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Feasibility of Integrating Mental Health Screening and Services Into Routine Elder Abuse Practice to Improve Client Outcomes

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Abstract

Objective—The goal of this pilot program was to test the feasibility of mental health screening among elder abuse victims and enrolling those victims into a brief psychotherapy useful with both depression and anxiety.

Methods—Elder abuse victims who sought assistance from a large, urban elder abuse service were screened for depression and anxiety using standardized measures. Clients with clinically significant depression (PHQ-9) or anxiety (GAD-7) were randomized to receive one of three different mental health interventions concurrent with abuse resolution services. This design helped determine the acceptability of each intervention offered and thus the optimal format for service delivery.

Results—Staff were able to integrate mental health screening for 315 individuals, with 34% of clients scoring positive for depression or anxiety. Of those with mental health needs, only 15%

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refused all services. The mental health intervention (PROTECT) was able to be implemented in two different formats, with collaboration between elder abuse and mental health staff workers.

Discussion—These findings support both the need for mental health care among elder abuse victims and the feasibility of integrating mental health screening and treatment into routine elder abuse practice.

Keywords

depression; elder abuse; integrating services; mental health treatment

Elder abuse affects an estimated one in ten older adults in the United States (Acierno et al., 2010; US Government Accountability Office, 2011). As the population ages and the national numbers of older adults grow, it is expected that there will be proportional growth in the rates of elder abuse. Lachs and Pillemer (2003), building on the definition provided by the US National Academy of Sciences, describe elder abuse as actions that cause harm or create a serious risk of harm (whether or not the resulting harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder (Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America, 2003; Lachs & Pillemer, 2004). They note that this definition incorporates two primary components: that the older person has suffered injury, deprivation, or unnecessary danger; and that a specific other individual is responsible for causing or actively failing to prevent such harm (Lachs & Pillemer, 2004). In addition to the self-report data estimating the national incidence of elder abuse (Acierno et al., 2010; US Government Accountability Office, 2011), the *Elder Abuse Prevalence Study in New York State* (the first of its kind in the U.S.) used self-report surveys and data from 231 elder service agencies to calculate an overall one-year incidence rate of any type of abuse. The self-reported prevalence study yielded a cumulative abuse rate of 76 cases per thousand older residents of New York State. Applying this incidence rate to the general population of older New Yorkers, an estimated 260,000, or one in 13, older adults were victims of at least one form of elder abuse between 2008 and 2009 (Lifespan of Greater Rochester et al., 2011). In addition, the study found that 25.6% of victims had multiple concurrent abusers, while self-reported abuse was 24 times greater than the number of cases ultimately reported to providers.

Elder abuse exacts tremendous psychological and financial costs from both the victim and society. Older adults who are abused have higher rates of mortality (Dong et al., 2009; Lachs, Williams, O'Brien, Pillemer, & Charlson, 1998), hospitalization (Dong, Chen, Chang, & Simon, 2013), and health problems (Bitondo Dyer, Pavlik, Murphy, & Hyman, 2000). In addition, the medical costs associated with abuse, neglect, and exploitation of older adults have been estimated to add over $5.3 billion to the nation’s annual health expenditures (Mouton et al., 2004). Financial abuse is also on the rise, with older Americans currently losing $2.9 billion annually to financial exploitation. This is a 12% increase from the $2.6 billion estimated in 2008, according to a national study of elder abuse prevalence (Metlife, 2011).

In the general population, mental illness is prevalent while often going undetected and undertreated. In the elderly population, depression is associated with declines in cognition

and medical status (Charney et al, 2003), increased disability (Barry, Murphy, & Gill, 2011; Bruce, 2002), and risk of falling (Druss, Rohrbaugh, & Rosenheck, 1999; Eggermont, Penninx, Jones, & Leveille, 2012; Moylan & Binder, 2007). Depression additionally worsens the outcomes of many medical disorders and increases the risk of suicide (Conwell et al., 2010) as well as non-suicide mortality (Gallo et al., 2005). The rates of depression are highest among community dwelling older persons with medical illness or disability (Marino & Sirey, 2012).

There is increasing recognition and emerging evidence of psychological distress, poor mental health, and depression among older victims of mistreatment. In a one-time telephone survey of community dwelling adults aged 60 years and older, both financial exploitation and psychological mistreatment were associated with depressive symptoms on a screening measure (Beach, Schulz, Castle, & Rosen, 2010). Emotional abuse has further been linked to poor global mental health when controlling for social support, health, and functioning (Begle et al., 2010). In one epidemiologic study, older women with a history of interpersonal violence had significantly higher rates of mental disorders including PTSD, anxiety disorders, and depression, underscoring the relation of personal trauma to mental disorders in this population (Cook, Pilver, Dinnen, Schnurr, & Hoff, 2013). Recently, a population-based study in China found that older adults who were mistreated had significantly higher rates of depressive symptoms (31.6% versus 6.8%) and suicidal ideation (16.4% versus 3.4%) than non-mistreated older adults (Wu et al., 2013). In the Women's Health Initiative (WHI) where older post-menopausal women were followed over time, abuse was associated with depressive symptoms and worsened mental health three years later (Mouton, Rodabough, Rovi, Brzyski, & Katerndahl, 2010); this was true for verbal abuse as well as physical abuse. By contrast, social support and optimism were associated with better mental health outcomes. In one population-based study examining concurrent mistreatment and depressive symptoms among older adults, long term follow-up assessment (mean 7.6 years) found that participants with both difficulties had higher rates of mortality than those victims who suffered from mistreatment but not depression (Dong et al., 2011). In addition, relatively low levels of social support predicted increased mortality risk among victims of elder abuse.

In spite of the emerging link between distress and depression among older victims of mistreatment, more systematic clinical research is needed to better understand the impact on victims (Dong, 2012; Dong et al., 2013). Single time assessments often cannot untangle the interplay of psychological distress and victimization over time. Integrating interventions to improve psychological well-being into elder abuse services may offer the potential to reduce adverse effects of depression on victims as they take steps to resolve the abuse. Targeting improvements in social support and integration into the community also may mitigate victimization by reducing feelings of social isolation and thereby minimizing the consequences of mistreatment (Luo & Waite, 2011).

Depression affects an individual's perception of his or her need for care, the efficacy of treatment, and the ability to follow through on a recommended treatment regimen (DiMatteo, Lepper, & Croghan, 2000; Sirey, Bruce, & Alexopoulous, 2005). Victims of abuse with anxiety or depression may thus face dual challenges to seeking outside

assistance: at the same time that they seek help to protect themselves, coexisting depressive symptoms may undermine their motivation, initiative, and energy. Abuse victims with mental health needs who seek protective assistance may be coached to take challenging steps to defend themselves; for example, they may need to create a safety plan, limit contact with alleged perpetrators, or move to change their current living situation. However, hopelessness, lethargy, guilt, and lack of interest in activities are symptoms of depression that may reduce individuals' self-efficacy and consequent desire to take self-protective steps. If these feelings are not identified as potential depressive symptoms, elder abuse resources may subsequently be underutilized.

The National Institutes of Health (NIH) and leading experts in elder abuse have highlighted the challenge of mental health integration in elder abuse services, noting that: "In the area of mental health and elder abuse, salient findings include the lack of collaboration due to poor coordination and a basic misunderstanding about the goals of different agencies" (The National Academies Committee on National Statistics, 2010, p. 11). Most recently, the Department of Justice has included a consideration of mental health in planning their roadmap for policy, research, and practice. They have argued that the development of elder abuse interventions requires greater research based on sound theory and systematic evaluation of efficacy (Jackson & Hafemeister, 2013). This challenge is also an opportunity to integrate mental health care into elder abuse services and provide support to these vulnerable adults. To date, there appear to be no elder abuse services that provide systematic mental health screening as part of their usual practice.

Research and clinical practice changes have integrated mental health into other service settings such as primary care (Alexopoulos et al., 2009; Unutzer et al., 2002), aging services (Sirey, 2008; Bartels & Naslund, 2013), and homecare (Bruce, 2007) to improve the detection and treatment of depression among older adults. When mental health intervention strategies are integrated, staff are taught to screen for depression and anxiety using standardized tools that can be readily administered. The mental health assessment is built into the existing system to create a seamless and holistic approach to mental health as part of the other services being accessed. Further, the integration of screening into services that support older adults offers the potential to identify mental health needs in a less stigmatizing environment, yielding a greater potential for referrals and engagement in mental health services.

The purpose of this paper is to present pilot data on the feasibility of integrating a depression and anxiety screening and mental health intervention into one New York City elder abuse resolution service, to address mental health concurrently with services for elder abuse. The aims of the project were: 1) to examine the feasibility of implementing routine screening for depression and anxiety into an elder abuse service system; 2) to test the acceptability of a mental health intervention called **Pr**oviding **O**ptions **T**o **E**lderly **C**lients **T**ogether (PROTECT) to improve depression and elder abuse outcomes; and 3) to identify the most acceptable format to deliver mental health services within elder abuse practice.

For the first aim, it was hypothesized that elder abuse counselors in a large, urban elder services agency could implement routine depression and anxiety screening to identify

victims in need of mental health services. To test the second aim, the acceptance rate of the new intervention (PROTECT) was recorded. Finally, three different strategies were used to identify the optimal format for service delivery: mental health and abuse services provided by the same counselor ("combined"); mental health and abuse services provided by different counselors who shared the client ("shared"); and standard referral ("referral") to nearby mental health services, which was the usual procedure.

In the "combined" strategy, a single counselor offered both elder abuse services and the PROTECT psychotherapy. The victim thus had a single staff member providing combined services, although during different points of contact. By contrast, in the "shared" strategy victims still received the PROTECT psychotherapy, but two counselors worked together and shared each client. An elder abuse counselor offered abuse victims' services, such as case management and legal advocacy, and a mental health counselor offered the PROTECT intervention. The two counselors communicated with each other, but addressed different needs. In the referral strategy, counselors provided a referral to a nearby mental health facility that accepted the victim's insurance. While evidence suggests that referrals are often not accepted by older clients, making an outside mental health referral remains the usual method for addressing mental health needs in non-mental health settings (Bartels et al., 2004; Sirey, Franklin, McKenzie, Ghosh, & Raue, 2014). Previous research found that clients were more likely to attend mental health services that were closer to home (McCarthy & Blow, 2004).

By implementing three different strategies for service delivery, it was possible to determine whether clients found the delivery of the psychotherapy in shared or combined format more acceptable, and whether staff in an urban, acute care, abuse resolution agency could work in concert successfully with a mental health professional.

Method

This pilot program was designed to examine the feasibility of implementing routine mental health screening and mental health services, offered in three different ways ("combined", "shared" and "referral"), within a large New York City agency offering typical elder abuse resolution services.

Sample

Participants were older adults (age ≥ 60) receiving services from the New York City Department for the Aging's Elderly Crime Victims Resource Center (ECVRC). ECVRC has been funded by the New York State Office of Victim Services (NYSOVS) since 1981, and is housed within the Department for the Aging (DFTA) (http://www.nyc.gov/html/dfta/html/services/crime-victims.shtml). ECVRC provides face-to-face and phone elder mistreatment resolution assistance including information and referrals, emergency assistance, personal advocacy, assistance with family court orders of protection, and consultative services to older adults who are capable of taking self-protective measures. ECVRC and DFTA also conduct ongoing elder abuse outreach and public awareness activities, and provide training and technical assistance not only to community-based agencies overseen by the Department,

but also to law enforcement, criminal justice communities, hospitals, and home care programs.

This PROTECT pilot program is the product of an academic-community partnership between DFTA, ECVRC, and Weill Cornell Medical College. Cornell staff time was supported by funding from the Weill Cornell Institute of Geriatric Psychiatry Advanced Center for Intervention and Services Research (NIMH P30 MH085943). The data review for this project was approved by the Weill Cornell IRB to utilize coded and de-identified data provided by ECVRC and DFTA.

Training

As part of the partnership, ECVRC took steps to integrate depression and anxiety screening into their routine case assessment. Elder abuse social workers within the ECVRC were taught to screen victims for depression and anxiety by Weill Cornell faculty using the Patient Health Questionnaire 9 (PHQ-9) and the Generalized Anxiety Disorder 7 (GAD-7), supplemented by online training (www.mentalhealthtrainingnetwork.org). ECVRC and DFTA added the screening tools to the existing database used to record contacts with victims. This allowed mental health screening to be conducted as part of routine evaluation, and provided a reporting system to review the screening rates. In addition, a staff member with a Master's degree in social work joined the ECVRC staff for this program, and was trained in both abuse resolution and the PROTECT psychotherapy.

Randomization

The ECVRC Unit receives 5–10 calls per day from numerous sources. The Unit leader distributes new cases to counselors in the Elderly Crime Victims Resource Center on a daily basis. Social work staff conduct an initial assessment to evaluate the needs of the client and determine appropriate intervention strategies. The mental health screening is conducted during this initial evaluation with the client (within the first three contacts). Clients whose screenings indicated no mental health needs received elder abuse services alone. Individuals with clinically significant depression or anxiety (PHQ-9 or GAD-7 $\geq$ 10, respectively) were recommended to receive one of the three mental health strategies (combined, shared, or referral).

PROTECT intervention

The PROTECT intervention combines problem-solving psychotherapy with anxiety management techniques and offers psychoeducation about the impact of depressive and anxious symptoms in general, as well as the potential impact of symptoms on taking steps to resolve the mistreatment. Problem-Solving Therapy (PST) was chosen because it is an empirically validated, brief psychotherapy with demonstrated efficacy in reducing depressive symptoms among older adults (Alexopoulos, Raue, & Arean, 2003; Arean et al., 1993; Arean et al., 2010). For this population, PST offers the flexibility to work synergistically with elder abuse resolution services and imparts problem solving skills that target a broad range of problems including those related to ongoing abuse. The PROTECT intervention uses evidence-based techniques that have been tailored to the population and vetted by our community partners.

Clients in both the shared and combined groups were offered the PROTECT intervention designed specifically for victims of mistreatment. PROTECT is delivered in 8 sessions, with the first session (at a minimum) conducted face-to-face. Each subsequent session is conducted using problem-solving worksheets completed either in person or over the telephone. Degrees of homework completion, client satisfaction, response to elder abuse interventions, and perceived improvement are documented on session progress notes by the PROTECT therapist. For this pilot program, flexibility in delivery format (in person or over the telephone) was provided to take into account the potentially unstable living situations of the clients (who often lived with their abusers).

Data analysis

All data was collected by DFTA staff and entered into a DFTA database with the baseline screening data; DFTA staff conducted descriptive analyses, and a de-identified dataset was provided to Weill Cornell (IRB 1301013434) for further analyses. Feasibility data were collected on rates of completed mental health screening assessments (PHQ-9 and GAD-7) for elder abuse victims and the victims' willingness to accept a mental health service; for the shared and combined groups, the rates of initiation and completion of PROTECT were collected as well. Descriptive statistical analyses were conducted on the screening data to determine the rate of clients who had clinically significant depressive symptoms as recorded on the PHQ-9 and GAD-7. As this was a pilot program designed to explore feasibility, the current study did not address outcome analyses or conduct inferential tests due to its relatively low statistical power (Leon, Davis, & Kraemer, 2011). All analyses were conducted using SPSS Version 19.

Results

Training data

Eight ECVRC staff members were trained by Weill Cornell Medical College faculty to administer the PHQ-9 and GAD-7 measures to clients. All staff members were female and most (87.5%) had a Master's degree in Mental Health (MSW or MA in Counseling Psychology). In a pre-training screening, all of the social workers endorsed the belief that mental health services were within the responsibilities of the ECVRC. Despite this view, 25% of staff never or rarely inquired about clients' depression, 12.5% never or rarely inquired about anxiety, and 37.5% never or rarely assessed suicidal ideation. After training, all staff felt confident screening for mental health and agreed to implement the screening protocol within the first three contacts with the client.

Sample characteristics

Following training in implementation of screening measures, screening rates were monitored by the ECVRC director on a monthly basis. These data provided valuable statistics to ECVRC on the type of clients calling and rates of depression. In the past year, ECVRC received over 2300 calls with many of those calls not from elder abuse victims, nor persons eligible for this project. Of the calls received, 1433 were from non-English or acutely psychotic clients, crime victims, and general non-elder abuse concerns, or calls that could not be returned. Among the 951 potential abuse victims eligible to be screened, 99 were

referred for emergency services, 255 had cognitive impairment, and 228 were referred directly to Adult Protective Services (APS). Unlike most states, New York does not have mandatory reporting of elder abuse. Consequently, in New York City APS accepts only clients who are unable to care for themselves. The ECVRC handles all other alleged abuse cases where the victim appears to be capable of decision-making. Of the 369 eligible abuse victims remaining, staff were able to screen 85% (315) using the PHQ-9 and GAD-7.

Of the 315 clients screened, 34% (106) screened positive for depression or anxiety, and in the total screened sample 16.2% (51) endorsed having “thoughts of being better off dead or of hurting yourself” on the PHQ-9, indicating suicidal ideation. Clients with and without mental health needs did not differ significantly by race, gender, or age. The majority of clients were screened during the first contact (80.6%) with an additional 11.1% screened in the second contact and 8.3% in the third contact.

Of the 106 clients who were eligible for the mental health program, only 16 (15%) refused to consider mental health support of any kind. A total of 21 individuals were excluded for having a psychiatric illness other than depression, not being an elder abuse victim, already participating in long term treatment, or being too medically compromised. Of the 81 individuals who accepted elder abuse services and were invited to participate in the mental health program, to date 69 were randomized to either the referral, shared, or combined group. Rates of acceptance of a mental health program were equal across the three groups. For this manuscript we present the demographic, mistreatment, and clinical data on these 69 subjects.

Demographic characteristics for the sample are described in Table 1. The vast majority of clients were female (91%) with a mean age of 71.5 years. About half (51%) of clients reported more than one type of abuse. Psychological abuse was the most common form of mistreatment, affecting 87% of screened clients. In addition, 26% of older adults reported physical abuse and 33% reported financial abuse. In this sample, almost half (49%) of the reported mistreatment was from an adult child, while 7% of cases were from a spouse, 23% were from another relative, and 20% were from a non-relative.

The majority of clients (89.9%) scored 10 or above on the PHQ-9. Most clients reported depressive symptoms above the cut-off score of 10, with a mean score of 14.10 (SD=4.8). A smaller percentage of clients (53.6%) reported clinically significant anxiety on the GAD-7 (≥10). The mean GAD-7 score was 9.78 (SD=5.1) across all clients. In this sample, 33.3% (23/69) of older adults endorsed ‘thoughts that you would be better off dead, or of hurting yourself” several days or more in the past two weeks. Within the 33% who endorsed suicidal ideation, several (30%, 7/23) reported these thoughts more than half the days and a small group of clients (17%, 4/23) endorsed having suicidal ideation every day. In this small sample, there were no differences in the levels of depressive or anxious symptoms, or suicidal ideation associated with endorsement of a primary type of abuse, gender, or age.

Discussion

Findings from this program support the feasibility of integrating both a mental health screening and intervention into a large, acute elder abuse service. The majority of elder abuse social workers were able to screen for depression and anxiety during the first contact with the client, and most clients were willing to accept a mental health service. While the pilot sample is small, preliminary implementation of three different strategies to provide mental health support suggests that clients are willing to accept an offer of additional mental health services at the same time that they were receiving mistreatment resolution service. Additionally, the pilot data support the potential for elder abuse service providers to work in tandem with a mental health clinician. To our knowledge this is the first program to implement systematic screening and an evidence-based psychotherapy into routine elder abuse services.

Offering routine screening for mental health revealed high rates of need among older adults. One in three clients screened endorsed clinically significant depressive symptoms on the PHQ-9. These rates are notably higher than the 10–17% rates typically seen in other service settings, such as home care, home delivered meals, and primary care (Ell, Unutzer, Aranda, Sanchez, & Lee, 2005; Kroenke, Spitzer, & Williams, 2001; Sirey, 2008). Of particular concern is the number of clients who reported thoughts of death or dying on the PHQ-9. In the total sample of abuse victims screened, 16% endorsed suicidal ideation in the two weeks prior. Within the sample of clients who reported significant depression or anxiety, the rate is much higher (33%). Both the high rates of depressive symptoms and of suicidal ideation parallel rates documented among victims of mistreatment in China (Wu et al., 2013).

This pilot provided preliminary support for the feasibility of the PROTECT intervention by delivering the psychotherapy successfully in two different formats: either a single provider offering both PROTECT and elder abuse services (combined), or two providers each offering one specific service to the same client (shared). The rates of acceptance for mental health services were equal across groups, suggesting that once a client accepted elder abuse services, they were willing to consider mental health as an important element of treatment. By offering mental health services in three different formats, ECVRC was able to evaluate which method best suited their services for future practice. This preliminary data support the feasibility of PROTECT as a flexible intervention that can be embedded in an elder abuse setting, to address simultaneously an older adult’s abuse and mental health needs. Going forward, the ECVRC plans to implement the shared model of PROTECT into their routine elder abuse resolution services. Future work will evaluate the effectiveness of PROTECT in a larger sample. Follow-up data is needed to evaluate the rates of engagement among those victims who are referred to outside mental health services.

Limitations

While the screening implementation in this program was robust, limitations to the intervention program necessitate further work. The sample of victims who received one of the three intervention strategies was limited, leading to small group sizes. In addition, while screening is a useful method to detect symptoms, clinical assessment is necessary to

determine the diagnosis and severity of depressive symptoms. This was evident in the number of older adults who needed to be excluded after agreeing to participate. However, data from other aging samples support the usefulness of these screening tools to detect clinically significant depression and anxiety in older adults. In the home meal program sample, 51% of individuals screening 10 or greater on the PHQ-9 met criteria for major depression, with another 13% meeting criteria for minor depression (Sirey et al., 2013).

Another limitation is the selected sample of individuals who were able to receive the intervention. ECVRC provides services in English, limiting the delivery of the psychotherapy to English-only speakers. In addition, for this initial implementation, there were a number of cognitively impaired individuals who were unable to be screened. Such restrictions likely limited the scope of this pilot program, given the numbers of older adults in our screening sample who did not speak English (271) or presented with significant cognitive impairment (255).

Future work should include a larger study of elder abuse victims with mental health needs, to allow for further exploration of clinical characteristics and potential barriers to accessing mental health services among diverse populations. The efficacy of PROTECT should also be examined in a well-controlled, randomized clinical trial. Given the limited mental health services available to victims, PROTECT could be compared to an enhanced version of existing standard referral and follow-up procedures. This type of study could examine both engagement in psychotherapy and client outcomes for depression and anxiety. While there are limitations to the pilot data, preliminary findings document both tremendous mental health needs among elder abuse victims and potential opportunities for implementation of the PROTECT intervention.

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Table 1

Sample characteristics (N=69)

Demographic Characteristics	Number or Range	Percent/Mean (SD)
Female	63	91.3%
Age (years)	60–92	71.5 (11.9)
Race*		
African American origin	15	21.7%
Caucasian	12	17.4%
Hispanic	8	11.6%
Other	3	4.3%
Unknown	31	44.9%
Abuse Characteristics		
Abuser lives in home	55	79.7%
Relationship of abuser to client		
Adult child	34	49.3%
Spouse/Significant other	5	7.2%
Other relative	16	23.2%
Other non-relative	14	20.3%
Type of Mistreatment		
Physical	18	26.1%
Psychological	60	87.0%
Financial	23	33.3%
Clinical Characteristics		
PHQ-9 mean score	0–24	14.1 (4.8)
Percent PHQ-9 score ≥ 10	62	89.9%
GAD-7 mean score	0–21	9.8 (5.1)
Percent GAD-7 score ≥ 10	37	53.6%

*Not all information obtained by ECVRC staff for all individuals