



Area Agency on Aging 

Integrity. Independence. Quality of Life.

# STAGES BEHAVIORAL HEALTH PROGRAM

JACQUELINE CARVER, MSW, LISW-S, CCTP

CLINICAL DIRECTOR OF MENTAL AND BEHAVIORAL HEALTH OUTREACH SERVICES

# STAGES BEHAVIORAL HEALTH PROGRAM

Officially relaunched  
Stages in 2021

Individuals ages 60+  
and caregivers of any  
age

Cover 7 counties:  
Allen, Auglaize,  
Hancock, Hardin,  
Mercer, Putnam, and  
Van Wert

# STAGES – PREPARATION



*Stages Behavioral Health*

*Meeting You Where You Are*

- Credentialing – Medicare, Medicaid, and private insurances
- Community Outreach and Education – Reduce stigma
- Partnerships – Increased awareness and accessibility



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# PROGRAM GROWTH

## Referrals:

- 2021: 15
- 2022: 77
- 2023: 95
- 2024: 97 (as of 10/17/2024)
- Current caseload of 60 individuals
- Have provided services to over 185 individuals

# IN-HOME SESSIONS



## Pros:

- Increase access
- Inside scoop
- Assist while in the moment/environment
- Include family members

## Cons:

- Interruptions and distractions
- Insanitary conditions
- Adds drive time

Also offer in-office and telehealth sessions.



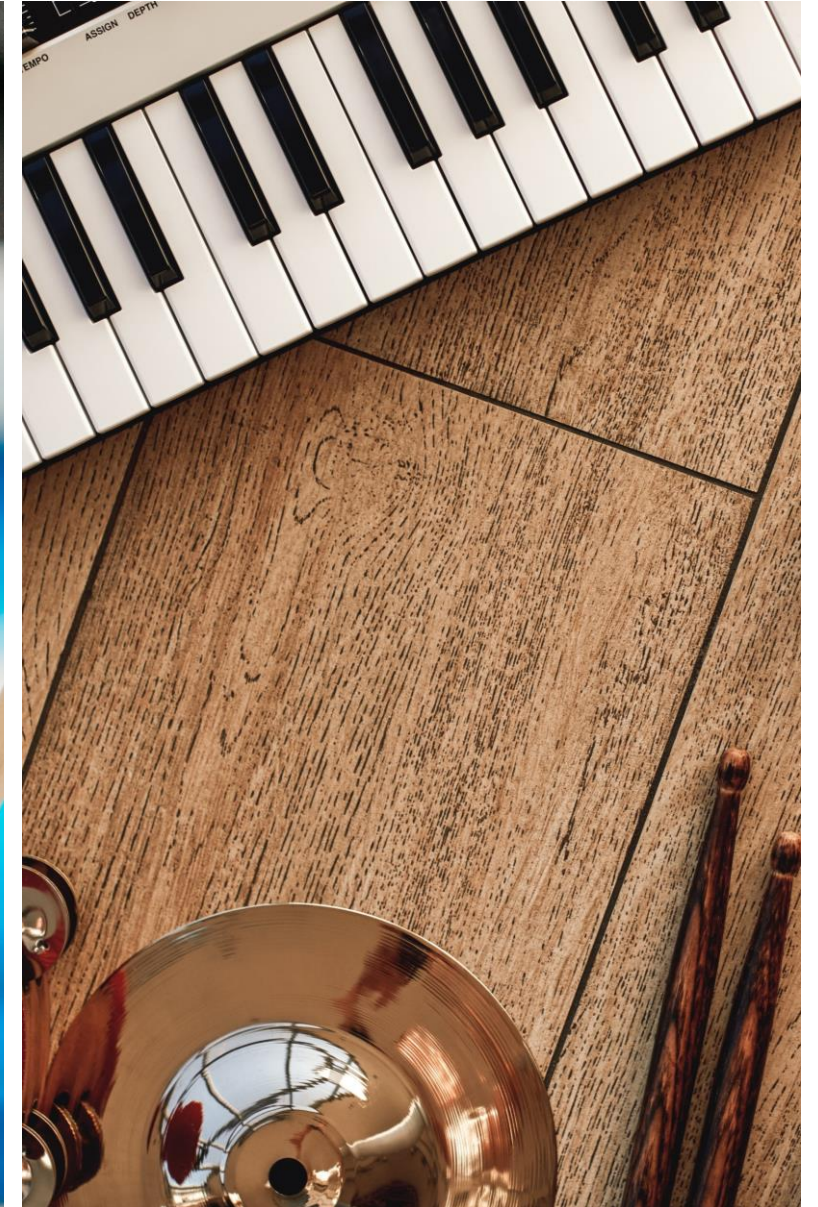
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## CONNECTIONS LIST

- Initiated October 11, 2023.
- 42 total have been added to the Connections List.
- 18 waiting for the initial intake appointment.
- Phone calls, send cards, community resources, and information about programs at AAA3.

## SOCIALIZATION GROUPS

- “Beyond the Canvas” art socialization group.
- “Rhythmic Reflections” music socialization group.



# COMMON CONCERNS

- Loneliness and/or isolation
- Fear
- Ongoing effects of childhood trauma
- Disempowerment/no longer feeling in control
- Passive suicidal ideation



# LONELINESS

- Quality and quantity of the relationship vs. what is desired
- Acute loneliness
- Chronic loneliness

# ISOLATION

- Lack of access and opportunity
- Can be the result of DV
- Hearing loss
- Depression and anxiety

PHYSICAL  
IMPACT OF  
LONELINESS &  
ISOLATION



# COMMON CONCERNS

- Adjustment Disorders
- Major Depressive Disorder
- Generalized Anxiety Disorder

## MDD - RISK FACTORS - BIOLOGICAL

Chronic health issues/physical pain

Sensory loss – eyesight and hearing

Neurotransmitters – low levels of serotonin and norepinephrine

Cognitive impairment

Family history or previous diagnosis

# MDD - RISK FACTORS - PSYCHOLOGICAL



Stress



Unresolved trauma



Hopelessness and helplessness



History of mental health disorders

## MDD - RISK FACTORS - SOCIAL



- Social isolation and loneliness
- Lack of support/social network
- Loss, divorced, or widowed
- Caregiver stress (caring for partner with dementia)
- Living alone
- Not a cause-and-effect situation

# MDD - PREVALENCE



- Depression should not be considered “normal” at any age, including later in life.
- Frequency vs. Impact



# MDD – RISK FACTORS - AGEISM



## Internalized Ageism

- Depression and suicidal ideation
- Increased risk for mortality
- Increased risk for anxiety
  
- A positive self-perception can add 7.5 years to life expectancy

\*E4 Center for Excellence, CATCH-ON, and Rush



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PERSON-  
CENTERED  
CARE

ARE WE  
DOING THIS?

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## PERSON-CENTERED

The therapist:

- - Actively listens with empathy
- - Is present without judgement
- - Reflects back
- - Validates the individual's experience
- - Encourages individuals to engage in self-discovery
- - Encourages clients to identify solutions



**The curious paradox is that when I accept myself just as I am, then I can change.**

*Carl Rogers*

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# TRADITIONAL MEDICAL MODEL

Focuses on:

- Diagnoses, deficits, disabilities
- Standardized measurements
- Structure
- Quality of care that is designed around regulations and professional standards
- Staff convenience

Lacks:

- Collaboration
- Human connection

([hhs.texas.gov](http://hhs.texas.gov))

# PERSON-CENTERED MODEL OF CARE

Focuses on:

- The person's abilities, preferences, and values
- Flexibility
- Collaboration
- Getting to know the individual
- What the individual defines as important

(hhs.texas.gov)

# WHOLE PERSON CARE



Focuses on:

- The whole person instead of one issue
- Physical, psychological, spiritual, environmental, and social health
- Coordination between providers, community resources, and other community partners.



It is the client who knows what hurts, what direction to go, what problems are crucial, what experiences have been deeply buried.

Carl Rogers

(1902 – 1987)

# TRAUMA-INFORMED CARE



SURVIVAL SKILLS/BEHAVIORS  
BECOME AUTOMATIC



STRESS, CAPACITY, AND  
TOLERANCE



A PROVIDER'S APPROACH  
MAKES A DIFFERENCE



# TRAUMA-INFORMED CARE



Focuses on:

- Creating a safe space
- Transparency
- Open communication
- Building trust
- Empowerment

QUESTIONS?



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**CONTACT INFO:**

JCARVER@PSA3.ORG

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