Rehabilitation at Boston University. And the moderator for today's Making Sense of Silver Research Webinar, silver stands for supporting individuals to live as Vibrant Elders in Recovery and is the name of the rehabilitation research and training center. Hosting this webinar, which is funded by the National Institute on Disability Independent Living and Rehabilitation Research. The webinar content does not represent the views or policies of the funding agency, and you should not assume endorsement by the federal government. The territory on which Boston University stands is that of the Wampanoag and Massachusetts people, and we honor and respect the history and current efforts of native Indi Indigenous communities. This webinar is being recorded so you can access it later. Also, closed captioning has been turned on, and you can access this by clicking the button at the bottom of your screen. In case this is your first webinar with us, I'm going to introduce our speaker. They will share their research with you, and then we will have a question-and-answer session at the end. If you have a question during the presentation, please post your questions in the q and a box, and I will pose them in order at the end. If you have a technical question, please send a chat to me directly using the chat feature. Also, we would really appreciate your feedback about this webinar, so we'll be posting a survey at the end of the session. Now, I would like to welcome Dr. Nathaniel Dell, who is going to present his work on promoting recovery among older adults with serious mental health conditions, strategies for implementing psychosocial interventions in community mental health settings. Dr. Dell is a licensed clinical social worker and assistant professor in the Department of Psychiatry, Washington University School of Medicine in St. Louis. He's an experienced evaluator of evidence-based practices for people with serious mental health and co-occurring conditions. His research interests include promoting the uptake of evidence-based recovery-oriented psychosocial interventions and leveraging big data and data science approaches to identify the behavioral health needs of hidden and hard tore populations, such as people experiencing homelessness. Dr. Dell, welcome. We are excited to hear from you.

Nathaniel Dell, PhD.:

Hey, good morning or afternoon, depending on your time zone. I'm very happy to be here, um, to share, um, this description of this program that I was fortunate to be a part of developing and evaluating. Um, uh, as I was preparing for this, um, I realized this is something that I had been working on in some capacity for the past eight and a half years from the time of being a practicum student in my Master's in Social Work Program until, uh, today, uh, in different capacities. So, this presentation is largely derived from an article that was published in social work in 2022. We submitted it in 2020 in the middle of the pandemic. And, um, my team and I, Alison Murphy, Maddie Stewart, um, Zuko, Sasaki, and Marina Clear, um, the last three were, um, graduate, graduate students at the time, um,

contributed to this article where we really wanted to describe the development of older adult focused psychiatric rehabilitation services at the community mental health center where I worked, uh, for the past 10 years, uh, before joining Wash U, just last July. Um, so I want to start with just a couple definitions, overview of recovery, and then set the stage for why this was something we wanted to explore and talk about how we develop the program, you know, what needs to address, uh, what purpose to fulfill, and do you have a sense of its impact and how it's been sustained. Um, great. So, when we talk about serious mental illnesses, um, we're often referring to conditions like schizophrenia, spectrum disorders, bipolar or major depressive disorders where people experience severe or persistent impairments in different areas of functioning across their life. When we asked the question, how many people in the general population have a serious mental illness, we could look at the national survey on drug use and health, which gives us an estimate of about 6% for adults, 18 or older, or about 15.4 million people. When you look at adults aged 50 and older, that's about 3% of that population, or 3.5 million. Now, this might be a bit of an underestimate because the survey excludes people who are in prisons, mental institutions, nursing homes, or hospitals where we know people with serious mental health conditions are overrepresented. So, this is an estimate of the general population, older, um, proportion of adults who are growing older, is increasing in our society. And, um, it it's just a growing area of concern for practitioners and researchers. And despite the sort of impairments and, um, that people might experience there, um, I know recovery is a guiding principle for behavioral health organizations in increasingly, and I'm not here to say like what recovery is for, you know, you as an individual if your person with lived experience, uh, but there are some common themes about recovery, and it is a complex phenomenon's pretty complicated. So, I just winna talk about a little bit what we might mean when we talk about recovery. Uh, often it refers to this sort of transformation from a negative identity state that is maybe marked by despair or feelings of brokenness or helplessness, even to a more positive state of psychological wellbeing. And for many, recovery is facilitated by having safe environment access to basic resources that you need a sense of agency and ability to make meaningful change in your own life. Uh, being able to fulfill roles and have relationships that bring with them a sense of belonging and meaning. And in addition, acceptance, and insight into how to promote, uh, one's own sense of wellbeing. Now, recovery, um, could often be talked about as a process or a clinical outcome. This may be, uh, something that is sometimes described more in clinical terms, it's symptom remission versus, uh, more personal growth and formation. And sometimes people emphasize, uh, individualistic aspects of recovery rather than, uh, the relational or communal aspects of of recovery. So, um, when we think of recovery, we, we think of, um, often positive psychology approaches or strengths-based models of social work that focus on opportunities for growth and self-direction, even in the context of enduring symptoms. So it doesn't necessarily mean that symptoms go away, but there's still this sense of agency and meaning recovery will look different across the life lifespan in, in response to different, um, developmental needs, uh, or where people are at in their life. Uh, there's not as much research on mental health recovery later in life for older adults with serious mental illness. Um, but there are some, um, great studies out there. And, and when we look at those, um, where, where they've interviewed people with lived experience and mental illness, there's some common themes of being able to maintain and then preserve, uh, an established identity. Uh, uh, people often talk about encountering new experiences, uh, for self-fulfillment, or emphasize really, again, the importance of social connection and continuing to find ways of belonging even as social roles change, uh, throughout the lifespan. Um, in

support of that, people have emphasized, you know, older adults with serious mental illness have emphasized being able to use coping skills to reserve that sense of continuity in their life, and to continue to do things that are meaningful and important to them. Um, as their age, there's an increased risk of having co-occurring physical health conditions. And so older adults with SMI will emphasize, uh, recovery is addressing both physical and mental health conditions. And while recovery is discussed in very positive terms. Um, it's important to note that, um, where people are in their experience might, it might be shaped by, uh, sort of reflection on loss in their lives and a concern for the future. Um, so their people might be wrestling with experiences of ageism, uh, or stigma that may be undermine these sorts of, uh, sense of continuity or meaningful, uh, participation in, in social or community activities. Um, so that kind of leads into this other area of, well, what are some potential barriers to recovery? And, um, here are two, the, I mean, there are many, but there are two that I'll discuss here, uh, because there, they're potentially modifiable, um, by mental health practitioners and peers and can-do things that impact this. Uh, the first I'll mention is both mental health related stigma and then age-related stigma. Um, I would add in, uh, that there are other overlapping stigmas that could contribute to distress, whether that's based on, um, being part of a minoritized racial or ethnic group, or minoritized sexual identity. Um, these could all contribute to distress as well. And so when people are confronted with these sort of beliefs, behaviors, or attitude that devalue them or show disapproval, um, to them just by virtue of the social groups that they're in, um, people experience poor health outcomes, uh, because of the discrimination and social exclusion that could limit access to, uh, programs or resources or, um, other, um, contribute to unmet needs. Um, in addition, if people can't access, uh, evidence-based practices that are recovery oriented, that that will undermine potentially their experience of recovery as well. Um, this is not to say that, um, recovery can be experienced if and only if people are in treatment actively engaged in treatment, but for many people with serious mental health concerns, uh, clinical intervention can be supportive of recovery as well. So, I focus a lot in my research on interventions that are what we call psychosocial EBPs or evidence-based practices, where, um, we're focused on that sort of therapy or case management or skills training approaches, um, that can improve outcomes, uh, and social functioning or mental health symptoms. Uh, but, and SAMHSA has issued some great guidance in the past three years on different psychosocial evidence-based practices that people can adopt within their practice settings to, uh, support the wellbeing of older adults with serious mental illness. One issue is, uh, the reach of those interventions in practice settings is unclear. We don't know the extent to which these psychosocial EBPs are really being tailored to older adults with serious mental illness. Um, if we look at national surveys of mental health and substance use treatment facilities, uh, the day I show that nearly one third of, um, facilities that reported that national survey say that they provide older adult, um, specific services. Um, but if we go back to when this, uh, program started to get developed in 2016, this is before SAMHSA issued a lot of guidance on this. This is before, um, as an agency, we were aware of a lot of these interventions. And so we were, we were looking for direction on how to best support older adults who were experiencing a lot of, uh, unmet health needs, unmet social needs, uh, enduring symptoms of mental illness. Uh, and so we developed, uh, a program, uh, I'm going to talk more about that. So, a little bit about my practice setting at the time. Uh, it's places for people in St. Louis, Missouri. It's a nonprofit community mental health center in the Midwest here. We, um, provided, um, we had four assertive community treatment teams, one of which was focused on people, um, involved in the criminal justice system. There were several intensive case management teams in addition to a CT, and there

was a programming specific for people with co-occurring substance use and mental health disorders. Um, at the time of this, um, planning process, there were nearly 2000 clients that were served by the organization with the average age of, of about 42 years plus or minus six. Um, we look at the percentage of adults who are 50 or older. It's about 39% of our clients in adult services. So, excluding those in our youth and family services, we looked at those who are 60 or older is about 50% of the people that we are serving. Um, same Louis, Missouri, uh, in St. Louis County. Uh, primarily the areas that the organization serves and, uh, the clients, uh, are primarily black or African American. There are slightly more males than females served in the organization about, uh, third, uh, and people in our adult services, um, had less in a high school, um, education as well. So there, you know, you could get a sense that there's, uh, potentially a lot of, um, social determinants of health-related concerns here. Um, housing is a major concern for many people served by the organization. Uh, and we noticed just looking at the, uh, demographics of our clients, that there was a higher proportion of older adults that we were serving those 50 older there. Um, we wanted to get a sense of more so what were the demographic characteristics of the people that we were working with, uh, what do the treatment recommend recommendations for older adults, uh, serious mental illness, because we did not have any specific programming at that time, and we wanted to better understand potential areas of unmet need. Um, so older adults made up more than half of the caseload on boo of our 12 case management teams. Um, and we say older adults who say 50 or older. Um, uh, we have that threshold lower than, for example, 65 or 60 because, um, we, we want to help people live longer and their people with serious mental illness, uh, have higher mortality than people in the general population and are dying years before your typical member of the general population. We want to intervene earlier to support them in living well and, uh, later into life. And two, there's some evidence, I'll talk about this a little later, about potentially, uh, biomarkers indicating accelerated biological aging in, in people with, uh, serious mental illness as well. Um, so again, I mentioned already that those high comorbidity of chronic physical health conditions like diabetes, um, or hypertension. Um, and then there's inconsistent documentation in our older adults on, uh, their psychoactive substance use as well. Uh, so when I was a graduate student, 2015, started doing chart reviews and gleaning information from there. And we moved into conducting more surveys of, of clients who are served, um, staff who are providing clinical intervention. Um, in 2016, I'll talk about a little how we got there to doing that more in depth needs assessment. Um, and older adult services committee was formed in 2016 as an interdisciplinary group formed in response to that initial chart review, it was really championed by our clinical director, Barbara Xavier. And it, uh, was intentionally designed to get occupational therapists, social workers, nurses, administrative staff evaluations, staff involved in this planning process. We really wanted to make sure that people knew, were aware of the sort of service needs of adults, 50 or older in our organization, and we wanted to learn from staff what they needed to feel confident and prepared in serving this population well. And to really discern what sort of additional intervention was needed to address those sorts of holistic physical health, mental health, and social needs of our older adults. We tested, um, assessing people with, uh, older adult, uh, specific, um, screening tools such as the geriatric depression scale. We started to assess for loneliness, um, post-traumatic stress, uh, symptomology as well. Um, and again, found a sort of unmet physical health related needs, high rates of moderate to severe major depressive symptoms, and not just in people who already had a diagnosed, uh, mood disorder, but these sorts of depressive symptoms are, you know, common. It's a trans diagnostic issue. There are many people with schizophrenia spectrum disorders, uh, with

this as well. Um, and then a lot of unmet, um, need related to social and community needs, whether that's housing, uh, instrumental support or emotional support, and high rates of loneliness as well in this population. Um, so we looked at the client need, but we also thought, again, as I mentioned, what are the training needs that service providers, uh, are asking for? And they really were questioning, how can we best promote people living independently? As many were entering into skilled nursing facilities or residential care facilities. Um, how can we identify and address medication interactions? Was a huge question for caseworkers. Um, or often, you know, they could be master's level or bachelor's level, um, social workers or other related professions. Um, and then how can we engage in planning for end-of-life care? Those two teams, there are two, uh, two teams that we transitioned into becoming focused solely on older adults, and they experienced a lot of loss, um, in our, in our industry, uh, publicly funded community mental health services, especially over the course of the opioid epidemic. We've all experienced a, a lot of loss, I think. But there is, um, sort of a question of how-to best support people towards the end of their lives as well, especially if they didn't have, uh, a lot of, uh, natural supports as well. We also sought to build local partnerships to meet these sorts of training and service needs. cause we recognize that we can do this all ourselves. Um, so we partnered with the federally qualified health center in the region, a local advocacy group for lesbian, gay, bisexual, and trans seniors, hospice providers and home health providers, sort of convened, um, a group of them to provide, uh, training and learn about their services and group, ensure that our staff were aware of what resources were available in the region. As, and I winna mention now, you know, as you could develop a great plan, but you always need the resources to sustain it. And there's not just one source of funding that we could go to to sort of cover all this, all this needs. So, there's one local foundation that was essential for supporting our evaluation efforts, our training efforts, supporting clinicians to facilitate different socialization activities for older adults. And, um, getting access to the, uh, training materials for different evidence-based practices. In addition, many of our clients are, uh, have Missouri Medicaid. And so routine sort of case management and psych psychiatry services were reimbursable, just speaks to sustainability of the program. In addition, um, to support older adults in meeting sort of, or optimizing their physical health. Um, between 2016 and 19, we had a substance abuse and mental health services administration grant, um, uh, P-B-H-C-I or primary fiscal, uh, and primary behavioral healthcare integration programming, uh, which allowed us to expand our services in that capacity as well. So, I'm going to start with, um, talking about integration and then our case management services, and then go into, uh, sort of the skills painting. These are the three sort of prongs, uh, not, not of attack, that's too al of metaphor, but the three area, uh, avenues we approach this, um, uh, program with. So, I think of, uh, healthcare integration goals. We wanted to expand our co-located primary care services. Um, the funding from SAMHSA was essential for being able to hire additional nursing staff, um, occupational therapists and, and peer support specialists as well. It also allowed us to sort of build processes for monitoring, uh, physical health indicators and implement some individualized and group-based health promotion interventions, such as, uh, nutrition and exercise for wellness and recovery, um, which supports people with mental illness and gaining new knowledge and skills for, um, uh, healthier eating and engaging in physical activity. And then Whole Health Action Management or warm, which is a peer support group model, um, that increases self-management, uh, behaviors, uh, for health and mental health related concerns. So, one aspect, so what do we see happen? Um, there, there's kind of mixed results. When we look at our older adults who are in, uh, evaluated as part of the Physical Health Integration

project, we saw a significant changes in indicators are important for cardiovascular health. Um, so increase in what is typically called good cholesterol, uh, decrease in what's typically referred to as bad cholesterol and decrease in triglycerides for people who are at risk. Uh, those indicators at baseline for people who are at risk of high blood pressure. Um, high A1C for maybe indie indicative of uncontrolled diabetes, uh, high body mass index or high, uh, breath carbon monoxide. We didn't see significant, uh, changes over time on those indicators. But for some, um, cardiovascular related Indic indicators, we did see significant, um, positive change in that regard. I want to say also, uh, may step back a little bit and think about the impact of physical health integration on agency culture. It, we were primarily a behavioral health organization, and this really forced all of us in the organization to consider, um, really a reflection on what our perceived roles and responsibilities are towards clients. How active should people be in promoting clients' physical health as well, and required sort of new skills, uh, for case managers or encouraged thinking about how to, um, adapt skills that they had used, for example, like motivational interviewing to support clients', management of chronic, uh, health conditions, whereas they had used those MI skills in the past to support positive change and, um, for example, substance use behaviors. Uh, so brief overview there, based on our initial needs assessment and seeing the, uh, high proportion of clients who had, um, who are older adults in the agency, we transitioned to case management teams to serving exclusively older adults. Initially, these were approx., there were approximately a hundred clients. Um, teams met with clients at least weekly, and they had, uh, 1.5 full-time equivalent or staff position of nursing access to a geriatric psychiatrist and a client to staff ratio of 15 to one. So, what's important to emphasize here is it was really, uh, a team-based approach. Um, and it said, but it was not as intensive as a CT Again, they were not meeting as frequently. They didn't have the same roles as in a sort of community treatment team. Um, but it was a sort of intensive case management where they met at least once weekly, if not more, depending on what the, um, treatment goals or immediate needs were. Uh, and then we also began to offer more socialization activities for our older adults, um, that were more about getting in, in involved in the community. And so, we're fortunate to have a psychosocial rehabilitation center, A PFP, uh, which is kind of based on the clubhouse model, and offered socialization opportunities around different, uh, community outings in the region. Um, so we had about 30 clients who intended at least one weekly socialization group with about four clients attending each session. Um, and in the second year, we saw an increase to, for about 24 to 31, uh, with an average of five participants in each session. So, there was increased engagement in those, uh, opportunities. That's great. There's also, again, I mentioned, uh, focus on, uh, monitoring depressive symptoms more closely, uh, due to the high levels of, um, moderate to severe symptoms that were found in our population. And we look at, um, you know, baseline to follow up for clients monitored in the first year relative to the second year of our older adult, uh, focus programming. We saw a small but significant decrease in our geriatric depression scale. Short form scores range from zero to 15. Anything over five, uh, indicates maybe some need for intervention, at least more evaluation. So, we saw on average, most people were above that cutoff of five, and we saw a decrease, um, significantly, but maybe not as robust as, as we would like, uh, to see. Um, so we also wanted to layer on additional skills training as well, um, because healthcare integration was really agency-wide, but we wanted to monitor more closely what its impact was on our older adults had intensive case management services, but we wanted to bring clients together and focus on supporting those staff at training, um, to increase their skills and see what sort of the effects were there. Um, but we didn't have any sort of skills training

interventions exclusive for older adults with, uh, serious mental illness. Um, so we think about skills training interventions. Uh, those include sort of behavioral strategies for promoting health and social functioning, such as bottling different behaviors, reinforcing them, sort of shaping people towards a certain skillset, and, um, being able to sort of overlearn a new skill such that becomes routine or automatic. And then also helping people to take a skill that they know and bring it to new context that they haven't used it before. Uh, the intervention we selected was helping ourselves pursue and experience success formerly, uh, uh, called, uh, helping Older People experience Success. Uh, it's a manualized intervention that promotes social skills, psychosocial and community functioning, feelings of self-advocacy for people with schizophrenia. Um, decreased negative symptoms such as like a, a social withdrawal or emotional numbing, uh, in, in a random, random, randomized controlled trial. Um, we've seen those positive gain pains, positive gains maintained after three years of the intervention as well. So, uh, that was work that Kim Meuser, Steven Bartels, and Sarah Pratt, and all others have, have worked on, and we're really compelled by the evidence available for that. Uh, I winna say a little more about the hope's curriculum. Initially, I had seven modules. There's recently, uh, an additional one on intimacy and dating that was added. Um, but other modules involve, uh, living independently in the community, communicating effectively, making, and keeping friends, making the most of leisure time effective use of medications, uh, healthy living, and then making the most severe, uh, doctor's appointment. And these modules include six to eight different skills, uh, with one taught each week. Uh, participants are given workbook that summarizes the skill areas, and home practice assignments are included as part of this as well. When we brought hopes to, um, PFP, we asked, uh, our clients what, how they wanted to begin. If they were interested in this, what modules would seem most appealing to start with. We didn't require people to go through all of them, but based on what their kind of self-reported needs were, um, let them guide us in selecting the which modules so people were interested in communication, which has a session, and then making and keeping friends. So, we went with those. Now those groups were held weekly, they're overseen by me and then facilitated by MSW Allison Murphy, and MSW prac practicum students like, uh, Nat Suki, Sasaki, and Marina Clear. Uh, the outcome measure that we were looking at was the Social Skills performance assessment, which is sort of a role play assessment to gauge different social skills and two different, um, scenarios. Uh, we had 19 people initially referred by case managers. Uh, 12 clients elected to participate, uh, five unique participants in the communication module, and seven in the Making and Keeping Friends module. So, what came up this well, uh, we're systematically monitoring those outcomes from the SSPA and then until, uh, the pandemic halted most things. So, this, we started implementing HOPES in 2019, and, um, as we were starting to conduct our post-test assessments, um, March 2020, um, that all sort of had to pause, but we did have seven participants who had completed both pretest and post-test measures. I'm just going to be very clear that this sample, uh, very, uh, too small to make any inferences about, you know, hopes effectiveness in our setting. Um, but we did see that most participants had higher rated clinician, uh, sorry, higher ranked clin clinician rated functioning scores at post-test. So, they perform better in these test scenarios than they had at the start of the intervention. So, we can't speak to the effectiveness in our setting. Fortunately, there's, you know, robust evidence about hopes, uh, in the literature already. Um, but this is more, it was feasible for us to bring a new intervention to find staff and space and clients who are willing to participate in it, and to sort of conduct a evaluation of it as well, even if it had to pause. So, uh, we did learn quite a bit from this process. Uh, think about the skills training a bit more.

There are a lot of barriers to group participation. So many people who wanted to participate in the intervention had a lot of conflicting healthcare appointments. They may be had, uh, unreliable transportation. And this is a huge issue for us. We're in a city, but the, um, reach of the public transit, uh, system, um, it, it's not what you might find, um, in other cities, uh, people had childcare duties. They were, um, very involved in, uh, if not raising, but uh, having a lot of, um, time with their grandchildren. And then people also reported mobility issues that made it difficult to come, uh, to group. So, uh, individualized hopes, um, might be more accessible for some. So as people think about if they want to implement something like hopes in their setting, there is a way of doing it. one-on-one that might allow for more flexibility. Uh, we also saw that, uh, clients who staff identified as really having more severe communication or, uh, interpersonal skills deficits weren't really engaged in a group process. They're hesitant to, uh, participate in the group and maybe would've been more open to sort of individualized approach. Um, what's required for all of this, whether it's healthcare integration or transforming a sort of case management team to have a new focus or bringing in new skills, training, intervention, uh, you really need to create buy-in with staff to foster openness towards any interne innovation or intervention. Um, uh, primary reason for this is, well, people who are doing the work day-to-Day know things and have perspective on what might work well. Uh, so we should probably, uh, listen to them. Um, but then also, um, when we introduce new practices to a setting, some of what's required of that intervention might run counter to what clinicians and clients expect for service delivery. So, when physical health integration hadn't been part of, uh, the culture or clients have not been talked about that, uh, you know, consistently, um, it's a new thing. And setting the expectation for there to be a new intervention or a new process and inviting participation in on that is, is important. Um, for some, it might require a shift from focusing on more immediate crises to, you know, continuing to address those, but then also working towards longer term goals that people have. Um, and, you know, staff need to really be brought into the planning process early to align service, what their expectations are for service, and so they know, uh, what is being asked of them. And so that was, I think, a, a huge strength of having that oversight committee that met monthly, um, sought out sort of interdisciplinary perspectives, um, on what might work, how it could work, and, um, just trying to maintain a sort of openness and flexibility. Uh, what was also required was advocacy with, uh, funders. So, some funders would only support programs serving older adults, age 65 or older, 62 and older. Um, we really advocated for a different threshold to be considered for those. With SMI, we look at the, uh, study, um, on hopes, uh, from Camus and colleagues, uh, they used, uh, that cutoff of 50 or older. And again, like I mentioned earlier, we, we advocated for that lower threshold because we wanted to make sure, uh, we wanted to do everything we could to help our clients get to that 65 and older, um, threshold. And we want, and we knew that we needed to start earlier for that due to increased mortality. And, uh, these, uh, biomarkers suggestive of maybe accelerated biological aging. Um, so higher levels of inflammatory or oxidative stress biomarkers and shorter telomere lengths, uh, suggesting, um, yeah, accelerated aging. We, we also, um, need to emphasize the importance of convening stakeholders. Um, you know, at the time of creating our older adult, older adult focused services, there wasn't a strong regional network focused on, uh, integrating aging and mental health. And those cross-disciplinary partnerships were really essential for helping us to feel more knowledgeable and confident in intervening in this, in this area. Um, and there's the importance of maintaining a recovery orientation as well. So again, stigma about older age and mental illness could contribute to sort of therapeutic pessimism and then poor outcomes. Um, people might have the sort of,

uh, unfounded assumption that older adults are, uh, too rigid or set in their ways to respond positively to therapy or psychosocial intervention. It's not, not the case. Um, so understanding your own biases a practitioner or program manager is essential. Um, and then it's important to explore and address is sort of stigmas that clients might have as well. cause they might, after exposure to the sort of external stigma that they encounter, day-to-day in society might, uh, internalize that and, and hold that to be true. And so, disrupting those beliefs, uh, are important as well. Um, I have years in evaluation. I'm bias towards this. I want to say that there's a positive role for evaluation and being able to maintain a recovery orientation as well, you know, uh, and that's using sort of standardized quantitative assessments. But, you know, really being open to the qualitative data collection, exploring processes and people's underlying values is very important. Um, documenting positive changes as that are associated with service use can be useful, I think, for challenging that therapeutic pessimism that might arise in people, um, and make recovery-oriented interventions available. Um, we found that social skills training in our very limited evaluation, it was feasible to implement. We had a modest reach, but it was in its early stages before global disruption. And we saw people sort of increase their, uh, mastery of functional skills. Um, and we saw, again, some people discontinue treatment or wanted to start, but didn't. And it's important to keep in mind that not everyone who stops the treatment does so because they think it was negative or unhelpful. Um, they might have thought they, they got what they need out of that as well. At the same time, we should be aware of like, uh, success for different barriers to participation to really facilitate engagement, some of our lessons learned. But I mean, it's, it's been a couple years now. So, is this program still going? Um, how has it grown? I'm going to tell you that now. Uh, there's been a lot greater cross sector collaboration in the region that I wanted to speak to. Um, since 2021, there's initially a St. Louis Aging and Behavioral Health Task Force, which is now a council and has, I think at least 27 partners. Initially it was formed to evaluate gaps in the safety net service, um, of like aging and behavioral health providers and want to educate member organizations about resources in the region. So, like a mini, uh, we had a sort of mini version of this internal, uh, starting 20 16, 17, and it sort of has gained, um, you know, other people were interested in this. And we were fortunate to partner with others to, uh, do this on a regional level as well. And then initially the task force sought to develop, uh, recommendations to really improve coordination between aging providers and mental health providers. So, there's a lot of information sharing, uh, exploration of other collaborative, um, models for older adults broadly, and, um, data collection within the network as well. So, uh, some of the systematic issues that we found in the region are like what was echoed and, and, uh, Samson's report on psychosocial interventions. And, um, people with serious mental illness. There's, uh, there's a lack of training specific to aging and mental health, or, uh, well, there's a lack of specific, uh, aging training that mental health providers have, and a lack of mental health specific training for older adults that aging providers have. There's a workforce shortage as well in the city, and there's a lack of, uh, integrated services for older adults as well. So, in 2022, there's, I was fortunate to be able to help, uh, write a grant with, um, behavioral Health Network and Slews St. Louis University's Geriatric Education Center and the Community partners, which is Systems A, B, C or Systems Change for, uh, aging and Behavioral Health Care, which is funded by Missouri Foundation for Health. And, uh, really allows us to work together to reduce fragmentation, fill different service gaps, and integrate those services between aging and behavioral health agencies. And really effort culminates hopefully in establishing a community of care that, uh, positively impacts the behavioral health of older

adults in the region. Um, having this as a resource, um, was, is essential for supporting staff at Places for People as well. So, this is a whole initiative that transcends, you know, goes beyond our initial program. Um, and it is, um, a great resource for our clinicians. Uh, I would say, um, I keep saying are like, I'm, uh, still part of VFP, but um, I spend a lot of time there. So, there's also increased internal support in the agency. So, there's been more new processes for conducting cognitive screening in, uh, older adults. There's been an additional team created to serve older adults, specifically with substance use disorders and co-occurring mental health disorders as well. Uh, we've received local foundation, uh, grant funding to increase access to occupational therapy and following the pandemic, uh, reestablish a service socialization activity. There's been a lot of, um, administrative buy-in and support of staff being able to access other training, uh, whether that's through St. Louis University's Geriatric Education Center or Rush University's Center of Excellence in Aging Training, or, uh, older Adult Mental Health First Aid, which is offered through alum, which is a behavioral health center of excellence, um, as part of places for people. Um, so there's been a lot of growth in sustainability, um, even coming out of the pandemic. Um, there are limitations, of course, to any kind of study this as a practice update. It's not your typical, uh, research article. It's more about describing the processes of how we did these things, um, and why that program came about. So, findings are maybe not going to generalize to other clinical settings. Um, our look at how social skills training, uh, was piloted, was disrupted by the pandemic, as I mentioned. And so, the focus was not really on conducting a rigorous trial, but assessing the need, planning response, and sort of conducting a formative evaluation to see what was working well. And I just want to conclude, uh, emphasizing that these external partnerships were essential for supporting change. We kind of continued to grow if there wasn't that network of support in the region. And, uh, it's important to identify all set champions across the organization. So administrative administration, clinicians, peers, service recipients, should really all be represented in, in planning. Uh, so older adult focused services for people with SMI, um, I must acknowledge there's a lot of people, uh, in organizations who, uh, made this possible as a place for people. As one where I spent, um, 10 years in different roles, uh, voice speaking up for equality, long-term care. Um, they've allowed me to present in different ways and been great partners. Uh, Merrill Lac Mission Fund, formerly Daughters of Charity Foundation. It's essential for, uh, our initial, um, evaluation and pilot and then again, behavioral Health Network of Greater St. Louis, St. Louis University School of Med, where the geriatric education center is in Ileum Behavioral Health Center of Excellence of Allman Great advocates and played important parts of, in my formation. So, in some individuals, I want to really shout out Bob Xavier at Places for People who kind of, um, was pushing for, for a lot of, you know, this clinical innovation back in 2016. Leon Ferro, Alison Murphy, Ellen Moore, Greg Seymour, Juris Miller, Michelle Pavlovich, Joey Blanco, Kara Zico, Christina Vidovic, a lot of the people, um, just within PFP itself. Um, Brittany Parson at BHN, Dana Silver blatt, Myla Wig, or Max Avia Shane Hung, uh, Sheehan hung Marjorie Moore and Sally Haywood. A lot of other people, I can't acknowledge, uh, just we're run outate time. I need to say space for questions. But when I make a point of shouting out, uh, all those different people because, uh, this, this is not just, I came up with an idea a couple years ago and it's something I wanted to do, but we, it's been a sort of sustained collaborative effort across years to, uh, make our system of care, uh, more responsive to older adults with serious mental illness. Um, so that's just where I want to leave it. I'm happy to take any questions that people might have.

Jane Burke-Miller:

Thank you, Dr. Dell, for sharing your, uh, research and project. It's interesting to hear that. Um, we do have some questions. Um, I just wanted to say, I think, you know, one thing that comes through clearly and is the intersection of we've got mental health, aging, and physical health, and all these things need to come together. And I think what really comes through clearly is, um, what worked in, in your setting was, was having, uh, kind of intersectoral cross sector sectors collaborating and working together. And that's kind of, I think, what we need to, to look at as we go forward. Um, but let me ask the questions that have been coming up and thank you everyone for posing your questions. Um, someone asked about ethnic statistics. I think they're asking about the ethnicity of the population, which I think you mentioned in an earlier slide.

Nathaniel Dell, PhD.:

Yeah. Um, so within, um, the practice setting, about two thirds of the clients were black or African American, and, uh, about 30% were non-Hispanic, white, and then there's just very small, um, remainder of the population that are other races or ethnicities. Um, yeah, which, uh, again, we, when we look at the St. Louis region or St. Louis City specifically, where I think it's 44, 40 8% black or African American, we see that demographic overrepresented in those who are, uh, served in community mental health settings.

Jane Burke-Miller:

Thank you. Um, someone asked, where would we be able to find the hopes program?

Nathaniel Dell, PhD.:

Oh, um, I can get a link, uh, and send you contact information about that. Okay.

Jane Burke-Miller:

So, I think some, um, some community mental health centers offer hopes, um, is that right? I think you would have to maybe contact your local, uh, resources.

Nathaniel Dell, PhD.:

And Dr. Sarah Pratt, um, would be a great contact at that. She's at Dartmouth School of uh, medicine, the Department of Psychiatry there. Um, so let me, yeah, pull up the link for that and I'll share that before I want to, yeah, I will put that in the chat before we all adjourn.

Jane Burke-Miller:

Thank you. Um, I have not seen or heard discussion of any special services for veterans, or are veterans referred to the VA for services?

Nathaniel Dell, PhD.:

Correct. Yeah, that's a great point. And so, um, that's an important aspect of our, our setting is, uh, typically those who are served by, uh, that agency is less than 5% of the patient population were, uh, veterans. Um, and that's including people who might be like non glossary prior service or have some, uh, or who might not be eligible for VA services because maybe their discharge status. Um, so, but yeah, those who are veterans who need additional mental health support, um, are we connect them with the VA in St. Louis.

Jane Burke-Miller:

Um, another question about a link for the Hopes curriculum. Um, and here's a question. How significant was dementia for either service users or their carers in the study?

Nathaniel Dell, PhD.:

Mm-Hmm, <affirmative>, that's a great point. Um, good question, because it wasn't until couple years after the initial pilot that with the support of St. Louis University's geriatric education center and the, um, A Systems A, b, C grant, that became more of a process for screening for cognition. Now we know that, um, executive dysfunction or cognitive impairment, uh, could be sort of a feature different time of, uh, serious mental illnesses, whether schizophrenia spectrum or major depressive disorders. And so, but we didn't see a lot of like minor major neurocognitive disorders, so we weren't seeing a lot of, um, dementia in the service users. And, um, we don't have information on whether that was something that, uh, caregivers had, um, many of the people they had worked with didn't have, uh, sort of consistent support from, um, or natural support networks as well that were intact. So that's information we don't have is very important. So to be mindful of, especially as we think about like trying to support people holistically and, um, uh, reconnecting with natural supports,

Jane Burke-Miller:

Do you think that may have been related to the fact that you were working with a community population and not, um, a population that was in like a nursing home, for instance?

Nathaniel Dell, PhD.:

Yeah. Yeah. And there were, uh, and yeah, there's a certain proportion of clients who would still be, that we had served that are in skilled nursing facilities, and, uh, that agency's not able to reimburse for those services because ostensibly everyone's needs are being met within the skilled nursing facility. Uh, but, uh, we still will work with people and in nursing homes who were already our clients, either a because they might transition from that wanna support the reintegration in the community or support the sort of quality of life they have now.

Jane Burke-Miller:

In a community without a program, what type of therapist might be best to provide psychosocial rehabilitation?

Nathaniel Dell, PhD.:

Um, let's see that, gosh, I don't know that I have good sort of recommendation for that because my ex, I'm not sure if my experience being embedded in a community mental health center, um, could be as useful for people in private practice, uh, settings. Um, so I don't want to hazard sort of a guess there. Um, but because, especially because of a lot of what we did was like by design, um, uh, team-based sort of intervention,

Jane Burke-Miller:

Um, someone was asking if you were able to provide services to home bound seniors.

Nathaniel Dell, PhD.:

Uh, y yes, I, if, if they have, uh, serious mental illness, uh, or they, and that would be maybe make them eligible for, um, psychiatric rehabilitation services I described here. And there are, um, with limited mobility that, that were served by the organization for sure. Um, but that's a sort of condition of like, to access this with more intensive, um, psych rehab services, it's if and only if there's that sort of, um, functional impairment, uh, and together alongside the sort of mental illness.

Jane Burke-Miller:

Um, did you collect any data on staff readiness or change in staff approaches to older adults outside the designated treatment teams during the project?

Nathaniel Dell, PhD.:

Mm-Hmm. <affirmative>, um, it was, yeah, beginning, so Wow, it's hard to, it's kind of wild to think 2016 was as many years ago as it was, but when we started that initial planning processes more, we didn't have, um, it was more qualitative, um, data collection and a little more informal. Um, there are interesting measures, uh, available now to look at, um, you know, organizational readiness to implement, implement change is one measure that I've used for different projects since then. Um, which is useful for thinking about what the sort of resources are needed to, um, at the institutional level to, um, support implementing change. But that was at the time of this project, um, when I was, you know, outside of academia, more embedded in the community organization. Um, it was more informal, but we we're looking to those people who are a, on part of the oversight committee, um, on their perspectives. And then b, when, uh, the two teams that kind of transformed from general, uh, psych rehab to older adult specific services, uh, working with them to understand their, um, perspectives on what would be beneficial or is this needed at all, et cetera. So, it was something that happened, but more qualitative, more informal and sort of like a recurring thing as well. And we didn't have a sort of systematic, you know, standardized assessment of that.

Jane Burke-Miller:

Okay. Um.

Nathaniel Dell, PhD.:

Oh, and I do see the point on the race ethnicity, beginning with the 2020 census being linked. I agree with that recommendation for sure. Um, the data were collected prior to that though, so, which is why they're in the format that they're in. But it's a very valid point.

Jane Burke-Miller:

Thank you for that comment. Um, so I think that's all the questions I'm seeing, um, and this has been a great discussion. Thank you everyone. Um, so I think, uh, did we, did you have a, um, a link for the hope's curriculum or

Nathaniel Dell, PhD.:

Yeah, no, I got engrossed in the comments though. Hold on. Let me,

Jane Burke-Miller:

That's okay.

Nathaniel Dell, PhD.:

No, I have hold music or anything you put on.

Jane Burke-Miller:

And were there any other questions? Oh, there.

Nathaniel Dell, PhD.:

We go. They dropped in the link for the Center for the Help Research. Great. Um, where there is a contact form, um,

Jane Burke-Miller:

Thank you for that. Um,

Nathaniel Dell, PhD.:

They have additional, you know, uh, programs as well. So yeah, I really emphasize their skills training, but then there are self-management, uh, interventions that they have for other tobacco dependence related interventions and other opportunities.

Jane Burke-Miller:

Great. Okay. Well, thank you very much, Dr. Dell. We really enjoyed your presentation today.

Nathaniel Dell, PhD.:

Well, again, I'm very grateful to be able to come out and share that, um, years of different, um, initiative and interaction, uh, appreciative of everyone who's been a part of that and could, uh, contribute to that as well. So, thank you all.

Jane Burke-Miller:

Thank you. Just reply to this person.

Nathaniel Dell, PhD.:

Oh, I only sent the link to hosts and panelists for some reason. Let me check.

Jane Burke-Miller:

Oh, yeah, Lemme send it to everyone. Hold on, everyone. Oh, you did it now. Okay. And Amanda did it too. Okay. <laugh>. So, everyone should be able to see it now. Great. Okay. Thank you very much. Take care everyone.