An Alliance for the Mental Health of Holocaust Survivors

Introduction

Novel social support programs developed for Holocaust survivors show promise as avenues to reduce disability in late life associated with dementia and other mental illnesses. By drawing attention to these programs and extending their reach, it may be possible to preserve their benefits for a larger population in need. Experience from the 2009 Professional Exchange Program to Israel sponsored by JDC-ESHEL in Israel and the Caring Commission of the United Jewish Appeal-Federation of New York suggested such an extension is possible. What follows are background and a progress report of “An Alliance for the Mental Health of Holocaust Survivors”, an effort to integrate mental health services into social programs serving Holocaust survivors in New York. The “Alliance” is a collaborative effort between community based agencies and academic medical centers made possible through the support from the Caring Commission of the United Jewish Appeal/Federation of New York.

Background

The development of dementia and depression, the loss of family members and self-reliance are major threats to older persons. But given the past circumstances of emotional trauma, physical deprivation, and confinement, these events are especially upsetting to Holocaust survivors. Fears of being stigmatized by psychiatric care or forced into nursing home or hospital raise added barriers to the provision of mental health care for these individuals. Over the next 5-10 years, the numbers of Holocaust survivors remaining will continue to decline, but because of advancing age and frailty their needs for supportive services and medical care will increase. Failure to address these needs will inevitably burden their family members and communities. As a result specialized psychiatric services, which provide expertise in geriatric care as well as experience with Holocaust survivors, are an urgent need. In as much as mental health specialists with training in geriatrics are an exceedingly scarce, how might they be deployed to maximize use of their expertise?

Allying mental health consultation for staff, clients and their families with existing social programs may maximize the reach of mental health specialists and minimize the stigma of psychiatric services. Services implemented for Nazi victims today will be available for their families and communities tomorrow. It is estimated that at least one naturally occurring or man-made disaster happens every day around the world. This sad fact insures that programs for traumatized persons will never cease to be needed.

Prior Experience

The Bronx Holocaust Survivor Project is a collaborative mental health program between the Self Help Bronx and Washington Heights Nazi Victim Services Programs and the Montefiore Medical Center Division of Geriatric Psychiatry. Over ten years more than 150 individuals have been seen by Montefiore geriatric psychiatrists accounting for in excess of 700 visits, close to half in the patient's home. Patients were referred by Self Help social workers and other social service agencies who had established a collaborative relationship with the Medical Center made possible by the support of the J.E. and Z.B. Butler Foundation and the United Jewish Appeal.

Half the referrals were made for the treatment of anxiety or depression and most often were addressed with an office visit. Social workers also made referrals when their
clients had experienced a recent loss, the onset of disability, or had begun to talk about death. Psychotherapy was often focused on reminiscence and end of life issues, medications, and family dynamics. Cognitive impairment if present was not the main concern. The psychiatrist frequently lead the care coordination effort by contacting the primary care physician or securing the services of the Medical Center’s Division of Geriatric Medicine which also had the capacity to make house calls either by physicians of a geriatric nurse practitioner.

The remainder of referrals were made for the care of older adults with dementia and behavioral management issues or for capacity assessment. These cases tended to be complex and time consuming. Most often the goal became sustaining the balance between the patients’ preference for independence and their need to rely on others for safety. Family guilt, anger and denial of the threat posed by illness to the patient's safety were recurring themes. Although applications for a court ordered guardianship did occur, most often concerns were managed with “watchful waiting” and supportive services while honoring patient's preferences. Much of the work for the psychiatrists was collaborative and supportive, reviewing treatment plans and goals to improve patient care and reduce staff burden.

Staff burden was and remains a sensitive issue. The tragic qualities of their clients’ lives are compounded by the highly selected character of the population served. Many if not most Holocaust survivors meet their mental health needs within primary care sites and community-based agencies. However those referred by Self Help tended to be more impaired as well as less trusting of conventional services and unwilling to initiate care through routine channels. Exceptional efforts are required to develop an effective helping relationship. Often staff work to prevent a near-term crisis rather than to solve a long-term problem. Continuous conflict mediation rather than permanent conflict resolution often lead to staff frustration and demoralization.

The Alliance

“An Alliance for the Mental Health of Holocaust Survivors” grew out of our experience with the Bronx Holocaust Survivors Project and the 2009 Professional Exchange Program to Israel sponsored by JDC-ESHEL in Israel and the Caring Commission of the United Jewish Appeal-Federation of New York. Following the Exchange Program the Caring Commission issued a request for proposals to integrate mental health services into social programs serving Holocaust survivors in New York. The alliance includes 1) The Bronx Holocaust Survivor Project, 2) the Jewish Community Center of Five Towns in Queens and Far Rockaway,v3) CAPE Mental Health Center of the Samuel Field Y in Little Neck, Long Island, 4) the Department of Psychiatry of Maimonides Medical Center in Borough Park, Brooklyn, 5) Self Help Nazi Victims Services Programs at Avenue M and at Church Avenue in Brooklyn, and 6) Bikur Cholim of Boro Park which has one of the highest concentrations of Nazi victims in New York City. The populations served by the Alliance represent substantial diversity in socioeconomic and housing circumstances as well as the full range of religious affiliation.

We sought to forge an alliance with established and emerging sources of mental health services to Holocaust survivors in order to generate a shared experience. Best practices as well as barriers to care will be identified through case conferences, patient and family consultation, and staff support. Our ultimate goal is to expand effective
models of mental health care across a diverse array of service settings and communities for Holocaust survivors and their families but for older adults in general.

Our program has proceeded in multiple steps to develop collaborative relationships with agency staff and enhance mental health care for patients. To do so required an initial needs assessment by the Montefiore consultants that grew out of shared presentations of program services, staffing patterns, and unique practices. In concert we shared perceived programmatic strengths and vulnerabilities as well as barriers to access and acceptance of mental health care by the survivors. Because it is not sufficient for agency leadership to simply endorse the effort, a sharing of experience as well as direct patient care was critical to the formation of trusting, mutually productive relationships between agency staff and the consultants. This required the consultants singly or as a group to travel regularly to each collaborating site to participate in inter-professional case conferences. Patients or agency clients and their families participated in the case conference and were interviewed by one of the consultants. Patients who declined but consented to a visit from the consultant were seen in their homes.

However in some instances the consultant is not be granted access to the patient and the conference proceeds without direct contact. Because the meetings fall under the aegis of staff supervision and quality improvement, and case discussions and patient contact are initiated by agency staff, HIPAA constraints regarding confidentiality are satisfied. As experience with the case conferences and consultations evolve, it will be possible to describe strengths and limitations originating from the care systems, patients and families as well as professional staff. More importantly the differences in communities, providers, and settings will allow us to identify a wide range of solutions to problems.

**Experience over the first Six months**

1. Consultations with staff for clients of Self Help equaled 78 plus 1 from CAPE for a total of 79. Total patients seen equaled 30 amounting to 21 office visits and 44 home visits or 65 direct patient contacts. Thus from July through December we averaged 3 patient visits per week with more than 60% conducted in the community, not in the physician's office. The total number of meetings at agency cites including case conferences with or without the patient present and educational in-services totaled 21 or slightly less than one per week. In summary the cases of 79 Nazi victims were discussed without direct patient contact; there were 71 direct contacts with 30 patients by our psychiatrists with 44 occurring in the patient's home, 5 at community based agencies and 1 at a nursing home.

2. We forged a new alliance with three community based agencies including CAPE in Little Neck, the 5 Towns JCC in Far Rockaway, YM&YWHA of Washington Heights and Inwood, and the with the Department of Psychiatry of Maimonides Medical Center. Monthly case conferences were established at CAPE and 5 Towns JCC. Educational meetings with agency staff included 3 for Self Help, 2 for the Washington Heights YM/YWHA, I for CAPE and 1 for the 5 Towns JCC. Staff consultation meetings included 6 with Self Help of Inwood Heights and Bronx, 1 with Brooklyn Self Help, 4 with CAPE, 2 with the 5 Towns JCC, 1 with the Tietz nursing home. Meetings with the Maimonides team equaled 4. The Maimonides psychiatric consultant Dr. Daniel Rosen saw 30 patients who
received a total of 51 visits, 33 in home. Sixteen were referred by from Bikur Cholim and 35 by the two Brooklyn Self Help sites.

3. Common diagnoses included dementia and depression with anxiety disorders and adjustments disorders, bereavement, and PTSD being less frequent.

4. Curricular materials. We also developed a “Psychosocial Issues in Work with Holocaust Survivors Curricula” a power point presentation by Debra Greenberg, MSW, PhD, Alessandra Scalmati, MD, Gary J. Kennedy, MD which will expand as the program unfolds. Present topics include cultural competency, elder mistreatment, end-of-life care, determination of decisional capacity, bereavement, and vicarious traumatization. The curriculum offers an emphasis on common issues encountered in late life by patients, their families and their providers both in health care and social service settings.

Conclusion

The initial stage of the Alliance has evolved as predicted with the community based agencies welcoming the opportunity to provide linkage to their clients to mental health specialists in geriatrics. By providing geriatric psychiatry services to clients identified and prepared by agency staff, Maimonides Medical Center achieved the first level of collaboration. Without sharing the burdens of care, a fully collaborative relationship resulting in coordinated model of care would be unlikely to emerge. As the Alliance evolves we will examine longer term outcomes including staff perceptions of the quality of the experience, the extent to which costs may be offset by fee for service billings, a more complete curriculum, as well as advantages and limitations of various agency settings.

About the authors

References


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