

CONNECTING OLDER KANSANS WITH  
COMMUNITY MENTAL HEALTH RESOURCES

# TRAINING MANUAL

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THE OFFICE OF AGING AND LONG TERM CARE

SCHOOL OF SOCIAL WELFARE

UNIVERSITY OF KANSAS

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2005

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# INTRODUCTION

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## **PURPOSE:**

The purpose of this manual is to provide systematic guidance to aging service providers who will supply information to their colleagues about: mental health issues faced by older adults, identifying older adults who might be experiencing a mental health problem, and making referrals to local mental health resources. This training includes an overview of mental illness, introduces a brief screening tool that providers can use with older adults to assist them in determining whether a mental health referral might be helpful, and a format for sharing information regarding local mental health resources.

## **TARGET AUDIENCE:**

The target audience for this training is anyone who provides services to older adults. This includes, but is not limited to: assisted living and nursing facility staff, social workers, social service designees, nurses, staff of physicians' offices, senior center staff, clergy, dietitians, audiologists, speech pathologists, CARE Assessors, and caregivers and family members of older adults.

## **DEVELOPMENT OF TRAINING MANUAL:**

This training manual was developed by the Office of Aging and Long Term Care (OALTC) in the School of Social Welfare at the University of Kansas. It was funded, in part, through a contract with the Kansas Department on Aging and the Kansas Department of Social and Rehabilitation Services. The manual was developed over a three year period with the guidance of an Advisory Council comprised of key stakeholders in the provision of aging services. (See Appendix A).

The impetus for the project, "Connecting Older Kansans with Community Mental Health Resources", through which this training manual was developed, came from previous research completed by OALTC. One study found that assisted living/residential care facility administrators reported that approximately 40 percent of their residents had a mental illness other than dementia and that customers with a psychiatric disorder such as anxiety or depression were nearly twice as likely to discharge to a higher level of care as those without a mental health problem (Chapin, Dobbs, Hayes, & Hickey, 2002). Assisted living facility administrators, older adults, and other key stakeholders were surveyed to assess the awareness of available mental health services and referral patterns and to identify barriers to accessing mental health services. Results indicated that there was a lack of education/information about older adults' mental health needs and a lack of information about the referral process and payment for mental health services.

As a result of these findings, the research project, “Connecting Older Kansans with Community Mental Health Resources” was undertaken. After a year spent completing a comprehensive literature review, surveying other states, and conducting focus groups with older adults to learn more about helpful ways to address mental health concerns with their peers, a training was piloted in two different Area Agency on Aging service areas. After the trainings, participants were interviewed twice in order to gather feedback which was used to enhance the training. After these suggestions and ideas were incorporated into the training, it was presented statewide in 2004. The wisdom of the older adults who were involved in the focus groups and the suggestions from the pilot participants were integral to the development of the training and this manual.

### **MATERIAL NEEDED FOR THIS TRAINING:**

- Audio-visual screen
- Laptop with Power Point program. (See Appendix B).
- Projector
- Flip chart, stand, and markers
- Prior Continuing Education Authorization (it is suggested this process is started at least two months prior to the planned training)

Kansas Department of Health and Environment Continuing Education  
Contact information for nursing facility administrators, audiologists/  
speech-language pathologists, and dieticians (785-296-3075)

Behavioral Sciences and Regulatory Board Continuing Education Con-  
tact information for social workers and psychologists (785-296-3207)

Kansas State Board of Nursing Continuing Education Contact infor-  
mation for all levels of nurses (785-296-4929)

- Sign-in sheet. (See Appendix C).
- Participant completion certificates. (See Appendix D)
- Evaluation forms. (See Appendix E).
- K6 Mental Health Screening Tool. (See Appendix F).

## OVERALL EDUCATIONAL OBJECTIVES:

By the end of this training, participants will be able to:

1. Give estimates of the prevalence of depression and anxiety disorders in older adults.
2. Explain how the designation of “severe and persistent mental illness” impacts what services an older adult can receive from a mental health center.
3. Give examples of consequences of alcohol abuse that may be enhanced or unique for older adults.
4. Discuss how co-existing physical health conditions may interact with mental health problems.
5. Discuss how ethnic and cultural differences may influence the use of mental health resources.
6. Utilize the K6 screening instrument with an older adult.
7. Give examples of community-based mental health resources, and explain how to access them.

## **ORGANIZATION/DELIVERY OF TRAINING:**

This six hour training is roughly divided into three didactic sections, preceded by a participant welcome section and concluding with an evaluation section. While suggested delivery is outlined below, any of the three didactic sections could be presented independently of the other two. There are vignettes in italics included through out the text of the training. The inclusion of these vignettes is optional.

### **I. Introduction**

**9:00 Welcome & Introductions**

### **II. Overview of Mental Illness**

**9:30 Depression & Anxiety Disorders**

**9:45 Severe and Persistent Mental Illness**

**9:50 Addictions**

**10:10 Co-Existing Conditions**

**10:30 Break**

**10:40 Mental Health and Ethnicity and Culture**

**11:10 Mental Health and Spirituality**

**11:30 Lunch**

### **III. Identifying and Addressing Mental Health Problems**

**12:15 K6**

**12:40 Addressing Challenging Situations**

**1:15 Break**

### **IV. Referral to Mental Health Resources**

**1:30 Accessing Service Providers and Other Resources**

**2:00 Local Service Providers**

### **V. Closing**

**2:45 Evaluation**

# PARTICIPANT WELCOME

## **MATERIALS NEEDED:**

Flip chart, stand, and markers

## **LENGTH:**

30 minutes

## **GOAL:**

To introduce participants to the training, trainers, and each other.

## **OBJECTIVE:**

Participants will be able to:

1. Understand the goals, objectives, and format of the training.
2. Discuss challenges and concerns in working with older adults who experience mental health problems.

## **CONTENT/ACTIVITIES:**

*[SLIDE ONE]*

1. Introduce the training, “Connecting Older Adults with Community Mental Health Resources” and yourselves. Include your name, and background. Cover “housekeeping details” including agenda, contents of folders, location of bathrooms, schedule, etc.
2. Ask participants to introduce themselves, tell about their background, and current position.
3. On flip chart, record a count of the number of participant in each of the various job title categories that they designate (using hash marks under each category). Explain that this information will be used later in the day when participants break into small groups.

*[SLIDE TWO]*

4. To gain understanding of participant motives for attending training, ask the following questions:
  - A. Why are you here today? (What is learned by asking this question: Do participants want to know more about certain mental illnesses or certain treatments? How to

**NOTES**

identify older adults having mental health problems?  
What to do once a problem is identified?)

B. What are the biggest challenges you face when providing services to older adults with mental health problems? (What is learned by asking this question: What unique challenges are experienced as service providers working with older adults with mental health problems? Stigma? Lack of transportation?)

5. State that today's training will address many of these issues and encourage questions and group dialogue throughout the day.
6. Ask for any questions regarding the agenda, schedule, training content, etc.

*NOTES*

# SECTION ONE

## OVERVIEW OF MENTAL ILLNESS

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### MATERIALS NEEDED:

Flip chart, stand, and markers

### LENGTH:

125 minutes

### GOAL:

Participants will be provided with a general overview of mental illness, co-existing conditions, ideas regarding culturally competent practice, and ways to appropriately address spirituality/religion in customers' lives.

### OBJECTIVES:

Participants will:

1. Learn or review prevalence, symptoms of and treatments for depression and anxiety, both in the general population and specifically for older adults.
2. Understand the designation, "Severe and Persistent Mental Illness" and how this designation impacts customer eligibility for mental health services. This discussion is specific to the state of Kansas.
3. Learn or review the prevalence, patterns of etiology, and treatment for addictions specific to older adults. This includes alcohol, prescription and illegal drugs, and gambling.
4. Learn about the ways in which co-existing conditions interact with mental health problems.
5. Brainstorm about ways in which to enhance the level of cultural competence in their work with people from cultures other than their own.
6. Discuss feelings experienced when thinking about discussing religion/spirituality with customers, when this discussion may or may not be appropriate, and ways to sensitively address spiritual/religious aspects of customers' lives.

**NOTES**

## SUGGESTED SCHEDULE OF SECTION ONE:

### Overview of Mental Illness

**9:30 Depression & Anxiety Disorders**

**9:45 Severe and Persistent Mental Illness**

**9:50 Addictions**

**10:10 Co-Existing Conditions**

**10:30 Break**

**10:40 Mental Health and Ethnicity and Culture**

**11:10 Mental Health and Spirituality**

**11:30 Lunch**

## CONTENT/ACTIVITIES:

**9:30-9:45 Depression and Anxiety**

[SLIDE 3]

In a report by the U.S. Department of Health and Human Services published in 1999, nearly 20% of respondents age 55 and older reported having a mental health disorder (U.S. Dept. HHS, 1999). This number is startling given estimates that indicate less than 3% of older adults seek mental health services (U.S. Dept. HHS, 1999). It is estimated that only half of older adults who acknowledge mental health problems receive treatment from any health care provider, and only a fraction of those receive specialty mental health services (3%) (Lebowitz, et al, 1997). This rate of utilization is lower than for any other adult age group (American Society on Aging, 2003)

[SLIDE 4]

What might be some possible reasons for this? First of all, what terms does our society use in describing people with mental illness? (**Training partner flip chart answers**) What have you heard said about places where people go for mental health services? (**Training partner flip chart answers**) What conclusions can you draw by looking at these words that are here on the flip charts? (Prompt: society has very stigmatizing ways of talking about mental illness and places people go to seek help.)

Another reason may be that some older adults, their family members, and the professionals who work with them believe that mental illness is a normal part of aging. In a public opinion poll commissioned by the Geriatric Psychiatry Alliance, nearly 93% of adults over 65 thought that depression was a normal part of aging (American Society on Aging, 2003).

**NOTES**

There is also the attitude among some people that aging and old age are by definition depressing (Hartford, 2002). Why do you think that people have that attitude? (Prompt: loss of abilities, independence, spouse/partner, friends, home)

[SLIDE 5]

The most common mental illnesses seen in older adults, in order of prevalence, are: anxiety disorders, such as phobias and obsessive-compulsive disorder; severe cognitive impairment, including Alzheimer's disease; and mood disorders, such as depression (U.S. Dept. HHS, 1999; Administration on Aging, 2001).

[SLIDE 6]

This slide lists the most common anxiety disorders. Considered in the category of anxiety disorders are: Generalized Anxiety Disorder, Panic Disorder, Agoraphobia, Social Phobia, Obsessive Compulsive Disorder, Specific Phobia, Post-Traumatic Stress Disorder, and Acute Stress Disorder. The two most common types of anxiety disorders in older adults are: Generalized anxiety disorder (GAD) and Panic disorder (U.S. Dept. HHS, NIMH, 2003).

[SLIDE 7]

Anxiety disorders affect approximately 5% of people age 65 and older (Markovitz, 2001; Stanley & Beck, 2000). Anxiety disorders frequently exist along with depressive disorders, eating disorders, or substance abuse, and women are more likely than men to have an anxiety disorder (Markovitz, 2001). Anxiety may be the most common and difficult to identify among older adults because of its general and pervasive nature as well as the tendency of older adults to deny psychological symptoms or attribute the symptoms to physical illness. Generalized anxiety disorder, or GAD, is known to affect about 4 million adults. Some of the factors which might exacerbate GAD include chronic physical problems, cognitive impairment, institutionalization in a nursing home, and experiencing significant losses. (U.S. Dept of HHS, NIMH, 2003).

[SLIDE 8]

The DSM-IV TR criteria for Generalized Anxiety Disorder include what is listed on the PowerPoint (American Psychiatric Association, 2000). The DSM-IV TR is the manual listing the most widely accepted and clinically validated criteria for a particular mental health problem or illness. Licensed mental health clinicians refer to this manual after assessing an individual customer. The resulting diagnosis, or diagnoses that the clinician assigns to a customer can indicate the types of treatment that are most often effective (if treatment is necessary). It also can impact what type of mental health professional provides service to an individual, and, whether an individual will receive payment assistance from his/her insurance or from Medicaid/Medicare.

Because DSM diagnoses are important in this way, they are being presented to you. However, a person can experience some of the symptoms listed and though

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they don't officially meet the criteria for the disorder, they can still benefit from and receive support from a mental health service provider or various other mental health resource. The purpose of the training today is not so that you can go back to your organizations and diagnose people with DSM diagnoses. This is something best left up to licensed clinicians. It's to provide you with additional information about how to identify people who might be having mental health problems, regardless of the type of problems, and then, how to assist those individuals who want services or support to get them. With that in mind, it's helpful to look at the DSM criteria.

We all experience anxiety at various times; most of us worry about things as well. The difference with GAD is that people can become fixated and unable to get the thoughts that make them anxious out of their minds. This obviously can interfere with social functioning and physical functioning, the ability to undertake daily activities, and engage in relationships (U.S. Dept of HHS, 1999). Without treatment, GAD can severely restrict peoples' lives.

**[SLIDE 9]**

In the treatment of anxiety, it is recommended that an individual participate in a thorough assessment from a licensed professional. It is important that physicians are kept informed about any symptoms of anxiety as older adults are most likely to seek care from and to disclose their feelings to them because of the relationship and comfort level they have developed. It is generally thought that a combination of psychotherapy and medication are optimal to reduce symptoms of anxiety and restore functioning (U.S. Dept of HHS, 1999).

**[SLIDE 10]**

Depression is one of the most common mental health disorders seen in older adults (AoA, 2001). According to the Surgeon General's Report (1999), it is estimated that between 8-20% of community dwelling older adults exhibit symptoms of depression and depressive syndromes. That translates to about 5 million of today's 33 million Americans 65 and older. By 2010, it is estimated that of the 40 million Americans who will then be over 65, 20 percent may experience problems related to mental health (AoA, 2001). Depression in older adults is often chronic, undiagnosed, inappropriately treated, (or untreated) and linked with decreased functioning (Blazer, 2002).

**[SLIDE 11]**

Here is a list of selected depression criteria from the DSM-IV-TR ( American Psychiatric Association, 2000).

While adults over 65 have relatively low rates of major depressive disorder, they have relatively high rates of depressive symptoms that do not meet DSM-IV criteria for major depressive disorder (Newmann, 1989 cited in Karel & Hinrichsen, 2000, p. 708). Although these sets of symptoms do not meet the full criteria to be classified as a specific mental disorder, they can be severely distressing and impair-

ing. Older adults who have a functional disability or medical illness are at highest risk for depression (Karel & Hinrichsen, 2000). Depression can be in the form of a recurrent chronic problem that someone first experienced as a young adult, or it can appear for the first time in late life. (Karel & Hinrichsen, 2000).

[SLIDE 12]

While feelings of helplessness, hopelessness, and uselessness are experienced by persons suffering from depressive disorders at all stages of the life cycle, older adults, however, more commonly will describe feeling a sense of hopelessness and helplessness about the future (Blazer, 2002). You may readily recognize some of the common symptoms of depression by behaviors such as withdrawing from social activities, for example. In addition to what you see happening, it's important also to listen what older adults might be saying which can provide clues to the existence of depression. You may hear things like, "I'm no good anymore", or "I can't do anything right", or "What's the use?", "I have nothing to look forward to" (Blazer, 2002, p. 40). Loss of motivational ability may also be seen in older adults. In addition, older persons with depression tend to be more introspective and therefore withdraw from social activities. Constant thinking about present and past problems is also characteristic of depressed older adults (Blazer, 2002).

"Despite common stereotypes that depression is inevitable and unchangeable in old age, major depression affects a small amount of older adults and is generally as responsive to treatment as depression in younger people" (Scogin & McElreath, 1994 cited in Karel & Hinrichsen, 2000, p. 707). The greatest barrier to effective treatment of depression in late life is probably inadequate recognition of depression in older adults, by elders themselves, their families, and physicians (Ibid). Again, older adults and others may assume that symptoms of depression are simply a part of growing older. Symptoms of depression can also overlap with symptoms of medical illness such as poor appetite, sleep disturbance, low energy; older adults are less likely to report symptoms of depression and this contributes to the under-diagnosis of depression in older adults (Karel & Hinrichsen, 2000; Blazer, 2002).

Depression is an important risk factor for suicide, and is, indeed a significant predictor of suicide in older adults (Conwell & Brent, 1995). Older adults have the highest rate of suicide in the United States; older men are the highest risk group (U.S. HHS, 1999), with a suicide rate six times higher than that of the general population (Lantz, 2001). Depression is present in more than 80% of older persons who commit suicide (Lantz, 2001). Several studies have found that many older adults who commit suicide have visited a primary care physician very close to the time of suicide:

20 percent on the same day,

40 percent within one week,

70 percent within one month of the suicide (Conwell, 1994).

**NOTES**

[SLIDE 13]

There is no fool-proof way of predicting suicide. However, certain factors have been associated with increased suicide risk, such as age (adolescent or elderly), alcohol dependence, and a history of suicide attempts (Conwell & Brent, 1995). If you suspect that a customer is having either passive or active thoughts of suicide, a formal suicide risk assessment and appropriate follow-up should be completed according to your particular agency's policies or procedures. If you are not familiar with these policies and/or procedures or if you are not the person who does risk assessments with regard to suicidality, you should immediately consult with your supervisor and get assistance.

[SLIDE 14]

Though depression can be very distressing for older adults, their families, and care providers, the good news is that most late life depression responds successfully to treatment. According to the Geriatric Psychiatry Alliance, depression is curable in 80% of all cases (American Society on Aging, 2003). There are many interventions that are successful in treating older adults with depression. Some of these include psychotherapy and anti-depressant medication (Karel & Hinrichsen, 2000). Psycho-educational classes, music therapy, narrative therapy, adult day services and other social interaction; family support and community support; and case management services can also be helpful.

Now, let's talk about severe and persistent mental illness.

**Severe and Persistent Mental Illness 9:45-9:50**

[SLIDE 15]

“Severe and persistent mental illness”, or, “SPMI”, is a term that you will hear used by the community mental health centers, or, CMHCs, various state agencies, the state psychiatric hospitals, and other mental health providers. It is an important term to understand, because, older adults who meet the definition of SPMI can access mental health services through the publicly funded mental health system that older adults who do not have SPMI cannot access.

The Federal government provides funding to States to assist them in paying for a publicly funded mental health system. It requires States to designate which individuals are so affected by symptoms of mental illness that State systems need to target services specifically for them.

In Kansas, the State refers to such individuals as “severely and persistently mentally ill”, or, “SPMI”. And, they have established a list of criteria to identify those individuals. While most of you are not the staff who make determinations of whether someone is SPMI, it is important to understand how such determinations are made, because an SPMI designation may allow your customers to receive services from the CMHCs that they cannot receive otherwise. According to the Report of the Surgeon General, the prevalence of SPMI for adults 55 and older is less than 1% (U.S. DHHS, 1999).

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There are three sets of criteria that are used to determine whether or not a SPMI designation is utilized. A licensed person who is generally an employee of a CMHC assesses an individual using diagnostic, functional, and risk criteria ([www.srskansas.org/hcp/MHSIP/AIMS/Appendix%20F.pdf](http://www.srskansas.org/hcp/MHSIP/AIMS/Appendix%20F.pdf)).

Diagnostic criteria are set so that only individuals with serious mental illnesses such as schizophrenia and bipolar disorders are considered in the category of SPMI. Functional criteria looks at how much the individual's functioning is impaired by his or her mental illness; for example, whether an individual has recently been hospitalized for the illness or whether he or she has been unable to work or maintain housing. The risk criteria determines to what extent someone's thought processes, physical condition, and past behaviors put them at risk for harm ([www.srskansas.org/hcp/MHSIP/AIMS/Appendix%20F.pdf](http://www.srskansas.org/hcp/MHSIP/AIMS/Appendix%20F.pdf)).

The designation allows an individual to receive services that are specifically tailored to meet their unique needs. For example, all CMHCs have a division of their agency referred to as "Community Support Services", or, "CSS". CSS provides services such as case management, which are generally unavailable to CMHC customers who are not SPMI. Later in the day, the CMHC system will be discussed more in depth, including those services available primarily to SPMI customers.

#### VIGNETTE:

*To understand how the SPMI designation is utilized, we present two brief scenarios about Jim and Jean. Jim was convinced that a neighbor was trying to poison him. He had a long history of psychiatric hospitalizations and medication adjustments to help control his psychotic symptoms. He was refusing to eat because he was not sure if the food or drinks had poison in them. He was having difficulty falling asleep because he was concerned about this neighbor coming and killing him when he was asleep and defenseless, and he was making dozens of phone calls to his family every day to beg them to get him out of the house because he was going to be killed soon. When he became physically aggressive, he was sent to the local hospital emergency room, who connected him to the local CMHC. They determined that he met SPMI criteria due to the following: his diagnosis of Paranoid Schizophrenia, his extensive history of psychiatric services (hospitalizations, medications), his inhibited ability to function on a daily basis (his refusal to eat and decreased sleep), and his high risk toward others due to his paranoid thoughts leading to physical aggression. This man was hospitalized and then received case management and psychiatrist services through the local CMHC.*

*Jean was brought into the CMHC by her adult children because she was having problems at home with self-care. Jean was disoriented much of the time, often appeared depressed and tearful, had lost a significant amount of weight due to not preparing her own meals, and had been found by family wandering around after dark confused and dressed inappropriately. Because*

**NOTES**

*Jean was a risk to herself due to confusion and disorientation, she was hospitalized briefly in a gero-psych unit and eventually moved into a facility where they could better manage her particular problems with cognition. When assessed for services through the CMHC, she did not meet SPMI criteria. Specifically, Jean did not have any history of mental health problems, was found to be more likely to be experiencing dementia of some sort, and although she was a risk to her own safety, did not meet criteria for SPMI status. She was therefore ineligible for services targeted to adults with an SPMI.*

*In conclusion, these are examples of two adults with somewhat similar symptoms and similar levels of risk to self or others where one meets SPMI criteria and one does not. The purpose of giving these two examples is not to provide training to differentiate between diagnoses, but to illustrate the sometimes subtle differences and reasons which may or may not enable customers to receive certain services.*

Now, we'll move on to addictions and co-existing conditions.

### **Addictions 9:50-10:10**

**[SLIDE 16]**

Now, let's talk about older adults who have problems with and sometimes addictions to alcohol, prescription or illicit drugs, or gambling. As it is probably the most common, we'll focus most of our discussion on problems with alcohol.

**[SLIDE 17]**

Although alcohol abuse generally declines with increasing age, it is still a common problem in older persons. Community surveys have estimated the prevalence of problem drinking among older adults to range from one percent to fifteen percent (Adams, Garry, Rhyne, Hunt, and Goodwin, 1990; Fleming, Barry, Manwell, Johnson, and London, 1997). Numerous studies document alcohol abuse and risky drinking as 2 to 6 times more common in older men than women (Deblinger, 2000).

Alcohol has a greater impact on older people due to physiologic changes associated with aging such as reduced water content in tissues, which can result in higher blood alcohol levels in older adults. Metabolic changes associated with aging also increase blood alcohol levels, placing additional burden on the liver. Older adults have higher self-reported feelings of intoxication, cognitive function deficits, and problems associated with balance (U.S. Dept of HHS, 1999).

The most common psychiatric co-existing condition with alcohol abuse is depression. The largest study of the link between depression and alcoholism found that in people over 65, more than 13% of those with major depression also had an alcohol use disorder, whereas only 4.5% with no depression had an alcohol use disorder (Grant & Harfor, 1995).

**[SLIDE 18/24]**

**NOTES**

There are several factors which may increase the likelihood that an older adult will have problems with alcohol (Graham & Schmidt, 1999):

## RISK FACTOR AND RELATIONSHIP

Male Gender: Studies consistently indicate that older men are much more likely than women to have alcohol-related problems;

Loss of Spouse: Alcohol abuse is more prevalent among older adults who have been separated or divorced and among men who have been widowed;

Other Losses: Other losses of aging such as death of family members or friends, losses associated with retirement, chronic illness, or disability;

Inpatient Hospitalization: Inpatient hospitalization for medical or psychiatric problems;

History of Substance Abuse: Those who have a substance abuse disorder earlier in life are more likely to experience a recurrence later in life;

History of Psychiatric Disorder: Some mental illnesses have been shown to play a role in late life substance abuse;

Family History: Genetic factors are important in alcohol-related behaviors;

Other Substance Use: Older adults who use nicotine and psychoactive prescription medicines are more likely to abuse alcohol;

Other risk factors include: Decreased mobility, declining health, being a caregiver, and having custody of grandchildren (Graham & Schmidt, 1999).

[SLIDE 19]

While there has been a lot of research about what places an older adult at risk for alcohol problems, little research has been done about what helps to protect an older adult from having problems with alcohol. These three protective factors have been identified by Mazarek & Haggerty (1994):

- Social support in the form of family;
- Health and social services such as respite care;
- New and productive social roles.

[SLIDE 20]

Not everyone with a drinking problem drinks every day. It appears that people tend to have certain patterns of problem drinking and that only in the pattern known as continuous problem drinking is the use almost constant. Intermittent drinkers

**NOTES**

have periods of time where they do not drink at all or in such a way as to cause them difficulties. Binge drinkers may drink infrequently but when they do, they tend to consume large amounts of alcohol.

The time in a person's life at which drinking becomes a problem is usually categorized as:

- Early onset (before age 60) or
- Late onset (after age 60).

And, early onset occurs in 2/3 of older adult problem drinkers, and late onset occurs in 1/3 (Deblinger, 2000).

**[SLIDE 21]**

One of the most important barriers to diagnosis, referral, and treatment of problem drinking is the stigma associated with having an alcohol problem. This stigma may be experienced not only by older adult problem drinkers themselves, but also by their families, who may ignore or actively hide evidence of the drinking problem (Deblinger, 2000).

Another barrier is that older adults tend to exhibit less of the behavioral stereotypes that are associated with alcohol problems. Typically, problem drinkers are identified by the negative consequences of their drinking, such as being fired from a job, getting a DUI, etc. For older adults, those negative consequences may be much less obvious and may mistakenly be attributed to physical health problems (U.S. Dept of HHS, SAMSHA, 2000).

Another barrier is that physicians are less likely to identify alcohol problems in older adults. Hazelden and Columbia University completed a study in which 400 physicians were tested for their responses to a hypothetical case study in which symptoms that might indicate alcohol abuse were present. Less than one percent of physicians considered the influence or role of alcohol (Peck, 2003).

Another barrier may be that many people may see drinking in old age as a harmless diversion and that talking with an older adult about seeking treatment is interfering with their decisions about how they choose to enjoy the rest of their life. There are, however, some good reasons to talk about alcohol problems, because, older adults face serious consequences when abusing alcohol.

**[SLIDE 22]**

Age-related physical changes cause an increase in the effect that alcohol has on the body, even if the person is not drinking more than they were when they were younger. Alcohol is toxic to almost every organ system; therefore, common consequences of alcohol use and abuse include those listed on the screen (U.S. Dept. of HHS, 1999).

**[SLIDE 23]**

**NOTES**

The good news is that older adults have been found to be more compliant with treatment and have treatment outcomes as good as or better than those of younger people (U.S. Dept of HHS, 1999).

Now, let's briefly discuss prescription drug misuse and older adults.

[SLIDE 24]

Some estimate that older adults use prescription drugs 3 times more than the general population, thereby increasing the opportunity for abuse ([Http://nida.nih.gov](http://nida.nih.gov)). Many older adults are managing multiple health conditions, which involve taking several medications. On average, older persons take 4.5 medications per day (Golden, Preston, & Barnett, 1999).

[SLIDE 25]

Between 40% and 75% of older adults do not take their medications at the right time or in the correct amount (National Institute on Drug Abuse, 2001). This may be due to a variety of problems, such as arthritis, poor eyesight, and memory lapses (Williams, 1997). Many aging service providers talk about medication misuse, but "misuse" may be a misnomer, as there are many older adults who would like to take their medications correctly, but they can't afford to do so.

According to the National Institute on Drug Abuse (2001), some drugs are more likely to be abused than others. The three classes of prescription drugs most commonly abused are 1) opioids, such as codeine and morphine, which are used to treat pain; 2) central nervous system depressants, such as Valium and Xanax, which are used to treat anxiety and sleep disorders; and 3) stimulants, such as Ritalin and Dexedrine, which are sometimes used to treat obesity.

[SLIDE 26]

Little research has been done regarding older adults' use of illegal substances. In 2000, however, in a national household survey, 568,000 persons aged 55 and older reported using illicit drugs in the past month (U.S. Dept of HHS, SAMSHA, 2000). Among older adults, Caucasians had higher rates of past month illicit drug use than African Americans or Hispanics. Alcohol abuse experts believe that the aging of the "baby boom" generation will lead to increase in this problem for older adults.

And, finally, let's talk about gambling addiction and older adults.

[SLIDE 27]

In many ways, gambling addiction resembles other addictions to substances such as alcohol and drugs. One of the leading researchers in this field says that, like other addictions, "Problem gamblers have an intense preoccupation with gambling. Their lives are focused on gambling, to the exclusion of other interests. They gamble more often and with more money than they intend, and they have great difficulty controlling the amount of money they wager or the amount of time they spend

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gambling. Like people addicted to drugs, problem gamblers develop tolerance. They need to increase the amount of money wagered in order to achieve the desired excitement. . . . Problem gamblers also experience withdrawal symptoms when they attempt to cut back or stop their gambling. . . . Probably the most important thing that distinguishes problem gamblers from recreational gamblers is chasing. When they lose, compulsive gamblers chase their losses in an attempt to get even or win back what they have lost.” (Pavalko, 1999).

**[SLIDE 28]**

Between one and five percent of the general population appears to experience problems with gambling. As the number of older adults who gamble has increased significantly, from 35% in 1975, to 80% in 1999, it can be expected that the number of older adult problem gamblers has also increased (Kallick, Suits, Dielman & Hybels, 1976; NOPR, 1999). While gambling does appear to decline with age (Mok & Hraba, 1991), some research indicates that women, in particular, begin gambling at a much older age than men, and, that they gamble significantly more of their monthly income (Petry, 2002).

Now, let’s talk about conditions that may co-exist with mental health problems.

**Co-existing Conditions 10:10-10:30**

**[SLIDE 29]**

In younger individuals, mental health disorders may occur by themselves. In older adults, however, mental health disorders frequently occur in conjunction with any one of a number of chronic health conditions. In combination, these disorders impact functioning in subtle and complex ways. The declines that typically accompany aging, such as stamina, memory, and alterations in metabolism, can be compensated for by many older adults so that their daily functioning is not noticeably affected. But, when mental health and physical health disorders coexist, typical declines become more pronounced, impacting their long-term recovery and threatening their abilities for self-care (Kelley, 2003).

A lot of research has been devoted to this interactive relationship between mental and physical disorders in older adults. In fact, disability has been referred to as the hallmark of depression among older adult. Dr. Harold Koenig, a leading researcher in the field, has noted that one of the most significant ways that depression can affect medical outcomes in older adults is that they lose the motivation to keep their doctor appointments or take their medications (Koenig, 1999).

**[SLIDE 30]**

Specific conditions that are known to have an interactive relationship with mental illness include:

- Vision Impairments. Older adults with vision impairments are 2-5 times more likely to experience depression. Even minimal vision impairment can put an older adult at risk for depression; in fact, in a 1998 study, Williams

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found that older adults who were legally blind in one eye were more likely to be depressed than those legally blind in both eyes. He concluded that that could be due to them worrying about eventually losing vision in both eyes (Horowitz, 2003).

Many believe that the reason that visual impairment is so significantly linked to depression is that society views vision loss as such an extraordinarily traumatic disability. One researcher noted that vision loss directly affects two of the most common and valued activities of older adults, can you guess what they would be? Reading and driving. He says that, not only is reading for pleasure affected, but inability to read newspapers and magazines can break one's connection with larger society, difficulty reading menus and materials for religious services may threaten an older adult's connection to his/her social community, and difficulty reading price labels, street signs, and medicine bottles further contributes to problems with everyday activities (Horowitz, 2003).

Perhaps even more stressful, though is the impact of vision impairment on the ability to drive. And, I am sure that everyone in this room has worked with an older adult struggling with relinquishing driving, and so you know that, for older adults, it's much more than just the ability to drive; it's about their ability to be autonomous and independent. Research has shown that older adults who've had to stop driving have much higher levels of depression than those who are driving, and that this depression persists for years after the driving stops (Horowitz, 2003).

When older adults with vision loss also experience depression, they are more likely to reject low-vision aids and are more likely to drop out of or not comply with rehabilitation. However, for those who will accept and comply with rehabilitation interventions, the subsequent improvement in functional skills and adaptation directly reduces levels of depression among adults. And that works both ways; interventions that directly treat the depression can also have far-reaching beneficial effects on rehabilitation outcomes and can lead to reduced disability (Horowitz, 2003).

- Stroke. 40-50% of stroke survivors experience depression. Researchers found that depression can linger for up to three years or more following a stroke (Robinson, 2000).
- Heart disease. The mortality rate for those who have experienced a myocardial infarction and have a major depressive disorder is 2 – 4 times that of those without depression (Miller, 2001). They are also more likely to experience additional infarctions than are those without depression (Koeing, 1999).
- Chronic Obstructive Pulmonary Disease (COPD), the most common respiratory disease among older adults can be associated with shortness of breath and in turn, anxiety and limited activity, which can then lead to depression. (Merck Manual of Geriatrics, 2002).

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- Asthma. Asthma is associated with a high rate of anxiety disorders.
- Cancer. It was reported by the APA in 2003 that one in four people with cancer experience depression. It has been found that those receiving treatment may be better able to tolerate the side effects from chemotherapy (Weintraub, Furlan & Katz, 2002).
- Type II Diabetes. A 1997 study found that treatment for depression helped stabilize blood sugar in diabetics (Weintraub, Furlan & Katz, 2002).
- Immune System. Depression puts enormous stress on a person's psychological system. The adrenal glands react to that stress by producing high levels of cortisol, which affects the immune system's ability to fight infection (Koeing, 1999).
- Dementias.

### **VIGNETTE:**

*A social worker was involved in a dementia education program that offered free dementia screenings to older adults. A woman came to the screening and was certain she had dementia because she was experiencing a lot of memory problems. When the worker began talking with her, he learned that her husband had died only a week before and upon further evaluation, it was determined that she did not have dementia, but in fact needed psychiatric hospitalization due to severe depression. What the worker observed was that a good deal of the time, people who came in for the screening didn't have dementia, but were experiencing other mental health problems such as depression or anxiety. The worker observed that it seemed more acceptable to the older adults to talk about the possibility of having dementia more than another mental health problem.*

While most of you don't have the job of diagnosing someone with any type of mental illness, it might be helpful to have the information that is on the next two slides, as it might assist you in talking with a customer or a family member about the differences between dementia and depression.

[SLIDES 31 & 32]

[SLIDE 33]

Depression is a common occurrence in Alzheimer's disease, and in other dementias. It is estimated that approximately 20 to 40 percent of people with Alzheimer's disease experience depression, although one of the foremost authorities on co-occurring mood disorders and dementia, Dr. Constantine Lyketsos, has said that he believes that virtually every individual experiencing dementia will also experience symptoms of a depressive or anxiety disorder at some point in the course of their disease process (Rosenblatt et al, 2004).

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Men and women with Alzheimer's experience depression with about equal frequency. Although depression in Alzheimer's is often similar in its severity and duration to the disorder in people without dementia, in some cases it may be less severe, not last as long, or not recur as often. Depressive symptoms may come and go, in contrast to memory and thinking problems that worsen steadily over time. Memory problems in early stages of dementia might compromise patients' self-report of depressive symptoms. Language and communication difficulties in later stages of dementia might change the expression of depressive symptoms. All of these factors can impede the ability of a health care professional to identify and treat depression when it is present (Boustani & Watson, 2004).

What tends to happen when someone does get diagnosed and treated for co-occurring dementia and other mental illnesses is that there is not only an improvement in their mood, but they can also have a decrease in behavioral problems, and, subsequently, in caregiver burden. Effective treatments include not only psychiatric medications, but also exercise and behavior management programs (Boustani & Watson, 2004).

[SLIDE 34]

#### **BREAK 10:30-10:40**

Now, we'll talk about mental health and ethnicity and culture.

#### **Mental Health Ethnicity and Culture 10:40-11:10**

[SLIDE 35]

It is important to first be clear about what is meant by the term minority. This term is being used as a term to describe a group that has historically had little power or influence. While it is sometimes used to imply the group is small in number compared to the majority group, this may not be the most accurate and helpful way to think about the concept. Thus, it will be used within the context of having little power or influence. Minority groups are being discussed because they face significant risk factors that cause them to be particularly vulnerable to mental health struggles, including depression and anxiety. These risk factors will be covered in more detail in just a moment, and specifically, what this means to service providers.

It is also helpful to think about the idea of how groups determine what is a "mental health problem" what is "normal" in reference to mental functioning, and how this determination impacts people who are not of the majority group. Who in our country has historically determined what is "well" and what is "sick" when talking about mental health and illness? Discussion. Clearly, the dominant culture for much of U.S. history focused on beliefs, norms, and values of European Americans and this includes the shaping of the ideas of mental health and illness, as well as ideas about treatment. What has this and does this mean to minority groups?

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Discussion.

**VIGNETTE:**

*A case manager is making her first visit to a sixty-eight year old Hispanic woman. While gathering information, the case manager learns that her son died nine months ago. She is very demonstrative in her grief, crying loudly when she speaks about him.*

*After talking with the woman's daughter, the case manager learns that the grieving period is expected to last a year or more, according to cultural norms. The daughter states that this outward show of emotion is "expected" and very normal within their culture.*

*In conclusion, according to Western psychiatric standards, the woman might be considered depressed or experiencing an adjustment disorder, when, in fact, she is grieving in a way that is expected and healthy, according to her cultural perspective.*

**[SLIDE 36]**

In moving on to talk about risk factors, it is important to first be clear about the idea that being a member of any minority group does not, in and of itself, make one more susceptible to having a mental health problem. Instead, being a member of a minority group can place one in a situation where risk factors for mental health problems are more prevalent. For example, it has been well documented that minority groups in the United States have decreased access to healthcare (including mental health care), receive poorer quality care and are more likely to live in poverty. (Be clear about the connection between physical injury/disability and depression/anxiety.) All of these challenges put one at increased risk for mental health problems and, consequently, cause minority groups to bear a disproportionately high burden of disability. (DeNoon, 2001)

**[SLIDE 37]**

An example of the impact of these risk factors is that Hispanic Americans are the least likely of all ethnic groups in the U.S. to have public or private health insurance, with the rate of uninsurance among this group being 37% (U.S. Dept of HHS, SAMHSA, 1998). Clearly, this impacts this groups' ability to access mental health treatment and increases their susceptibility to mental health problems. Barriers to treatment also contribute to the fact that alcoholism is a leading cause of death among Native Americans, with Native Americans being five times more likely to die an alcohol related death than Caucasians (President's New Freedom Commission on Mental Health: Final Report, 2003). The suicide rate among Native Americans is 50% higher than the national rate (U.S. Dept of HHS, SAMHSA, 1998).

**[SLIDE 38]**

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Let's now move on to demographics, both locally and nationally. The importance of pointing out these trends is that numbers of older adults who are of minority groups are increasing, and when that fact is paired with the fact that these people bear a disproportionate burden of disability from mental health problems, the need to pay particular attention to them becomes clear. Looking at trends around the state, in the 2000 U.S. Census, in Finney county (Garden City), for example, of people 65 years and older, 12% were Hispanic (compared to 1.8% statewide). In Wyandotte county in the same year, of people 65 years and over, 26% were NOT Caucasian (compared to 5.6% for the state as a whole).

Speaking generally, the population of minority older adults is expected to increase by 500% in the next 50 years. While fewer than one minority person in every ten is now age 65 and over, by 2050, this proportion will increase to one in five. Additionally, current projections show that by 2025, racial and ethnic minorities will account for more than 40% of all Americans (President's New Freedom Commission on Mental Health: Final Report, 2003). Pairing these dynamics with the above mentioned risk factors makes it clear that minority groups need specific consideration and concern in reference to mental health care.

[SLIDE 39]

Culturally competent care involves understanding of cultures other than one's own, acknowledging and making accommodations for differences in language, and a willingness to be patient in the process of communication. Identifying and addressing mental health problems depends greatly on verbal communication and trust between customer and service provider. All such factors can greatly impact quantity and quality of care for people of minority groups.

[SLIDE 40]

Now that we've covered some basic ideas about ethnicity, culture, aging, and mental health let's take some time and make it applicable to your work with older adults.

Here is a "real life" case example to discuss in small groups. Specifically, talk about what dynamics would be particularly important for you, as a service provider, to consider when working with the older adults in the scenario. (Participants break out into groups according to position as determined in Introduction Section. Encourage groups to alter the details of the case example to make the scenario applicable to their professional setting.)

You are an aging service provider who has gone to see a 78 year old Hispanic woman, Martha, who has lived by herself since her husband passed away six months ago. She and her husband immigrated from Mexico 15 years ago. Her daughter has helped care for her, but is now requesting assistance due to her continuing debilitation as a result of chronic rheumatoid arthritis. She speaks limited English and is assisted during your meeting by one of her daughters. The daughter speaks fluent English and usually interprets for her mother. Martha appears depressed and becomes tearful when asked about her husband.

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What are some specific techniques that might be helpful in interviewing Martha?

What are some insights on Mexican culture that might be beneficial to keep in mind during the interview and follow-up visits?

*Ideas regarding responses:*

- Service provider may want to consider utilizing an interpreter other than daughter, due to the idea that the mother/daughter relationship may cause Martha to censor herself, or the daughter may unknowingly communicate what she thinks her mother is saying, and not conveying the message her mother is meaning to communicate.
- Service provider may want to consider what is considered “normal” grieving in Martha’s culture. The behaviors she is displaying may be healthy and an expected part of the grieving process. On the other hand, they may not. It is important that the worker ask and learn as much as possible about the entire situation.

### **Religion and Spirituality 11:10-11:30**

[SLIDE 41]

As we begin to talk about aging, mental health, and religion and spirituality, it might be helpful to begin with a basic discussion. First of all what do you think about talking with customers about their religious/spiritual needs? (This can be an area that some service providers are uncomfortable talking about or “shy away from”. Prompts: Have you talked with customers about this? Why or why not? Do you think it can be a strength and support when addressing mental health concerns?) How have you helped customers access faith-based resources? (While a service provider can ask a customer about the role of spirituality/religion in his/her life, stress importance to training participants of customer “taking the lead” in this discussion.)

[SLIDE 42]

There has been a considerable amount of research done on the ways in which a strong religious faith or spiritual understanding and connection can positively contribute to successful aging. Spirituality has been associated with a reduction in levels of depression and distress (Williams, Larson, Buckler, Heckmann, Pyle, 1991) and levels of religious commitment have been shown to predict speed of recovery from depression regardless of initial depression severity (Koenig, George, & Peterson, 1998).

Nearly 850 studies have now examined the relationship between religious involvement and some indicator of mental health. Many of the studies have been conducted in medically ill patients or older persons suffering with chronic disability. The vast majority of such studies do indeed find that religious involvement is associated with greater well-being and life satisfaction, greater purpose and meaning in life, greater hope and optimism, less anxiety and depression, more stable marriages and lower rates of substance abuse (Koenig, McCullough, & Larson, 2000 as cited in Crowther, Parker, Achenbaum, Larimore, & Koenig, 2002, pg 616).

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While this doesn't mean that everyone can and does benefit from spiritual or religious meaning in their lives, it does seem to indicate that it can help to provide strength and support.

[SLIDE 43]

What are some changes that happen in customers' lives that might indicate the consideration of accessing a faith-based resource? This slide summarizes the following ideas:

- Losses
- Changes in mobility and/or skill
- Job loss
- Retirement –forced or voluntary
- Transition from family care to AL or NF
- Separation from religion and/or culture (moving from native area or church)
- Death of a loved one
- Personal or family disaster (\$\$\$, estranged family member)
- Changes in environment, health, or self-concept

[SLIDE 44]

If appropriate, what are some concrete strategies to enhance spirituality/meaning in older adults' lives? (Group Discussion)

- Assess past spiritual/religious coping skills/mechanisms and reconnect
- Refer to appropriate clergy
- Access outreach services provided by chosen faith organization
- As we all know, it is also very important to keep separate your values and spiritual beliefs that are different than the customer's. While it can be very appropriate to ask about spiritual and religious needs and practices, it is important to allow the customer to "take the lead", so to speak, in letting you know what they want and need.

**BREAK FOR LUNCH [SLIDE 45]**

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## SECTION TWO

# IDENTIFYING AND ADDRESSING MENTAL HEALTH CHALLENGES

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### MATERIALS NEEDED:

K6 Screening Tool . (See Appendix F).

Flip chart, stand, and markers

Prior to the presentation of this material, it may be helpful for the trainers to review the articles included at the conclusion of Section Two that provide background regarding the K6 screening tool.

### LENGTH:

60 minutes

### GOAL:

Participants will become familiar with the K6 mental health screening tool and discuss ways to address challenging situations when having a conversation with their customer's about mental health.

### OBJECTIVES:

Participants will:

1. Be introduced to the K6 screening tool, an instrument used to identify depression and anxiety in older adults.
2. Discuss times to consider utilizing the K6.
3. Increase their knowledge of ways in which to begin conversations about mental health (specifically depression and anxiety) with the older adults with whom they work. This includes ways in which to address the influence of stigma.

### SUGGESTED SCHEDULE FOR SECTION TWO:

Identifying and Addressing Mental Health Problems

**12:15 K6**

**12:40 Addressing Challenging Situations**

**1:15 Break**

*NOTES*

## CONTENT/ACTIVITIES:

12:15-12:40 K6

### [SLIDE 46]

During the next hour, the K6 mental health screening tool will be introduced. To begin this section, we'll talk about your struggles and successes you and your customers have experienced around mental health issues, reasons why it could be beneficial to consider incorporating the K6 into your work, ideas about when and how the tool could be utilized, what you should do if the tool indicates a need for services, and what you should do if the tool doesn't indicate a need for services but you still think there is reason for concern. Then, the referral process and referral resources will be discussed.

### [SLIDE 47]

I would like to start our discussion by asking you a few questions.

- What would be an example of a change in routine or behavior that would make you think someone was having a mental health problem? (Write observations/ideas on flip chart. Prompt: Think back to the information shared earlier in the day regarding depression and anxiety.)
- How would you address this problem with this person? (Write observations/ideas on flip chart. Prompt: Have you utilized a psychiatrist? A mental health center? A clergy member?)

Judging from your responses, you already have a well-established level of skill and knowledge when identifying and addressing mental health issues. What we are going to do today is provide you with a brief instrument and some ideas to add to the skills you already have.

I'm going to hand out the screening tool now and give you a few minutes to look at it.

(Hand out K-6 – allow time for participants to examine it.)

### [SLIDE 48]

I've given you the K-6. The K-6 has been used by the World Health Organization, it has been used for large studies in England and Australia, and for a National Health Survey here in the U.S. It has been used in a large study of older adults. It was designed by Dr. Ronald Kessler from Harvard. It may be hard to believe that a tool utilizing only 6 questions can be effective, but Dr. Kessler has done extensive work to test its effectiveness and he has found it to be quite useful in at detecting the need for further assessment of mental health issues.

With this in mind, it is important to be very clear that this is only a screening tool and is by no means intended to make any sort of diagnosis.

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[SLIDE 49]

Now let's talk about the actual use of the K6. If you only see a customer once, you can utilize the K6 then, and pass the information along to service providers who see the older adult after you. If you see the person daily over a long period of time, you can use the K6 at admission, and at various subsequent points in time.

There are no definitive guidelines regarding times to administer the K6. The K6 is a resource that can be utilized at any time in the helping relationship that you believe is appropriate.

What thoughts do you have about times when you might utilize the a screening tool to assist you and your customer in determining whether a mental health problem exists from which he/she may benefit from referral to a mental health resource? (Prompt: At admission/intake? When customer experiences loss or illness?)

[SLIDE 50]

The scoring of the K6 is self-explanatory and easy to use. The six questions are asked one by one and scored. The scoring of the K-6 is on a scale ranging from 0-24, with each of the six questions coded 0-4 and summed. One of the most important inherent characteristics of the K-6 is that it will allow you have a conversation about these issues. Thus, if the customer seems to want to talk about a particular question, by all means, allow them to do so. There is no reason to rush through the tool. You can take as much time as both you and the customer need.

Let's go through now and look at some examples of scoring of the tool. Dr. Kessler considers a score of 13 to be the point at which referral for additional mental health screening is recommended. This is absolutely not to say that if you think a referral is needed, but the score is lower than 13, that a referral should not be made. Trust your instincts and experience and err on the side of caution and make the referral.

### **Addressing Challenging Situations 12:40-1:15**

[SLIDE 51]

During the pilot implementation of this training by the Office of Aging at Long-Term Care at the University of Kansas School of Social Welfare, one of the pieces of feedback received from the pilot participants was a request for some ideas around how to address difficult or uncomfortable situations that are encountered when talking about mental health. The pilot participants asked that ideas be included about how to handle, and specifically, what to say, when these scenarios are encountered. For example, one case manager completed the K6 with one of her customers and, as a result of this, the case manager believed a referral to mental health resources was appropriate. After sharing this observation with the older

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adult, the older adult said, “I’ve felt this way my whole life, why should I do anything about it now?” Consequently, the case manager stated she would like to have some ideas about how to talk with her customers when these types of responses come about.

**[SLIDE 52]**

Thus, we’re going to talk about and problem solve around challenging situations that are encountered when talking with customers about mental health and the possibility of accessing mental health resources. There are some specific techniques and ideas to share with you, but those of you here today have a great deal of experience and it’s our hope that this can be an interactive process and we can all learn from each other. The other point to stress is that while some ideas and approaches will be presented, it is not intended for this to be like a “cookbook” for you to take back to your work and use word for word. Everyone’s personality and helping style is different. These are suggestions for you to think about integrating with the knowledge and skills you already have.

First, I’d like to ask everyone to share some difficult or uncomfortable situations you’ve encountered when you’ve talked about these types of issues with your customers. After we talk about some different ways to address these situations, we’ll come back to the scenarios you’ve shared and discuss how you might approach them, as well.

(Brainstorming and informal discussion - record on flip chart for later use. Prompt: What about particularly resistant clients? Have you had some one that was concerned about “what everyone would think” if they received mental health services? Have you worked with someone who was fearful of mental health services? Describe these situations.)

**[SLIDE 53]**

Before we get into specific skills and steps to be taken, if you become aware that one of your customers is suicidal it needs to be addressed. Above all, you need to be aware of your agency’s/facility’s protocol and consult your supervisor if you have any questions. Protocols and guidelines can vary, so I’d just like to emphasize how important it is to be fully informed about what is expected by your place of employment, so that you can be of the greatest help possible to your customers.

**[SLIDE 54]**

Let’s take a step back and start with some basic ideas about active listening. This is probably one of the most important, but often unacknowledged ways in which we can be supportive of our customers. How do you know when someone isn’t listening to you? How does that feel? (Prompt: What does active listening mean? Why is it important?)

What behaviors indicated that you are actively listening to a customer?

(Use the following as prompts, but first elicit ideas from participants.)

**NOTES**

- Facing customer
- Appropriate eye contact
- Leaning toward customer
- Nodding at appropriate times
- Open posture

Another component of active listening is listening. As helping professionals, we tend to want to “fix” and problem solve quickly. While it is important to address customer struggles and concerns, the value of not interrupting, listening, and being empathic to the customer’s experience can be invaluable.

As you begin to talk with the customer, one helpful idea to keep in mind is not to assume that you understand how your customer feels about the situation, regardless of how clear it might seem to you. For example, I spoke about a customer earlier who said, “I’ve felt this way my whole life, why should I do anything about it now?” What are some assumptions we might make about how she feels? Discussion. (Prompt: words like frustrated, hopeless, angry, despondent, resolved, fatalistic, hostile, irritated, upset, sad, pessimistic)

The important point about the idea regarding how she might be feeling is that some of these words are very different from each other. For example, feeling hopeless and despondent is very different than feeling angry and hostile. If you were feeling angry and hostile and someone reflected to you that you were feeling hopeless and despondent, how would you respond to that person? How would it affect your willingness to continue to visit with him/her about how you are feeling?

After you believe you have an understanding about how the customer feels, a next step that can be helpful is to affirm the customer’s experience or feelings. You might also think of this as “being with the client” and really trying to understand and validate what they are experiencing. Using the same customer as an example, let’s assume that when you ask her how she feels about her situation, she responds, “It just makes me really sad.” How might you respond to her to validate her experience and let her know that you are really listening to her and trying to understand her perspective? (Example: “I’m sorry this is how it has been for you. I can only imagine how sad it would make me if I had struggled my whole life like you have.”)

This leads to two different ideas that can be helpful in this point in the conversation. First of all, it can be very helpful to normalize the older adult’s experience so that they understand others have had the same experience and have received help. During the research at KU that contributed to this training, focus groups were conducted with older adults and they were asked for ideas regarding the best way to approach other older adults about mental health struggles.

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The frequently heard response was that it is important to reassure our customers that “everybody gets down now and then”. The focus group participants emphasized that this was probably one of the most helpful and effective ways to be of assistance to our customers and also to serve as a pathway to encourage them to seek help, if appropriate. The other thing this can do is help to address the stigma that the older adult may be experiencing, by pointing out that they are not alone in their struggle.

The other approach that can be useful that was also a theme from the focus groups, is about providing the customer with hope that their situation can improve. One woman in the focus group said, “if you don’t have hope you don’t have anything”. One important point you can make with your customers is that the medical community has learned a tremendous amount about depression and anxiety in the last couple of decades and there are many things that can be done. It can also be important to stress that depression and anxiety respond really well to all sorts of interventions and there is reason to have hope that things can be better for them.

In summary, the five techniques or ideas that might be helpful to you in a difficult situation are:

- Remembering the value of active listening
- Doing your best to understand your customer’s experience and feelings
- Validating her/his understanding of their experience and feelings
- Normalizing her/his experience and feelings
- Providing optimism, hope, and information

[SLIDE 55]

Let’s go back to the difficult situations you shared and we wrote the flip chart. Right now, we’ll have you divide up into the groups we created earlier in the day and each group will take one of these situations. (Or each group can use the same one, depending on the number of situations that the group identified earlier.) Using the framework we’ve discussed, as well as any approaches or ideas you have personally found helpful, write out how you would be of help to customers in the scenario provided. When you’re done, we’ll have you share your approach with the rest of the group.

Give the groups time to discuss, then reconvene to share ideas.

**QUESTIONS?**

**BREAK [SLIDE 56]**

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## SECTION THREE:

# REFERRAL TO MENTAL HEALTH RESOURCES

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### MATERIALS NEEDED:

Flip chart, stand, and markers

### LENGTH:

75 minutes

### GOAL:

Participants will learn about mental health resources in their geographic area and about how to access those resources.

### OBJECTIVES:

Participants will:

1. Increase their knowledge of formal and informal mental health resources available to older adults in their geographic area.
2. Brainstorm about informal resources that can be helpful to older adults who experience mental health problems.
3. Increase their knowledge of ways in which to start a peer support group.
4. Increase their understanding of how to access formal and informal resources.

### SUGGESTED SCHEDULE FOR SECTION THREE:

Referral to Mental Health Resources

**1:30 Accessing Service Providers and Other Resources**

**2:00 Local Service Providers**

**2:45 Evaluation**

### CONTENT/ACTIVITIES:

**1:30-2:00 Accessing Service Providers and Other  
Resources**

*NOTES*

[SLIDE 57]

To get started with this section, let's hear from you about situations where your customers have accessed mental health resources.

- In the course of addressing their mental health needs, what resources have your customers utilized? (Write on flip chart)
- How did they come to the decision to utilize that/those resources? (Write on flip chart)
- Did you assist them in using those resources?
- Have you ever had a situation when a customer/customer wouldn't/couldn't access a mental health resource, even though you, and maybe they, thought that it would be helpful?
- What happened in those situations that kept them from accessing services? (Write on flip chart)
- We know that not every older adult is willing to access what we think of as traditional mental health services (and the responses to the above questions should reflect that). Because of this, we're going to spend this afternoon not only discussing traditional services, but also brainstorming about informal resources that might be a useful alternative for some older adults.

We are going to attempt to cover information about most mental health service providers that you may encounter this afternoon. We realize that some of you may utilize particular service providers much more or less than others but we do think that it important to briefly touch on all of them. Because we all come from a variety of backgrounds, before we talk about specific services, let's make sure that we are all familiar with some of the most common abbreviations and definitions.

[SLIDE 58]

1. What is a CMHC? (Community Mental Health Center)
2. What is SPMI? (Severe and Persistent Mental Illness)
3. What is the difference between a psychiatrist and a psychologist? (Psychiatrist is an MD)
4. What is NAMI? (National Alliance for the Mentally Ill)
5. What is Title Nineteen? (Medicaid)
6. What is a catchment area? (Service area for CMHC)
7. What is an LMLP? (Licensed Masters Level Psychologist)
8. What is an LMFT? (Licensed Marriage and Family Therapist)

*NOTES*

9. What is an LSCSW? (Licensed Specialist Clinical Social Worker)
10. What is an LPC? (Licensed Professional Counselor)
11. What is an ARNP? (Advanced Registered Nurse Practitioner)
12. What is a counselor? (Anyone can call themselves this, but they may or may not have the appropriate license or experience to provide and bill for services, so, if someone calls themselves this, it is important to ensure this person has the proper credentials)
13. What is a therapist? (Same with a counselor)
14. Is dementia considered a mental illness? (Technically, yes. It is in the DSM; however, CMHs do not provide treatment for dementia)
15. What is a PASRR Level II? (Screen for nursing facility admission for adults with serious mental illnesses)
16. What is the DSM? (Diagnostic and Statistical Manual)
17. What is a warm line? (A service to call, not when in crisis, but when needing social contact)
18. In which State agency is the Kansas Department of Mental Health located? (SRS)
19. What is an SRS Mental Health Field Staff? (Person employed by SRS whose role is to ensure CMHCs are in compliance with state regulations, requirements, and their respective contracts with the State. They also field complaints from consumers and other providers.)

[SLIDE 59]

Now that we're all clear on some of the language, let's move on to some specific information about the CMHCs. We want to spend most of our time on the CMHCs as, they are nonprofit agencies that receive federal, state and county funds to provide mental health treatment in community settings. For those of your customers who have lower incomes, the CMHCs may be the primary mental health service provider available to them in your community. There are CMHCs in every part of the state, and each serves individuals who live in their catchment area, or what they refer to as, "County of Responsibility". The CMHC catchment area may be one county, or, they may serve several. In Western Kansas, one CMHC, High Plains, serves 20 counties. Often, when a CMHC serves multiple counties, it has satellite offices in some or all of them.

It's important to know your CMHC's catchment area, because, it may not be the same as your AAA, or other service provider. For example, the Southeast Kansas AAA's catchment area is the nine counties in the southeast corner of Kansas. Those nine counties fall into five different CMHCs' catchment areas. If a

*NOTES*

customer does not live in a CMHC's "County of Responsibility", even if they work in their county or go to other providers in their county, the CMHC will not be able to offer them access to their sliding fee scale and may not be able to serve them at all.

CMHCs accept Medicare, Medicaid, and private insurance. Many also offer sliding scale fees for those who have no other way to pay for services. All of the CMHCs offer crisis services for those individuals experiencing a psychiatric emergency; in routine situations, however, individuals may have to wait several days or even a few weeks for their first appointment.

CMHCs provide a range of services including: individual, group, and family therapy, crisis services, psychiatric/medication services, and psychological testing. In addition, they may offer specialty services for subpopulations such as deaf/hard of hearing, the homeless, the incarcerated, non-English speakers, and those with addictions. They may offer special services such as grief groups, stress management, and employee assistance programs. Generally, such services are provided through the outpatient services division of the CMHC.

Community support services, or, CSS, are federally mandated programs that provide services for people who experience severe and persistent mental illness (SPMI). These services include case management, supported housing, supported employment, attendant care, and medication/psychiatric services.

Some CMHCs employ Aging Specialists. At different CMHCs, Aging Specialists provide very different services. For example, some CMHCs employ an LCSW, who provides therapy at the CMHC. Some CMHCs employ an Aging Specialist who specifically serves older adults with SPMI. Not only do they provide different services, but, some are able to provide only part-time Aging Specialists. Theoretically, then, if your customer wants to use the services of an Aging Specialist, he/she may have a longer wait to begin services, because of the existing demands on that person's time. If your CMHC doesn't have an Aging Specialist, there still may be a person known by the CMHC staff who schedule appointments as someone who particularly enjoys or is experienced at serving older adults.

In many ways, the individual CMHCs are more different than they are alike. Like any human service agency, they're constantly changing to meet the demands of their customers, funders, and regulators. If your organization doesn't currently have a relationship with your local CMHC, you might think about developing one. Not only might this relationship assist you in referring your customers, but, some CMHCs are able to provide education to community providers and their customers, and, some CMHCs have been able to provide onsite mental health service outreach to community providers' customers.

In particular, here are some things that you might want to ask your local CMHC:

[SLIDE 60]

- Do you have an Aging Specialist? If so, what services does he/she provide? What is his/her name and contact information?

**NOTES**

- If you don't have any Aging Specialist, do you have any services specifically for or of particular interest to older adults?
- Can any of your staff provide home-based services? If so, what kind?
- What is your sliding fee scale?
- Are services available for individuals who cannot pay for them? If so, what?
- What is the average wait for services?
- I'd also add:
- What else should I as an aging service provider know to better assist my customers in accessing your services?
- Does anyone else have any other ideas about what questions to ask a CMHC?
- Does anyone have any other questions/comments about CMHCs?

[SLIDE 61]

Now let's talk about other types of service providers. Who is the service provider older adults are most likely to see about a mental health problem? They're often more willing to talk to their primary care physician than anyone else. What do you think that they say when they go to their physician – what kind of symptoms do they describe (are they physical or mental). They're much more likely, and probably more comfortable, describing physical symptoms such as not sleeping or having no energy, than they are in talking about depression or anxiety.

How much time do you think physicians spend with their patients? In 2000, the Harris poll reported that physicians spend less than 15 minutes with patients. In less than 15 minutes, we're expecting the doctor to figure out that someone who may have multiple physical health problems already is reporting symptoms that are, in fact, related to a mental health problem which the older adult may either not have realized that he or she is having or who may be too uncomfortable to talk about with anyone?

What can you do when you suspect an older adult is having some mental health problems and you know that he/she has a doctor's appointment scheduled? (Prompt: Go with customer to appointment, contact clinic in advance (if confidentiality permits))

[SLIDE 62]

In addition to the CMHCs, there are other types of service providers, including: private psychiatrists, psychologists, and therapists. Some free health clinics have mental health services available. It also can be useful to think about to what special groups the older adult might belong that may qualify him/her for services through a particular organization, or may pay for all or part of his/her services – for

**NOTES**

example, is she a Veteran? Is he an American Indian? Also, some older adults might be receptive to a service provider with a particular type of background or experience; for example, in many areas of the state, you will find a listing in the telephone book for licensed therapists who have received some type of education so as to be able to provide “Christian counseling”.

Also, while most older adults will never need inpatient psychiatric services, it is important to know where they are available in your area and how to access them. If you believe that someone is experiencing a mental health crisis such as having difficulties that cause them to be a danger to themselves or others, your local: CMHC, hospital emergency room, Adult Protective Services, or, the police department can assist you in getting help for the older adult.

In general, when someone is accessing any type of mental health services, here are some good rules of thumb:

[SLIDE 63]

- When making the first appointment, make sure that the service provider is aware what insurance/public benefits will be used to pay for the services, so that the appointment can be made with a clinician with the proper credentials. For example, Medicare will only reimburse for services from an LSCSW, MD, or PhD, so, if Medicare is the payment source, it is important that the older adult doesn't see someone with a different type of credentials.
- Before the first appointment, contact the “800” number on the most current insurance/public benefit card to find out what services are covered, and how much they will reimburse the service provider.
- Before the first appointment, contact the service provider's admissions or financial office to discuss any billing questions and to learn the amount of co-payment to expect.
- Bring the most current insurance/benefits card to the first appointment.

[SLIDE 64]

Now, let's talk about informal mental health resources. What might be an informal resource? (Prompt: How about a spiritual leader or a religious organization? What about support groups or grief groups? How about warm lines?) If you don't know what is available in your area, who can you contact to learn about community resources? (AAAs, senior centers, CMHC, check the newspaper and local TV/radio)

[SLIDE 65]

As previously mentioned, several older adult focus groups were conducted by the OALTC at the University of Kansas, and information gathered through these focus groups contributed to this training. Specifically, older adults were asked

what they thought about accessing mental health services. What was learned from them is that, first of all, they seemed to have difficulty with the idea that some people have mental health symptoms that are so severe as to require mental health treatment of some kind. The people in their lives who had mental health problems such as depression or anxiety, in their opinion, could best be helped in two ways: 1) by someone reaching out to them, and, often, they spoke of that person being a peer, not a service provider – one person even suggested that what they thought would help someone who was struggling with mental health symptoms would be for a service provider to identify someone else in the facility or the agency who was at a similar point in their lives but was coping well, and then pairing them up; 2) by getting them involved in something to help take their mind off of what was bothering them. They had lots of ideas about how to do that, from hobbies or volunteer work, to having the service provider take them for a drive, paint their fingernails, or get their hair done.

Social Support is a broad term. It can apply to family, friends, and even staff at different facilities. The beneficial effects of social support from family members are well documented (Pierce, Sarason & Sarason, 1996) but a growing body of literature also has highlighted the positive influence of friends and acquaintances with whom adults have informal contact.

Peer-counseling, sometimes referred to as peer-listening, has been gaining popularity in the past two decades as a viable option in the provision of emotional and social support to the older adult population with benefits for both the customer and counselor alike (Gatz, Hileman, & Amaral, 1984). Because peer counselors are often perceived as friends rather than therapists, they may be less threatening to those clients who see a need for traditional mental health treatment as a sign of weakness or illness (Hinshaw & Cichetti, 2000). A few examples of different types of peer-support groups are: health education groups, in which peer leaders and group participants can talk about shared experiences with specific health related issues, in-home peer counseling, sometimes referred to as Friendly Visiting, to help combat social isolation, loss, and loneliness, or a grief-bereavement related support group run by peers to help normalize and seek alternative reactions to loss.

[Slide 66]

Specifically, peer support groups can:

- Help consumers understand and stay with their treatment plan, as well as avoid hospitalization;
- Provide a place for mutual acceptance, understanding, and self discovery;
- Help consumers understand that a mental illness does not define who you are;
- Give consumers the opportunity to benefit from the experiences of those who have “been there” (Depression and Bipolar Support Alliance (DBSA) as cited in Miller, B. 2004, p. 9).

**NOTES**

Here are some ideas from a brochure entitled “Mood Disorders in Later Life”, published by the Depression and Bipolar Support Alliance (DBSA):

[Slide 67]

- Start with your own group of facilitators;
- Consider contracting with a professional advisor such as a social worker, psychologist, nurse practitioner, etc., who specializes in serving older adults.
- Select an appropriate meeting place such as a senior center, church, or community center.
- Advertise your meeting with local news media (don't forget web-sites and e-mail publications) and promote with flyers at senior centers.
- Maintain growth and increase visibility by providing news media interviews, participate in health fairs, and continually assess the needs of group members through questionnaires and surveys (“Mood Disorders in Later Life” brochure as cited in Miller, B. 2004, p.10).

Other ideas about starting a peer support group?

[Slide 68]

A specific type of peer support group is a Consumer Run Organization, or CRO. CROs are not-for-profit organizations that are run by current and former consumers of mental health services. The CRO network in Kansas consists of approximately 20 SRS funded Consumer Run Organizations. “Every CRO is an independent, confident, responsible, self-supporting, powerful, and empowered leadership organization... Their mission is to encourage the growth of new and existing CROs throughout the state. The CRO network is consumer-driven and promotes improved operation of CROs as not-for-profit businesses.” (<http://www.kansascro.com/>).

Specific activities of the CRO Network include:

- Mutual support where common concerns can be shared and accomplishments celebrated
- Clearinghouse for materials used by CROs such as brochures, newsletters, policies and procedures, and program information
- Training in a wide range of areas including grant applications and fundraising, program reporting, shared leadership, etc.
- Program information sharing through telephone and email contacts, visiting of each other's programs, and use of the buddy system
- Public and professional education offered to raise awareness of what CROs provide

**NOTES**

- Program development including new initiatives such as consumer run recovery models
- Statewide website designed for consumers by consumers” <http://www.kansascro.com/>).

To learn more about CROs in your area, go to: <http://www.srskansas.org/hcp/MH/MHRDmhconsumer.htm>.

## QUESTIONS?

### Local Service Providers 2:00-2:45

[SLIDE 69]

This is the section where local mental health providers provide a short, informal presentation to the training participants. Providers should be located and confirmed for the presentation with ample time to arrange their schedule appropriately. This outline allows for 45 minutes for this section. This allows for approximately 4 providers to present for 10 minutes. Clearly, each training will be different and trainers should adjust this time frame to meet the needs and characteristics of each individual training. Providers should be encouraged to bring any informational brochures about their agency or organization to use as handouts. These providers can include, but are not limited to:

- Representatives from area CMHCs,
- Area alcohol and drug treatment/prevention programs,
- Gero-psych units,
- Self-help groups, and
- Any informal resources

Suggested questions to be addressed by these providers can include, but are not limited to:

- What services does your group or organization offer?
- What is the process to access services through your agency/organization?
- Is there a specific contact person and number? If so, please provide.
- Is there a waiting time to receive services?
- If there is a charge for services, how is that handled?

*(Note to trainers: It is suggested that during this section one of the trainers {who is not introducing the guest speakers} begin completing the participation certificates and any needed CE documentation. This will facilitate an organized exit by the training participants at the conclusion of the training.)*

**NOTES**



# EVALUATION SECTION

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## MATERIALS NEEDED:

Evaluation forms. (See Appendix E).

Participation certificates. (See Appendix D) and

Continuing Education documentation, if applicable (this will be specific to each presentation and is not included in this training manual).

## LENGTH:

15 Minutes

## GOAL:

Allow participants to complete evaluation forms, and trainers to distribute participation certificates and Continuing Education documentation.

## CONTENT/ACTIVITIES:

[SLIDE 70]

Thank participants for attendance and direct them to the evaluation forms in their packets. At the time that participants turn in their evaluations, distribute their participation certificate and CE documentation.

*NOTES*



## APPENDIX A

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## PROJECT ADVISORY COUNCIL MEMBERS

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Dana Barton

Kristy Boaz

Anita Cooper

Melanie Douglas

Tom Gallegos

Annette Graham

Linda Gray

Rich Hall

Leslie Huss

Elizabeth Maxwell

Valerie Mellow

Bryce Miller

Dr. Rosemary Mohr

Dr. Sally Rigler

Daryl Rutschmann

Leslie Rutschmann

Elaine Schwartz

Nancy Trout

## APPENDIX B

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## “Connecting Older Kansans with Community Mental Health Resources”

This training is funded in part by The Kansas Department on Aging and the Kansas Department of Social and Rehabilitation Services.



## Overview of Mental Illness: Attitudes

- Stereotypical ideas about mental health
- Belief that mental illness is a normal part of aging
- Aging and old age are by definition depressing

4

## Connecting Older Kansans with Community Mental Health Resources: Discussion

1. Why are you here today?
2. What are the biggest challenges you face when providing services to older adults with mental health problems?
3. What concerns do you have about serving older adults with mental health problems?

2

## Common Disorders in Older Adults in Order of Prevalence

- Anxiety Disorders
  - (Phobias, obsessive-compulsive disorder)
- Severe Cognitive Impairment
  - (Alzheimer's Disease)
- Mood Disorders
  - (Depressive Disorders)
  - \*Some researchers believe that mood disorders, specifically depression, are more common than anxiety

5

## Overview of Mental Illness: Statistics

- Nearly 20% of respondents age 55 and older reported having a mental health disorder.
- Less than 3% of older adults seek mental health services.

3

## Anxiety Disorders

- Thought by some to be even more common than depression
- Two common types:
  - Generalized Anxiety Disorder
  - Panic Disorder

6

## Prevalence of Anxiety Disorders

- Anxiety disorders affect approximately 5% of people age 65 and older.
- Women are more likely than men to have an anxiety disorder.
- Generalized anxiety disorder, or GAD, is known to affect about 4 million adults.

7

## Prevalence of Depression

- Depression is one of the most prevalent mental health disorders for older adults.
- 8-20% of community dwellers and 15% of all older adults experience significant depression.
- 5 million of today's 33 million Americans age 65 and older experience symptoms of depression.

10

## Generalized Anxiety Disorder: Selected DSM-IV TR Criteria

- Excessive anxiety and worry
- Restlessness or feeling on edge
- Difficulty concentrating or mind going blank
- Irritability
- Muscle tension
- Sleep disturbance

8

## Depression: Selected DSM-IV TR Criteria

- Depressed mood most of the day
- Markedly diminished interest in all, or almost all, activities
- Feelings of worthlessness
- Recurrent thoughts of suicide
- Significant weight loss
- Insomnia or hyper insomnia
- Fatigue

11

## Anxiety Disorders: Assessment and Treatment

- Thorough assessment very important
- Psychotherapy and medication

9

## Depression: Symptoms More Common in Older Adults

- Hopelessness/helplessness about future
- Statements about worthlessness
- Apathy
- Social isolation
- Thoughts of suicide

12

## Risk Factors for Suicide

- Hopelessness
- Prior Suicide Attempts
- Caucasian Race
- Substance Abuse
- Male Gender
- Medical Illness
- Advanced Age
- Living Alone

13

## Addictions

- A. Alcohol
- B. Prescription Drugs
- C. Illicit Drugs
- D. Gambling

16

## Depression Interventions

- Depression is treatable – at any age
- Talk therapy
- Medication

14

## Prevalence of Problem Drinking

- Prevalence among community dwelling older adults: 3 – 10%.
- Problem drinking is 2 – 6 times more common in men than women.
- Two-thirds of older problem drinkers developed alcohol related problems before old age.
- Most common psychiatric co-existing condition with alcohol abuse is depression.

17

## Severe and Persistent Mental Illness (SPMI)

- **State of Kansas (SRS) Criteria**
  - Diagnostic
  - Functional
  - Risk
- **Community Support Services (CSS) – division of CMHC serving SPMI adults**

15

## Risk Factors for Problem Drinking

- Male Gender
- Loss of Spouse
- Other Losses
- Inpatient Hospitalization
- History of Substance Abuse
- History of Psychiatric Disorder
- Family History
- Other Substance Use

<http://www.ageworks.com><sup>18</sup>

## Problem Drinking: Protective Factors

- Familial Social Support
- Availability of Health/Social Services
- New and Productive Social Roles

19

## Consequences of Alcohol Abuse

- Alcohol is toxic to almost every organ system.
- Individuals are more susceptible to problems with:
  - **Cardiovascular Function**
  - **Cancer**
  - **Pancreatitis**
  - **Lung Infections**
  - **Brain Deterioration**
  - **Impaired Immune System**
  - **Liver Function**
  - **Malnutrition**
  - **Depression**

22

## Patterns of Problem Drinking

### Frequency

- Continuous
- Intermittent
- Binge

### Onset

- Early Onset (Before Age 60)
- Late Onset (After Age 60)

20

## Alcohol Treatment

- Older adults tend to be more compliant than do younger adults.
- Older adults tend to have the same or better treatment outcomes than do younger adults.

23

## Problem Drinking: Barriers to Diagnosis, Referral and Treatment

- Stigma
- Lack of behavioral stereotypes associated with alcohol problems
- Symptoms of alcohol abuse or withdrawal mimic signs of aging
- Physicians less likely to identify alcohol problems in older adults
- Lack of treatment reimbursement resources

21

## Prescription Drug Use and Misuse

- Older adults use prescription drugs three times more than the general population.
- On average, older persons take 4.5 medications per day.
- The number of older adults who misuse or abuse prescription drugs is estimated to be as high as 2.5 million.

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## Prescription Drug Misuse: Risk Factors

- Physical or cognitive problems impacting the ability to take the correct dose
- Financial limitations
- Prescriptions of medications for:
  - pain
  - anxiety/sleep
  - obesity

25

## Prevalence of Gambling Problems

- 1-5% of adult population has gambling problem.
- Older adult gambling has increased from 35% in 1975 to 80% in 1999.
- Women begin gambling later and gamble more of their monthly income.

28

## Illicit (Illegal) Drug Use

- In 2000, National Survey on Drug Abuse and Health reported 568,000 Americans age 55+ used illegal substances in the past month.
- Caucasians at higher risk than African Americans or Hispanics.

26

## Co-Existing Conditions

- In older adults, mental and physical health problems often co-occur
- Interactive relationship – one causes declines in the other
- Disability is the “hallmark” of depression in older adults

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## Gambling Addiction: Characteristics of Problem Gamblers

- Focused on Gambling to Exclusion of Other Interests
- Development of Tolerance
- Withdrawal Symptoms
- “Chase” Their Losses

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## Conditions That Interact With Mental Illness

- Vision Impairments
- Stroke
- Heart Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Asthma
- Cancer
- Type II Diabetes
- Immune System
- Gastrointestinal Disorders
- Dementias

30

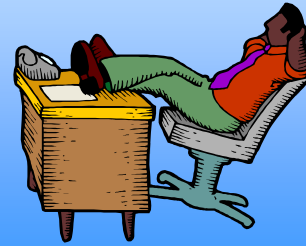
## Distinguishing Dementia from Depression

<http://dubinserver.colorado.edu/prj/aro/Observe.html>

Primary Depression	Primary Dementia
✓ Onset of symptoms was noticeable	✓ Slow, gradual onset of symptoms
✓ Rapid progression in symptoms	✓ Slow progression in symptoms
✓ Complaints of cognitive defects	✓ No complaints of cognitive defects
✓ Complains in detail	✓ Vague Complaints
✓ Emphasizes cognitive complaints	✓ Conceals or "explains away" cognitive complaints

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## Short Break



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## Distinguishing Dementia from Depression Continued

Primary Depression	Primary Dementia
✓ Highlights personal failures	✓ Delight in personal accomplishments
✓ Makes little effort at tasks	✓ Struggles with tasks
✓ Does not try to keep up	✓ Relies on notes, calendars to keep up
✓ Is in distress	✓ Is unconcerned

32

## Mental Health and Ethnicity and Culture

- "Minority group" defined as one which has historically had little power or influence
- Negative effects of historical determination of "wellness" and "sickness" by majority group/ culture

35

## Alzheimer's Disease

- Clinical depression exists in 20-40% of older adults with Alzheimer's disease.
- Depressive symptoms may come and go.
- Communication difficulties make discussing symptoms of depression difficult.

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## Mental Health and Ethnicity and Culture

- Role of risk factors in minorities bearing a disproportionately high burden of disability
- Some risk factors are:
  - decreased access to healthcare
  - poorer quality care
  - more likely to live in poverty
  - more likely to work manual labor jobs which brings about a greater risk for physical injury and disability

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## Mental Health and Ethnicity and Culture

- Examples of effects of these risk factors:
  - African Americans over-diagnosed with Schizophrenia
  - 37% of Hispanic Americans have no health insurance
  - Alcoholism is leading cause of death among Native Americans
  - Suicide rate among Native Americans is 50% higher than the national average

37

## Mental Health and Ethnicity and Culture: So what does this all mean?

Case example and discussion:

- Martha is a 78 year old Hispanic woman
- Immigrated from Mexico 15 years ago
- Lives alone since being widowed 6 months ago
- Daughter is requesting assistance with mother's care
- Speaks limited English
- Appears depressed and becomes tearful when asked about her husband

40

## Mental Health and Ethnicity and Culture

- Nationally, the population of minority older adults is expected to increase by 500% in the next 50 years.
- By 2050, in the U.S. one in five persons of a minority group will be age 65 and over.
- By 2025, racial and ethnic minorities will represent more than 40% of all Americans.

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## Religion and Spirituality

What do you think of talking with your customers about religion and spirituality?

41

## Mental Health and Ethnicity and Culture

- Culturally competent care involves:
  - Understanding of cultures other than one's own
  - Recognizing importance of verbal communication
  - Recognizing importance of patience

39

## Religion and Spirituality

- A strong religious faith or spiritual understanding and connection can positively contribute to successful aging:
  - Reduction in levels of depression and distress
  - Speed of recovery from depression
  - Overall greater well-being and life satisfaction

42

## Religion and Spirituality

- Times to possibly consider accessing a faith based resource:
  - Losses – spouse/partner, family member, friend, job, home, health
  - Changes in mobility/skill
  - Transition from home to AL or NF

43

## Mental Health Screening Tool

Use of the tool is not mandatory – it is an option for use to enhance your work.

We will discuss:

- Reasons to consider use of the tool
- Ideas about when and how to use the tool

46

## Religion and Spirituality

- Concrete strategies to enhance spirituality/meaning in customer's lives
  - Assess past spiritual/religious coping skills/mechanisms
  - Refer to appropriate clergy
  - Access outreach services provided by chosen faith organization
  - Allow the customer to take the lead in this process

44

## Mental Health Screening Tool: Questions for Thought

- What would be an example of a change in routine that would make you think someone was having a mental health problem?
- How would you address this problem with this person?

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## Break for Lunch



45

## Mental Health Screening Tool: K6

- Used by World Health Organization
- Used for large studies in England and Australia
- Used for a National Health Survey in the U.S.
- Designed by Dr. Ronald Kessler from Harvard
- Screening tool, **not** a diagnostic tool

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## Mental Health Screening Tool: How is the K6 used?

- Ideas about when to utilize the K6
  - Suggested as a screening tool and a way to begin a conversation with your customers about mental health
  - Nature of relationship will clearly guide use

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## Addressing Challenging Situations: Overview

- Sharing of specific helping strategies
- Recognizing importance of individual skills and helping styles
- Brainstorming about difficult situations

52

## Mental Health Screening Tool: Scoring

- Numerical scale, 0-24
- When is referral appropriate?

50

## Addressing Challenging Situations

Importance of awareness of and proper training in your agency's protocol regarding customer suicide risk.

53

## Addressing Challenging Situations

During pilot implementation, requests were received regarding ideas around how to address difficult or uncomfortable situations when talking about mental health.

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## Addressing Challenging Situations

- Importance and nuances of active listening
- Importance of understanding customer's experience and feelings
- Importance of validation, normalization, and optimism

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## Addressing Challenging Situations

Group exercise using the ideas of active listening, understanding customer's experience and feelings, validation, normalization and optimism.

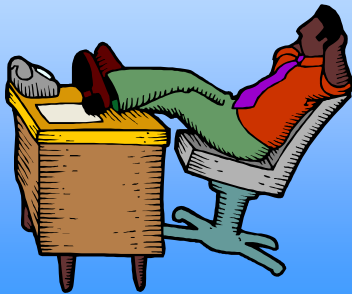
55

## Referral to Mental Health Resources

### Abbreviations & Definitions

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## Break



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## Referral to Mental Health Resources: CMHCs

- Local coordinating agencies for delivery of public community based mental health services
- "County of Responsibility" – catchment area
- Range of services – including therapy, medication, and testing
- Community Support Services (CSS) – division that serves SPMI adults
- Aging Specialists

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## Referral to Mental Health Resources

### Accessing Service Providers and Other Resources

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## Referral to Mental Health Resources: Questions to Ask Your CMHC

1. Do you have an Aging Specialist?
2. Do you have any services specifically for older adults?
3. Can any staff provide home-based services? What kind?
4. What is your sliding fee scale?
5. Are services available for those who cannot pay for them? What kind?
6. What is the average wait for services?

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## Referral to Mental Health Resources

**Who is the service provider that older adults are most likely to see about a mental health problem?**

61

## Referral to Mental Health Resources: Informal Mental Health Resources

**What are they?**

64

## Referral to Mental Health Resources: Other Mental Health Service Providers

- Private therapists, psychologists, psychiatrists
- Community health providers
- Specialized services for subpopulations
- Inpatient hospital units

62

## Referral to Mental Health Resources: Older Adult Focus Group Findings

1. Peer Outreach and Support
2. Involvement in Activities

65

## Referral to Mental Health Resources: To Ensure Service Reimbursement

1. Inform the provider what reimbursement method will be used.
2. Contact insurance company/public benefit to determine covered services/co-pays.
3. Before the first appointment, contact service provider's admissions/financial office for billing questions.
4. Bring the most current insurance/benefits card to the first appointment.

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## Referral to Mental Health Resources

### Local Mental Health Resources

66

## Connecting Older Kansans with Community Mental Health Resources

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Don't forget to fill  
out your evaluation  
forms and pick up  
your certificate!

Thank you!



## APPENDIX C

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## APPENDIX D

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**“CONNECTING OLDER KANSANS TO COMMUNITY MENTAL HEALTH RESOURCES”**

Presented by:

**CERTIFICATE OF ATTENDANCE**

Hours of CEU's: \_\_\_\_\_ CEU #: \_\_\_\_\_

\_\_\_\_\_  
Participant Name

Date: \_\_\_\_\_

Location: \_\_\_\_\_

Presenters:

## APPENDIX E

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# “ CONNECTING OLDER KANSANS WITH COMMUNITY MENTAL HEALTH RESOURCES” TRAINING EVALUATION

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Today's date: \_\_\_\_\_

**Your Agency** Please circle **ALL** that apply:

Assisted Living      Area Agency on Aging      NF      Hospice      Senior Center  
 Dr.'s office/clinic      Hospital      Congregate Meal Site      Home Health      Gero-Psych Unit  
 Adult Protective Services      Senior Apartments      **Other:** \_\_\_\_\_

**Your Title:** Please circle **ALL** that apply:

Nurse      Case Manager      CARE Assessor      Psychologist      Social Worker  
**Other:** \_\_\_\_\_

**Please rate the following aspects of the training by circling the appropriate number on the scale provided.**

**1. The trainers knowledge about the topics they presented**

Poor	Below Average	Average	Above Average	Excellent
1	2	3	4	5

**2. The training content's relevance to your practice**

Poor	Below Average	Average	Above Average	Excellent
1	2	3	4	5

**3. The usefulness of the training materials**

Poor	Below Average	Average	Above Average	Excellent
1	2	3	4	5

**4. The likelihood you will use the K6 in your practice**

Poor	Below Average	Average	Above Average	Excellent
1	2	3	4	5

**5. The comfort level of the facilities (temperature, lighting, etc.)**

Poor	Below Average	Average	Above Average	Excellent
1	2	3	4	5

**6. Your overall satisfaction with the training**

Unsatisfied	Below Average	Average	Above Average	Very Satisfied
1	2	3	4	5

**Comments:** (Use the back if necessary)

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## APPENDIX F

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# K6 MENTAL HEALTH SCREENING TOOL

About the Scale: The K6 Screening Scale was developed by Dr. Ronald Kessler, Professor of Healthcare Policy at Harvard Medical School, with support from the U.S. Government's National Center for Health Statistics. The scale was distributed for use by aging service providers as part of the University of Kansas School of Social Welfare Office of Aging and Long Term Care's pilot project, "Connecting Older Kansans with Community Mental Health Resources", funded in part by the Kansas Department on Aging and the Kansas Department of Social and Rehabilitation Services.

The K6 is not distributed for use as a diagnostic tool, but as a format to assist aging services providers and their customers in identifying a potential mental health problem from which older adults might benefit from referral to mental health resources. Please reproduce as needed.

**Customer Identification:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The following questions ask a person how he/she has been feeling during the past 4 weeks. For each question, please circle the number that best describes how often she/he had this feeling.

In the last 4 weeks, about how often did you feel..	All of the time	Most of the time	Some of the time	A little of the time	None of the time	Don't know	Refused
a...so sad that nothing could cheer you up?	4	3	2	1	0	0	0
b...nervous	4	3	2	1	0	0	0
c...restless or fidgety	4	3	2	1	0	0	0
d...hopeless	4	3	2	1	0	0	0
e...everything was an effort	4	3	2	1	0	0	0
f...worthless	4	3	2	1	0	0	0

\* If necessary, for question e., prompt: How often did you feel everything was hard and difficult to do?

**TOTAL SCORE:** \_\_\_\_\_

**In the last 4 weeks, how many times have you seen a doctor or other health professional about these feelings?** \_\_\_\_\_

**Don't know** \_\_\_\_\_ **Refused** \_\_\_\_\_

**Comments** \_\_\_\_\_

\*\* If the customer scores 13 or higher, it is recommended that service provider consider referring the customer to a mental health resource for further support. If the score is below 13, the customer may not need a referral; however, if the service provider or the customer feels that a referral to a resource should be made, proceed with the referral. If a mental health crisis is suspected, follow service provider organization's standard procedures.

For more information about the K6 and related mental health screening instruments, please visit:  
[http://www.hcp.med.harvard.edu/ncs/k6\\_scales.php](http://www.hcp.med.harvard.edu/ncs/k6_scales.php)

## APPENDIX G

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