

**The University of Kansas  
School of Social Welfare  
Office of Aging and Long Term Care**

**Barriers to Accessing Mental Health Services  
for Residents in Assisted Living and Residential  
Health Care Facilities From the Perspective of  
Residents and Community Mental Health  
Center Staff**

**Final Report  
June 2002**

**Debra Dobbs, Ph.D.  
Rosemary Chapin, Ph.D.  
Colleen Reed, MSW  
Ann Hickey, MA  
Chris Ellman, BSW**

**University of Kansas  
School of Social Welfare  
785.864.2659  
colleenreed@ku.edu**

**The authors wish to thank Mary Zimmerman, Holly Nelson-Becker and Roxanne Rachlin for their assistance with this project.**

**This research was supported in part through a contract  
With the Kansas Department on Aging and  
The Kansas Department of Social and Rehabilitation Services**

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## Executive Summary

### **A) Purpose**

The Kansas Department on Aging and the Kansas Department of Social and Rehabilitation Services contracted with the Office of Aging and Long Term Care at the University of Kansas School of Social Welfare to conduct this study entitled, *Barriers to Accessing Mental Health Services for Residents in Assisted Living and Residential Health Care Facilities: Resident and Community Mental Health Center Staff Perspectives*. Research indicates that depression and anxiety are serious mental health problems of older adults. These mental health problems often lead to physical health problems or exacerbate existing health conditions ultimately contributing to premature nursing facility placement (c.f. Badger, 1998; Chapin & Dobbs-Kepper, 2001; Collins & Abeles, 1996; Copeland, 2001; Wolfe, Morrow & Fredrickson 1996). The purpose of this study was to investigate the mental health needs and mental health service system interactions of elders living in assisted living and residential health care (AL/RHC) settings. Older adults in assisted living settings were asked about their need for, awareness of, access to, and use of community MH services. Information from Kansas Community Mental Health Center (CMHC) directors supplements resident responses regarding mental health service systems.

### **B) Overall Methodology**

Qualitative and quantitative research methods were employed. Face to face, semi-structured interviews were conducted with a sample of 32 residents from 14 AL/RHC facilities in Kansas. The AL/RHC facilities included 2 from “frontier counties,” 7 from rural counties, and 2 facilities in urban / metropolitan counties. Twenty-one Community Mental Health Center Directors responded to this study.

A risk and protection model served as the framework for examination of the study data (Fraser, Richman & Galinsky, 1999). Much of the literature dealing with institutionalization of older adults focuses on risk factors leading to nursing facility placement. This study adapts that framework to examine not only phenomena that are linked with negative mental health outcomes, but also at those that contribute to and protect mental wellness in older adults (Cohen, 1995; Dean, Kolody & Wood, 1990; Rowe & Kahn, 1997). Respondents’ experiences of risk and protective factors relative to their mental health outcomes inform policy makers about the need for mental health services for elders in AL/RHC settings.

### **C) Overall Study Findings**

#### Risk and Protective Factors

Respondents were asked about their experiences of both risk and protective factors. **Risk factors** include 1) personal history of mental health problems, 2) alcohol use, 3) personal losses and social isolation, 5) physical health problems, and 5) difficulty adjusting to the assisted living setting

To better understand respondents’ experiences of depression and anxiety, all were asked to respond to the Geriatric Depression Scale, a widely used standardized measure for depression and to three anxiety questions based on the Zung measure for anxiety (Yesavage & Brink, 1983; Zung as cited by Kane & Kane, 2000). Five residents had scores indicating clinical depression and another five had scores indicating sub-clinical depression. Because sub-threshold scores are viewed as clinically significant, nearly one third of participant’s scores indicated the presence of depression (Lewisohn, Seeley, Solomon & Zeiss, 2000). Eight of the 31 residents interviewed indicated that they experienced symptoms of prolonged anxiety.

Respondents overwhelmingly indicated little or no use of alcohol. This points to a preliminary finding that in AL/RHC settings, residents experience little risk to negative mental health outcomes due to the use or abuse of alcohol. However, these findings must be interpreted cautiously because the stigma associated with alcoholism may cause elders to under-report use and abuse.

Respondents further identified the risk factor of loss through their accounts of grief and sadness related to significant personal losses. Many respondents described ongoing feelings of depression related

to the loss of their primary social supports in general and the loss of their life partner in particular. The loss of physical health also emerged from the data as negatively influencing mental health. Respondents indicated that they were “down” about not being able to engage in life in ways they had previously found enriching.

Finally, respondents indicated they experienced challenges to good mental health with the transition to AL/RHC itself. A number of respondents cited the loss of independence and lack of autonomy as personal obstacles to good mental health. Many respondents indicated they had trouble with feeling socially isolated and that they had lost their sense of “home.”

Respondents additionally identified experiences of protective factors for mental health. **Protective factors** include 1) adequate social contact and close personal ties, 2) opportunities to provide social support to others and 3) experiences of autonomy and choice.

A number of respondents identified benefits associated with relationships with family, friends and AL/RHC staff in general and confidante relationships in particular. Respondents indicated that they relied on social ties not only for tangible assistance but also for emotional nurturance. A number of participants identified positive connections with a religious leader and to their “faith.”

The provision of social support also emerged as a protective factor. Participants described beneficial effects associated with helping others in many ways including actively welcoming new residents to the AL, providing encouragement to friends in difficult times, and helping family members. Those who identified their ability to be helpful to peers, in particular, found positive meaning in their actions.

Finally, a number of participants indicated that exercising autonomy and choice within their daily lives had pro-health benefits. Residents who had experiences in which they were able to exercise self-determination over their own lives reported having a sense of satisfaction with life. Participants who recounted actively planning for and participating in the move to the AL/RHC indicated feeling more prepared for the change and that they were better adjusted to the new setting than peers for whom the decision to move was made by another or who were not involved in the planning and choices regarding the move.

#### Access and Barriers to Mental Health Services

Residents indicated that they received information about the community and services through the newspaper, radio, television, facility bulletin boards and newsletters, and communication with facility staff. Despite the wide array of sources of information, residents indicated they new little, if anything, about community mental health services.

None of the participants reported receiving a referral to mental health services by AL/RHC staff. The few respondents who used services did so prior to their admission into the AL/RHC. Participants were asked if they had ever attended a presentation about mental health services in the AL/RHC and none responded affirmatively. In sum, the four primary barriers to the receipt of mental health services emerged from resident narratives included: 1) lack of awareness and education about mental health services; 2) stigma; 3) lack of staff involvement in facilitating use of mental health services; and 4) lack of transportation.

#### Feedback from Community Mental Health Center Directors

CMHC directors provided information about the services offered and the use of services in their catchment areas. Directors reviewed a briefing sheet detailing preliminary findings of this study. At the time of data collection, CMHC directors indicated that they served between 4-150 adults over the age of 60 in their respective catchment areas. CMHCs typically do not track the numbers of persons served who are residents of AL/RHCs. While the number of older adults served by catchment area varied, the CMHCs with aging specialists served a greater number of older adults than their counterparts.

Despite ongoing efforts to provide outreach and education to the community, CMHC directors acknowledged challenges to meeting the mental health needs of AL/RHC residents. The primary challenge is lack of awareness about CMHC services. CMHC directors indicated potential explanations for public lack of awareness related to 1) resources; 2) exposure to the issue of mental health in the

media; 3) lack of education among health care providers; and 4) poor coordination among aging providers to meet mental health needs.

Predominantly, CMHC directors identified education and outreach as important strategies to increase service to elders in the community. However, their responses indicated barriers to performing this function adequately including a general lack of resources (e.g. a lack of trained staff), geographic distance, and the large size of the service population. A corollary to challenges of limited resources is the lack of strong media attention to the mental health issues of older adults. Directors identified challenges related to primary care physicians' scope of experience with mental health issues and the limited use of referrals to mental health practitioners. Ultimately, directors indicated that environmental barriers hamper service provision.

#### **D) Implications**

Key actors in Kansas are coming together through the Mental Health and Aging Coalition and other initiatives to improve MH services for older adults in assisted living settings. Our study identified specific strategies designed to improve mental health care for older adults. Organized to mirror the presentation of the findings, the strategies address ways to mitigate mental health risk factors, augment protective factors, and decrease barriers to obtaining mental health services.

**Mitigating risks to good mental health** for residents of AL/RHCs could begin with pre-admission and routine mental health screenings. The adoption and implementation of sensitive screenings could identify depression masked by physical health problems and by high clinical thresholds.

**Protective factors can be augmented** through the strategy of increasing participation in enhanced AL/RHC social programming. Residents indicated interest in engaging, mentally stimulating activities. With the cultivation of informal opportunities within the AL/RHC, residents could be engaged in providing social support to others. An additional strategy involves enhancing the mental health knowledge and mental health service systems knowledge spiritual advisors could lead to referrals to service when need is expressed to the confidante. Finally, case managers and facility staff actively engaging elders in planning and preparing for the move to the AL/RHC setting could augment the protective factors of autonomy and choice as elders participate in an important life transition.

Existing initiatives to match elders with mental health service needs to existing service resources are working to **decrease barriers to mental health service** use among older adults. Increased support of those initiatives, such as the Mental Health and Aging Coalition, could allow current efforts to broaden and focus specific attention on the mental health needs of elders living in AL/RHC settings. Additional community outreach and multi-media public-awareness campaigns about specific mental health issues and available services are fundamental strategies for decreasing barriers to mental health service use. Similarly, increasing awareness of the mental health needs and referral process among AL/RHC staff is critical to initiating the use of services. Finally, through collaborative efforts, increased training and the addition of Aging Specialists to CMHCs' staff could augment the provision of services tailored to best fit the mental health needs of elders who live in AL/RHC settings.

#### **E) Conclusion**

Overwhelmingly, respondents indicated a strong desire to age in place. To honor this desire, it is important to examine the interplay of 1) mental health risks, 2) mental health protections, 3) awareness of and access to services, and 4) supports and barriers to service use. Mental health problems are linked to discharges from AL/RHCs both directly and by negatively influencing the physical health of older adults. Because of this link, elders with unmet mental health needs could be discharged to nursing facilities prematurely at high personal and financial costs to the elder, her/his family and the state. Collaborative efforts between CMHCs and AL/RHCs, when supported by policy makers, will improve successful service connections for older adults with unmet mental health needs who live in AL/RHC settings facilitating residents' goal of aging in place.

## **Purpose of Study**

The purpose of this study was to investigate the mental health (MH) needs and mental health service system interactions of elders living in assisted living (AL). Study participants were asked about their need for, awareness of, access to, and use of community MH services. Responses from Kansas Community Mental Health Center (CMHC) directors supplement resident responses regarding mental health services. The information in this report will provide policy makers with a clearer understanding of the mental health issues facing older Kansans in assisted living settings.

## **Background and Significance of Mental Health Issues for Older Adults**

According to a number of national reports, the mental health needs of the older adult population have become a national priority (Administration on Aging (AoA), 2001; Department of Health and Human Services (DHHS), 2000). These reports highlight the lack of access to mental health services for older adults (AoA, 2001; DHHS, 2000). Many problems are associated with accessing mental health services, making it a growing societal concern. The stigma associated with accessing mental health resources, the cost of medications, the lack of formal and informal support, and a general lack of education concerning mental health issues all may impede treatment. While everyone is susceptible to mental health problems, older adults are increasingly at risk for mental illness.

Depression is the most common mental health disturbance in older adults. Copeland (2001) estimates that as many as 15-25% of adults aged 65 and older have depression. Less than 3% of elders, however, see a mental health professional and only 17% of depressed elders receive some form of mental health treatment from a health professional of any kind (AoA, 2000; Lycos Health- Web MD, 2000; Barry, 1994).

Many older adults experience issues with mental health for the first time late in life; these problems are “frequently exacerbated by bereavement or other losses which tend to occur in old age” (AoA 2001, p. 6). The loss of a spouse or life partner has also been found to be associated with suicide among older adults (Barry 1994). While older adults aged 65 and older comprise 13% of the population nationally, they account for 25% of all suicides nationally (Barry, 1994).

Although many older adults who experience some form of mental health problem may not resort to suicide, they are at high risk for chronic health problems that may be directly linked to depression (Badger 1998). These chronic ailments or illnesses, along with many medications that older adults are currently taking, can actually mask or worsen symptoms of depression (Wolfe, Morrow & Fredrickson 1996). Referred to as “masked depression,” these physical symptoms of depression vary from insomnia, general physical problems, pain, and constipation (Collins & Abeles, 1996). The older adult will often deny being depressed and instead complain about how they are not appreciated in their old age (Collins & Abeles 1996; Golant 1998).

Previous research indicates that persons with depression have as difficult or a more difficult time functioning physically and socially than do persons with chronic physical illness (Wells et al., 1989). “Depressed elderly medical patients have more medical illnesses, greater pain, and increased medical complications than their non-depressed cohorts” (Badger, 1998, p. 137). Depression-related disabilities contribute more to an increased need for medical services than non-depression-related disabilities; however, those with depression-related disabilities use less of the types of services that might lessen incidence of depression, such as social and recreational services, than those older adults with non-depression-related disabilities (Badger, 1998). These findings support previous studies that suggest depression can compound existing medical conditions and possibly lead to premature nursing facility placement (Chapin et al. 2001). Depression for elders, whether masked, measured at a sub-clinical level, or diagnosed as major depression, is associated with higher health care costs (Badger, 1998).

Another problem related to mental health facing older adults is substance abuse, predominantly alcohol. It has been reported that between 5% and 12% of men and 1%-2% of women in their 60s have a drinking problem (Dunne, 1994). A study of 1,070 older men and women who were selected from general practice lists showed that almost one-fifth of both genders who were regular drinkers, exceeded the recommended limits of healthy drinking (Dunne, 1994). Some research indicates that the abuse of alcohol in the older adult population is overlooked because they are often isolated from the outside world (Hospitals and Health Networks, 1995).

## **Mental Health Needs of Assisted Living Residents**

A recent report by the Administration on Aging (2001) documented that anxiety disorders and depression are two of the most prevalent mental illnesses among older adults. One national assisted living study reported the percentage of persons with depression and/or anxiety disorder at approximately 27 % (National Investment Conference, 1998). Consistent with national trends, it was found in a study conducted by the Office of Aging and Long Term Care that approximately 30% of residents in a sample of assisted living and residential health care (AL/RHC) settings in Kansas were diagnosed as having depression, anxiety or a combination of the two disorders. Interviews with a small pilot sample of AL/RHC facility administrators (N=10) indicated that residents' mental health status is an important factor that affects the successful integration of residents in assisted living facilities and their capacity to age in place.

Recent discussions with mental health and aging specialists indicated that elders who reside in assisted living facilities have difficulty accessing mental health services. It was suggested that while community dwelling elders not in assisted living are increasingly reached through innovative outreach programs (e.g., targeted efforts at nutrition and senior centers), elders in assisted living facilities often rely on facility staff to act as a liaison to mental health service providers. Staff knowledge of mental health services and their willingness to cooperate with outside providers may also differ across facilities, further affecting access to services. These factors may influence the resident's ability to successfully integrate into an assisted living environment, and could thereby lead to premature institutionalization (e.g., nursing facility admission).

Older adults consistently report that they want to have options other than nursing facilities for receiving long-term care services (Leon and Moyer, 1999). Assisted living (AL) is an increasingly popular long-term care options for people seeking a less restrictive environment. A recent national study funded by the Retirement Research Foundation indicated a 30% increase in the number of assisted living units from 1998 to July of 2000 (Mollica, July 2000). In Kansas, AL continues to be in high demand. The percentage of older adults age 65 and older residing in AL increased from 1.27 % in 1999 to 1.47%

in 2000 (Chapin et al., 2002). The number of AL/RHC beds in Kansas also increased by 36% from 1997 to 1999 (Chapin et al., 1999).

As our population continues to age, it is important to know whether assisted living facilities are indeed equipped to address residents' mental health needs and to examine the related policy implications. Given the prevalence of depression and anxiety disorders among residents in assisted living, these conditions merit specific attention. Yet, the capacity of assisted living facilities to handle the current and projected mental health needs of their residents is unknown. An estimated 10- 27% of elders in assisted living facilities nationally exhibit symptoms of depression and a majority of these exhibited symptoms are often mistaken for a physical chronic ailment associated with aging (National Investment Conference, 1998; Grayson, Lubin & Van Whitlock, 1995, Copeland, 2001; Lycos Health- Web MD, 2000; Badger, 1998).

Recent research suggests that a significant percent—as high as 40 %—of at-risk older adults in assisted living facilities “go unserved or remain unidentified as potential beneficiaries of mental health care” (Russell, 1997). A concurrent study being conducted by the Office of Aging and Long Term Care found that 75% of AL administrators report frequently referring residents with mental health needs to primary care physicians (Chapin et al., 2001). Primary care physicians, however, may not have the necessary training to adequately treat older adults' mental illnesses (Chapin et al., 2001). Previous studies have reported that only 5 to 10% of older adults take advantage of community mental health services and providers, such as community mental health centers (KDOA, 2001).

According to the U.S. Surgeon General's Report on Mental Health (2001), 20 percent of the 55 years of age or older population are in need of some form of mental health care. Using the U.S. Surgeon General's estimate of 20% of older adults who were in need of some form of mental health care, roughly 1,544 Kansas residents in assisted living facilities could be expected to need mental health services. This estimated figure is based on the number of beds in licensed assisted living facilities and residential health care facilities in Kansas as of January, 2001, 7,718 (Dobbs-Kepper 2001). The estimated number of Kansas elders living in AL who need of mental health services is probably even higher, given the fact that

the risk factors for depression increase as adults age (George, 1983). The Surgeon General's estimate of 20% is for a much younger age group (55 years of age and older), and the age group served in ALs is, on average, 75 and older.

In a survey of older adults in Kansas, KDOA found that nearly 55% of older adults concerned about mental wellness did not know where to obtain services (KDOA, 2001). One factor contributing to under utilization of mental health services could be the lack of providers trained to treat older adult's mental illness (Barry, 1994). For example, only seven out of the 29 Community Mental Health Centers in Kansas have aging specialists (KDOA, 2000).

There are a number of reasons to examine the issues of access to and use of mental health services among residents in assisted living settings. Residents in AL may encounter more difficulty than their community dwelling counterparts in obtaining mental health services. Unmet mental health problems may exacerbate other health problems, increasing health services use and the cost of overall care. Further, unmet MH needs may contribute to premature discharge of AL residents to nursing facilities, placing elders in a more costly service setting for longer periods of time. Stakeholders' concerns for the well being of older Kansans and for the best use of state resources are addressed by this study.

Residents in assisted living facilities can offer valuable insight into their perceived need for mental health services as well as the difficulties they have obtaining mental health services. This study conducted by the Office of Aging and Long Term Care (OALTC) in FY 2002 allowed us to collect information about resident's awareness of, need for, access to and use of mental health services. In the following sections of the report, the study methods, findings and policy and practice implications are discussed.

### **Study Methods**

Between August, 2001 and February, 2002, face to face, semi-structured interviews were conducted with a sample of 32 residents from 14 assisted living/residential health care facilities (AL/RHCs) in Kansas, about their need for, awareness and use of mental health services in their

communities and facilities as well as any difficulty they had obtaining services for mental health problems (refer to Appendix A for the interview guide). The 32 residents interviewed originated from a sample of 238 residents from 37 facilities who participated in a previous two-year longitudinal study conducted by OALTC about AL/RHC residents' ability to age in place in AL/RHCs. This sample of residents was a particularly useful group to interview because detailed longitudinal data on these residents were already collected that helped to provide a more complete picture of their mental health needs (e.g., cognitive status, mental health diagnoses). Because ALs and RHCs are very similar (the only difference is that ALs are required to have kitchens for their residents), through the remainder of the report, residents in ALs and RHCs are referred to as AL residents.

### **Sampling and Data Analysis**

Administrators from the 37 facilities who had residents participate in our previous two-year longitudinal study were sent follow-up forms to complete about the residents in their facility who participated in the previous study and were still residing in the facility as of March, 2001, the end date of the longitudinal study. The information collected included whether the person had discharged, changed payment status, had a change in mental health diagnosis and the nature of the changes. In addition, because we were only interested in interviewing residents who were cognitively appropriate, we asked the administrators to indicate whether they felt this person was cognitively able to be interviewed.

We received information about 97 of the 238 residents in 17 facilities. Of these 97 residents, five had died, five were cognitively inappropriate to be interviewed and nine had discharged to a nursing facility. The remaining 78 residents eligible to participate in the study were sent informational letters, consent forms and self addressed stamped postcards to return, requesting a convenient time to be telephoned to schedule an interview. Thirty-two residents from 14 AL facilities across the state responded and were interviewed in person.

**Data Analysis** Interviews were transcribed and the transcripts were coded to discern themes and sub themes about mental health service need, awareness, access and use, both in the AL/RHC facility and

community. The findings of the study are reported below. As often done in qualitative research, participants' direct quotes are presented to illustrate emergent themes.

### Facility Descriptives

The thirty-two residents interviewed resided in facilities that were representative of AL/RHC facilities across the state of Kansas on key characteristics such as length of time in operation, geographic location, facility type (freestanding or part of an NF/CCRC), resident capacity size and whether the facility accepted Medicaid recipients or not.

Length of Time in Operation Facilities in the study had been opened from 1.75 years to as long as 14 years.

Geographic Location The size categories of the fourteen facilities were categorized as frontier, rural, densely settled-rural or metropolitan statistical areas (MSAs), as defined by the University of Kansas HealthWave Study. These categories are based on number of persons per square mile, calculated using U.S. Census Bureau population estimates (University of Kansas Health Services Research Group, 1999). Two of the facilities were located in a frontier county, having fewer than 6 persons per square mile. Seven of the facilities were located in a rural county, having 6 to 25 persons per square mile. Two of the facilities were located in a densely-settled rural county, having more than 25 persons per square mile. Three of the facilities were located in an MSA, having a city with 50,000 or more persons and a total population of at least 100,000. The geographic location of study facilities is highlighted in Map 1 (pg. 8).

Other Facility Characteristics Eight of the fourteen facilities (57.1%) were part of an NF or CCRC. The mean resident capacity size was 24 with facilities having a capacity size between 10 and 62 residents. All but two of the fourteen study facilities reported they accepted Medicaid residents (85.7%). Only three of the thirty-two study participants, however, were receiving Medicaid.

[Click here to request Map 1 showing the geographic location of study facilities.](#)

**Insert Map Here**

## **Resident Characteristics**

Demographic and mental health status information was collected about 28 of the 32 AL/RHC residents who participated in this study in March, 2001 by the OALTC research team, for a separate study.

### **Demographics**

The majority of the AL/RHC residents (n=27) were female and five were male. The average age of the AL/RHC residents was 87, with ages ranging between 59 and 97 years of age. All AL/RHC residents in the sample were White.

### **Mental Health Status**

Because one of the criteria to participate in the interviews was the absence of a diagnosis of dementia or Alzheimer's disease, none of the residents in the study were reported to have these diagnoses. Twenty of the respondents did not have short- or long-term memory problems. The remaining eight respondents had either short or long-term memory problems. Eight out of the twenty-eight residents had a diagnosis of depression. One person had a diagnosis of both depression and anxiety disorder.

Anxiety and depression were reported to be the most prevalent mental health problems experienced by older adults in assisted living (Gann, 2000). Participants were asked to respond affirmatively or negatively to three questions about anxiety based in part on the Zung anxiety scale that cover respondents' sleep patterns, ability to relax, and degree of worry (Zung in Kane & Kane, 2000). Thirty-one of the residents responded to the questions and responses ranged from "no" on all three to "yes" to all three questions.

The Geriatric Depression Scale (GDS) was administered to all current study participants (Yesavage & Brink, 1983). Scale scores were evaluated and categorized against clinical cutoff scores of 11 and sub-clinical cut-off scores of 8 with the scale anchor at 0 for the absence of depression (Kane & Kane, 2000). Respondents' scores on the thirty-item measure ranged from 1 to 26. The median score was 5 and the mean score was 6.7.

### Functional Status

On average, the resident sample needed assistance with only .81 of the six activities of daily living (ADLs) (bathing, dressing, toileting, transfers, walking mobility, and eating) and 3.9 of the seven instrumental activities of daily living (IADLs) (meal preparation, shopping, money management, use of telephone, transportation, housekeeping and medication management).

### Prior Residence

We also collected information about where the resident resided prior to being admitted to AL/RHC. The majority of the 28 residents we had information about were admitted from home (n=20). One resident was admitted from another AL. Three residents were admitted from the hospital after an acute episode and four residents were admitted from a nursing home.

### Study Findings

A model of risk and protection factors provides a useful framework from which to examine residents' responses to inquiry about mental health needs for, awareness of, access to and use of mental health services. Risk and protective factors, in this application, relate to negative and positive mental health outcomes for elders living in AL (Fraser, Richman, & Galinsky, 1999). Older adults often experience a number of both physical and mental health concerns simultaneously. These co morbid conditions not only evidence themselves in common ways but also interact with one another (Cooley, 1998).

### **Risk Factors for Depression**

Commonly identified risk factors for depression in older adults include a personal history of mental health needs, stress, physical illness, loss, alcohol abuse, and decreases in autonomy (George, 1983). These risk factors act on depression outcomes directly and interact with one another (National Institute of Mental Health, 2001). Risk for physical and mental health problems, loss, alcohol abuse, and dependence increase as adults age. In turn, those elements increase elders' risk for depression (George, 1983).

Potential risk factors related to mental illness were explored in this study. The risk factors discussed below include: 1) personal history of mental health problems, 2) alcohol use; 3) personal losses and social isolation; 4) physical health problems, and 5) difficulty adjusting to assisted living.

#### Personal History of Mental Health Problems as a Risk Factor

A personal history of mental health problems contributes to the likelihood that elders will experience ongoing difficulty in this arena (Cooley, 1998). Further, elders who currently experience mental health problems that go under diagnosed and/or untreated are likely to have persistent trouble in this area (Cooley, 1998). In this study, only three residents indicated that they had a specific history of mental health difficulties including having been diagnosed with depression. Despite the fact that only three persons acknowledged having a history of mental illness, records indicated that seven residents had a diagnosis of depression. Additional incidences of depression were discovered through the use of the GDS (Yesavage & Brink, 1983).

Nearly one-third of respondents' GDS scores indicate signs of depression including those above the clinical cut-off of 11 and those with sub-threshold, yet clinically significant, scores of 8-10 (Lewisohn, Seeley, Solomon & Zeiss, 2000). Analysis of residents' GDS scores indicates that five residents' had clinical levels of depression (Kane & Kane, 2000; Yesavage & Brink, 1983). Another five residents had scores that indicated sub-threshold levels of depression. Review of the GDS scores for the seven respondents with diagnoses of depression provides confirmatory evidence of depression. Of those seven with the diagnosis of depression, five had GDS scores above the clinical cutoff ranging from 12 to 20 and two had GDS scores indicating sub-threshold levels of depression. This finding is consistent with mental health and aging literature; the distinctions blur between sub-threshold depression and clinical depression on the GDS and diagnosis of depression from mental health practitioners and primary care physicians (Lewisohn et al., 2000).

Anxiety is commonly associated with depression in elders (Cooley, 1998). Based on this association, participants were asked three questions about anxiety: 1) Do you worry most of the time?;

2) Are you unable to relax?; and 3) Do you have difficulty sleeping because of worry or not being able to relax? Thirty-one of the participants responded to the questions. Eight of the 31 residents interviewed, indicated “yes” to one or more of the anxiety questions. Only one person responded affirmatively to all three of the anxiety questions. Notably, this particular person had never been referred to nor had ever used mental health services. The quotes below are exemplars of residents’ descriptions of their own mental health problems, specifically depression and anxiety.

*My mother and grandmother were worse than that; nervous people and they just couldn’t handle it. And, I didn’t want to fall in the same route...*

*I’ve got depression like you wouldn’t believe.*

*...I have also been cursed with depression, clinical depression. Years ago people would have called me insane. If you’ve never had it, you can’t, you really can’t understand how horrible it is. You hardly can function. You don’t want to dress, you don’t want to bathe, you don’t want to see anybody, you don’t want to....*

#### Alcohol Use as a Risk Factor

One risk factor known to be related to depression is alcoholism. The use of alcohol is often evidence that the elder has inadequate coping resources with which to manage life stresses such as physical pain, death of a spouse, or loss of independence. The lack of needed coping resources is also a risk factor for depression (Cooley, 1998).

Residents were asked about both their current and past consumption of alcohol. Respondents indicated neither moderate alcohol use, nor problematic alcohol abuse. Many residents denounced the consumption of alcohol, claiming a personal history of temperance. Only four participants indicated any use of alcohol. Their responses were “tried once,” use one time per year, use once every 2-3 months and use once every 2-3 weeks. Presentation of these findings is accompanied by a caution from the researchers. While elders themselves reported no “problematic” use of alcohol, one facility staff member anecdotally reported a respondent’s long history of alcoholism. In addictions research with older adults, social stigma often leads to self-censoring in reporting alcohol use and thus incidences may be under-

reported. The quote below is by an AL staff person who suggests that there are residents with problems of alcohol use.

*...some people are alcoholic here, I expect, but I don't know any of them.*

#### Personal Losses and Social Isolation as Risk Factors

Older adults are at risk for depression from inadequate social support. For example, unresolved grief following personal losses can result in feelings of isolation and depression (Cooley, 1998). In addition to open-ended questions about social connections, a 24-item social support scale was administered to all participants (reference). Scale items focused on attachment, social integration, feelings of worth, and a sense of available help, guidance and opportunities for nurturance or the reciprocation of support.

Over two-thirds of respondents experienced the loss of their spouse/partner to death. Nine respondents cited the death of their spouse as the reason for their move to the AL. One participant in her late nineties described her survivorship, beyond that of her spouse, an adult child, two siblings and a number of friends as overwhelming. While some residents lacked sufficient social contact, many respondents indicated having members in their social networks. However, of those with ample social networks, few had relationships with emotional intimacy.

*After the death of my husband, I decided that I didn't want to live alone. I didn't want to be dependent on my neighbors.*

*I just didn't think I could ever get over it [the death of her spouse].*

*I just don't see—see my close friends aren't here. I don't have contact with them now.*

#### Physical Health Problems as a Risk Factor

Physical health problems in general, and chronic illness in particular, such as diabetes or heart disease, act as a risk factor for depression and as a co-occurring condition (Cooley, 1998; NIMH, 2001). Older adults are more likely to have depression as a result of poorly managed pain and the limitations placed upon their levels of activity due to illness (Cooley, 1998). Almost half of the 32 residents

interviewed, indicated that declines in physical health and functioning precipitated their move to AL. An additional two residents moved to the AL because their spouses had significant health problems.

Residents indicated that physical illness reduces their ability and/or desire to participate in activities or to connect socially. In response to the question on the GDS about whether she was “generally happy,” one respondent indicated that she would be if she did not have to cope with “these darn [symptoms] all the time.” This same participant, like another who cited foot pain as her physical health problem, indicated that she has reduced the frequency with which she leaves her room. Another respondent shared an activities calendar of a local senior center with an interviewer. When asked about those activities in which the participant engaged, she responded that she no longer participates in either the larger community or in AL activities following the onset of a chronic illness. Residents’ comments exemplify the ways in which declines in physical health are associated with mental health, due in part to not being able to participate in activities or substitute new activities.

*Because once your physical health starts to decline, your mental health starts to decline.*

*Well, because I can't do them [activities] anymore. Like I can't crochet. I used to crochet all the time, but I have trouble crocheting. You know, I can't loop. Ever since I had this stroke, my hands don't work just right.*

*I used to when I first come [participate in group activities]. [But lately] I haven't felt as well as I should, and I got the edema to contend with*

*Well, at one time I could have, [participated in community activities shown on her community calendar] but I can't now. I would need too much help.*

#### Difficulty Adjusting to Assisted Living as a Risk Factor

Older adults also experience risks for mental health problems, such as adjustment disorder, anxiety, and depression that are most commonly associated with the stress of coping with new and persistent circumstances such as physical illness, loss, and relocation (Cooley, 1998; Rosswurm, 1983). A variety of risk factors for the onset of mental illness are associated with relocation to AL (Mitchell, 1999). Residents indicated that the lack of autonomy in the moving process, and the social elements of moving, taxed their personal coping resources. Moving into assisted living often caused adjustment

difficulties with leaving one's own home, loss of personal belongings, and loss of privacy. Many of the older adults' relocations to AL were preceded by the loss of a spouse.

Older adults' experiences of autonomy and personal choice regarding moving to AL were also influenced by their perceptions of family involvement and available social supports. In their responses to the qualitative prompt "Please describe the circumstances that brought you to AL," residents consistently identified the person or people who made the decision about the move. Twelve of the twenty-five stated that family members or physicians made the decision for them to relocate from their homes into AL. Thirteen of the twenty-five chose to come to the AL themselves. For these thirteen, autonomy and choice was a protective factor that could decrease their risk of having mental illness.

Residents' sense of autonomy was supported when family and/or friends were available to provide the necessary supports such that the elder chose to enter AL. Autonomy and choice were complicated when elders did not have available supports. A number of the residents indicated that they did not have anyone who could care for them. For residents who had family or friends, many stated that these potential informal caregivers were unavailable or unable to provide care.

The socialization process of adjusting to AL also presents a number of challenges. Residents reported feeling disconnected and alone upon transitioning to AL. A number of residents expressed difficulty forming new relationships in a new environment. Many residents not only had a hard time getting to know new people but also experienced social challenges exacerbated by grief and inability to participate in activities with social components because of physical illness. The following quotes highlight respondents' sense of disempowerment, perceptions of support availability and experiences of social disconnection associated with moving from the community to AL.

*I wasn't feeling well. The doctor told me I couldn't live by myself.*

*Oh, well, I lived alone. I lived alone, but I had a stroke. ... [the doctor] asked if there was somebody at home to take care of me. I said, 'No, I live alone.' He said, 'Well, you can't ever go back home.' ..... Oh, I could go live with my kids. I said, 'I'm never going to live with my kids and put that burden on anybody.*

*So I moved in up here so I wouldn't be a burden to my family.*

*She probably would be glad to be rid of me [family member who encourages participant to move to AL further away].*

*So, many of them have a hard time adjusting. One day I was walking through the dining room... and there was a little lady sitting there in a wheelchair.... I had been always troubled about her because she just seemed to be sitting, and so I bent over and kissed her on the forehead and said, "Good morning, Sarah." And, she grabbed my hand. "Oh," she said, "thank you for touching me." So, you see, touching is a very important point.*

*[Moving means] you have to start all over again...*

*I don't know whether you've noticed or not, but like when a new person comes in, they can't find anyone to sit with [at meals]. She [the new resident] went around to three or four different tables and said, 'May I sit here?' and those people would say, 'No, that chair's taken.' You know, they didn't want anyone new.*

*Well, I'm used to things more accessible. I really can't get those services. The shopping. Everything. The medical situation is not what I'm used to. There is a hearing aid place where I come from and there's an eye place. [For] all of that stuff [now], I have to go somewhere else.*

### **Protective Factors for Mental Wellness (Against Depression)**

Respondents reported the benefits of rich AL environments. They described nurturing opportunities including chances to give and receive social support, to exercise choice in living arrangements and to have safety, and to engage in spiritual practices that provide meaning and support. Social support, experiences of autonomy and choice, and spiritual connections are identified as mental wellness protective factors (Cohen, 1995; Dean, Kolody & Wood, 1990). They are associated with mental wellness and mitigate risks associated with stressful life events (Cohen, 1995; Dean, Kolody & Wood, 1990; Rowe & Kahn, 1997).

This study explored potential protective factors related to mental wellness. The protective factors discussed below include: 1) adequate social contact and close personal ties (social support), 2) opportunities to provide social support (reciprocal social support), and 3) experiences of autonomy and choice.

### Adequate Social Contact and Close Personal Ties as Protective Factors

Research indicates that having social contacts and personal ties decreases the risk of having mental illness (Rowe & Kahn, 1997). Residents indicated that they experienced positive benefits from social contact and the maintenance of close social ties. As an indicator of social support for our sample, we asked residents who they had contact with on a weekly basis, not including people who work or live in the AL facility. The majority of respondents had weekly social contact with family or friends. Thirty of thirty-two respondents had at least weekly social contact and six respondents had daily contact with a member of their social support network outside of the AL. The majority had social contact in person or by telephone with family members. Three people mentioned a pastor or someone from the church and three others mentioned friends instead of family members. Thirty residents indicated they had someone to turn to in times of need and twenty-six residents responded affirmatively to the interview prompt asking if they had “close relationships that provide [them] with a sense of emotional security and well-being.”

*So, I can stay here and be active, and that's the way it is now. I play Bridge twice a week, go to church on Sunday and there isn't a week that one of them don't ask me to go along to [a neighboring community for a visit]. So I'm busy all the time.*

*I haven't lost contact with my friends up there [where 'home' was prior to AL].*

*I'm very close to some of the people in here. Because, this place is really – well, it's a small town.*

We also asked residents to whom they turn when they may be sad or feeling depressed. Most of the 32 residents had at least one person if not more, to turn to, when they were feeling sad or depressed. Residents overwhelmingly responded that they would speak to spiritual/religious advisors and would advise peers in need to do the same. Respondents not only identified pastors and ministers as individuals with whom they could talk when experiencing sadness or depression, they also indicated that faith served an important role in coping with life challenges.

*I mean just when you've got faith in God it makes a lot of difference.*

*People are beginning to realize they can't live without God.*

*If a fellow didn't have faith in the Lord, God, you just wouldn't have much to live for, especially right now [in reference to September 11, 2001].*

### Reciprocal Support as a Protective Factor

Findings indicate that residents provide social support in addition to receiving social support. Additional positive benefits come from the provision of social support to others. This reciprocation of support is often overlooked in older adults due to the negative stereotype that elders' needs are too great to allow them to offer any type of support in exchange with caregivers or peers (Spaid, 1998). Resident responses, in this study, dispute ageist thinking. Twenty-two of 32 residents responded affirmatively to the social support scale prompt "there are people who depend on [me] for help." The following quotes serve as exemplars of residents' provision of social support.

*She [friend who said she didn't have anyone to talk to] couldn't talk to her mother, but she could to me because I'd listen. And, uh –[I started a group for people to come together and talk. I recommended that the person find five things that she was grateful for]. .... I think the next day or so she called me. She was so elated. ... She said, "I found five." ... If you do something for someone else, even if they don't do anything for you, that doesn't matter, because you get to do something for someone else \*. ... It isn't because you have to, it's because you want to.*

*Maybe have a prayer with them [friend who is sad or depressed] and kind of talk with them myself, in regards to, you know, feeling it out and see if there was anything I could do for them.*

*I like to try to help people out. I'll talk to them. I'm a good one to listen and talk to.*

### Autonomy and Choice as Protective Factors

The degree to which elders perceive control over their own lives affects mental wellness. The greater the elder's sense of autonomy and agency over her/his life, and the ensuing life choices, the more positive the mental health outcomes are (Brandt, 2001). Residents indicated benefits of personal choice regarding their approach to coping with life circumstances.

Autonomy and choice are particularly important in the process of coming to AL. A number of residents indicated that they lacked an adequate sense of safety living alone in their homes. This limits their opportunity to exercise choice regarding living in the community or moving to AL.

Once the determination to move to AL had been made, respondents indicated positive benefits of participating in the moving process. The thirteen respondents who chose to come to the AL on their own stated that they had planned for the move. Advance planning, significant time to adjust to the idea of a move and maximized participation in the process all serve as protective factors for mental wellness during and as a result of transitioning to a new living environment for older adults (Rosswurm, 1983).

*So, I'm fairly alone, but didn't feel that I was – for one thing, I was – I had a feeling that I didn't want to be alone and maybe have a stroke or heart attack or perhaps something like that and not be able to be in contact. I wanted to be where there would be somebody – near in case I couldn't get to a phone or something like that. And, the next step would be – I wasn't ready for a nursing home. But assisted living to me was the next step.*

*I got to where [at my home] I couldn't scoop the snow or mow the yard and it's hard to get somebody to do that. And here, those worries are lifted off your shoulders.*

*...and I didn't need to [move into AL], I'm in good health. ...So, I'm up here, in good health, and I'm just waiting for something to happen to me that I need to be here! And I just love it!*

### **Awareness of Mental Health Services Within the Facility and the Community**

Respondents indicated little awareness, overall, of mental health services. When residents were asked about their awareness of community services, they would predominantly mention medical services.

*What [when asked about a community mental health center]? I don't know anything about that.*

One finding that emerged from the data was that prior mental health service use increased awareness of available services. Residents who used mental health services were more likely to be informed of other service modalities. We also were interested in the role that AL facilities played in increasing residents' awareness about mental health services. A number of residents did rely on AL staff to inform them about what is available in the community. We asked if the AL facility scheduled community presentations on mental health at the AL. None of the respondents were aware of presentations related to mental health services at their respective AL facilities.

The findings from one facility indicated that, as a result of having CMHC staff presence in the AL, there was an increase in the awareness of available facility and community mental health services. Residents from this study facility were aware of Prairie View MHCs' active older adult program. Through this program a number of initiatives have been developed, incorporating community education, outreach and advocacy to the older adult population.

This particular facility also was participating in an intervention study with the Nursing School at The Wichita State University, to examine the effectiveness of a therapy room, for residents using psychotropic medications, known as the Snoozelan Room. The Snoozelan Room provides tactile, visual and auditory stimulation for persons who suffer from mental illness or cognitive impairment. An aroma therapist is also available to provide aroma therapy in the Snoozelan Room. Residents from this facility were very familiar with the Snoozelan Room as a service offered for residents with depression, anxiety disorder or cognitive disability.

Residents were asked a series of questions about the ways in which they receive information regarding services available to them both in the AL and the community. Overwhelmingly residents indicated that they learned of services through print and electronic media sources. For example, most facilities had a bulletin board or monthly newsletter and many watched television. Many respondents noted that groups came to their AL yet none identified presentations related to mental health services.

### **Mental Health Service Use by Residents In Study**

The overall use of formal community mental health services by the residents in this study was low, especially the use of community agencies that offer mental health services such as CMHCs, KDOA, AAA, and extension agencies. The incidence of low use can be explained in part to the lack of awareness of what community services were available. Only three residents knew of any organization that offered mental health services. Residents often confused CMHCs with inpatient hospitals such as Menningers, and those who knew of county extension agencies used them strictly for non-mental health purposes. Only two of the residents had ever heard of the KDOA Mental Health Guide for Older Kansans.

## **Access and Barriers to Mental Health Services**

There were four major barriers that emerged from resident narratives as a result of questions about the difficulties of accessing mental health services either within the facility or in the community. Barriers include: 1) lack of awareness and education about mental health services; 2) stigma; 3) lack of staff involvement in facilitating use of mental health services; and 4) lack of transportation.

### Lack of Awareness and Education about Mental Health

As mentioned above in the section on awareness of mental health services, residents had little awareness of what mental health services were available in the community or the benefits of these mental health services. This lack of awareness clearly translates into a barrier to accessing needed mental health services. The absence of outreach and education to the AL population, by both AL staff and community mental health providers, about what mental illness is and how it could be treated, could explain in part the lack of awareness about service availability.

Most residents interviewed were uneducated about what mental illness was and how to treat it. This was apparent in resident responses to the question, “what advice would you give to a person who is sad or depressed?” One resident said to “change your attitude,” while another said “I would do something about it myself.” A third resident said to “accept it and adjust yourself,” meaning that somehow the depressed individual could come out of a depressive state on his or her own. This indicates that there is little education for residents about mental health issues and how they can be treated.

The findings regarding lack of awareness and education are especially important, considering that close to one-third of the sample of residents had Geriatric Depression Scale scores that indicated signs of depression at either above or just sub-threshold clinical levels according to the Kane & Kane scales (2000). Although nearly all of the residents had no definition of mental health, a large number of them may be suffering from mental illness. The few residents who were knowledgeable of mental health issues and concerns were also the same residents who had previous personal experience with mental health problems.

## Stigma

Research shows that older adults and their family members equate mental illness with an unflattering and shameful stigma, resulting in a systematic barrier that separates older adults from the mental health services they need (U.S. Department of Health and Human Services 1999). This stigma was often manifested in the OALTC's study of residents in assisted living. One resident referred to a person who seeks out mental health services as "desperate," while another resident who suffers from clinical depression, claims that people would just refer to her as "insane." Several residents stated that, if they were feeling down and excessively sad, they would not talk to anyone because they would rather keep it to themselves, thus indicating a stigma that is attached to seeking help.

## Lack of Staff Involvement in Facilitating Access to Mental Health Services

Out of 32 assisted living residents who were interviewed by the OALTC, no residents were referred to mental health services by someone in the assisted living facility. This is vitally important, considering that the OALTC found that nearly one-third of all residents interviewed—10 residents—indicated signs of depression. Though several residents indicated that they could turn to assisted living staff members if they needed someone to talk to, this did not translate to the staff referring residents for mental health services.

## Lack of Transportation

As part of the question "what services are available inside the assisted living facility?" the residents were asked if there was any type of transportation service available to them for their use. This question received mixed responses for answers, and should be explored further. One concern is the there was no availability of transportation in some areas of the state for AL residents. An additional concern is the general lack of awareness concerning available services. Half of the residents who responded did not know of any available transportation services, while the other half were vaguely aware of services but did not use them because they had their own transportation, knew of someone who had a car, or simply could not afford the transportation services. For example, one resident complained that the cost for taking the facility's transportation ranged from \$10 to \$20 per trip, and this did not fit into the resident's budget.

Another resident inferred that transportation was only available for those who had Medicaid to cover the expense. The residents who relied on someone else for transportation did so in order to save the expense. Transportation typically was also not available without an appointment, making it even more difficult for some residents.

Based on additional research of available community transportation options for older adults, we found that many counties offer transportation for older adults either at no charge or on a sliding scale fee basis. Several residents were simply not aware that there were community transportation options designed specifically for seniors. Some did claim that, although there was not a transportation service available in the facility, they could always call a public transportation service to get them where they needed to go. Others said they thought that the facility had “something like that” [transportation service], but they were not sure, because they always called a friend or family member if they needed to go anywhere.

Given the responses from residents interviewed, there was a general lack of knowledge concerning available transportation services. This general lack of knowledge translates into a barrier; if the residents are not aware of what is available, they will be unable to take advantage of services that could possibly make it easier to obtain mental health services. If mental health services were not readily available in the assisted living facility, the resident would have to find them in the surrounding community. As the AoA (2001) found, if transportation is unavailable or affordable for the resident, or they are unaware that this service exists, they will not be able to obtain these mental health services, rendering transportation a barrier.

### **The Ability to Age in Place in Relation to Mental Health Needs**

In a concurrent study being conducted by the OALTC of 366 Kansas AL residents from 37 AL facilities, we were interested in examining how having a mental health diagnosis affects a resident’s ability to remain in AL. In the concurrent study, a number of factors that could potentially increase the risk of AL/RHC residents discharging from AL/RHCs to a nursing facility (NF) were examined over a 12 month period, from March, 2000 to March, 2001. Mental health diagnosis was included in the analysis as

one of the factors. An analysis of these factors indicated that residents with a mental health diagnosis were almost twice as likely to discharge to an NF as residents without a mental health diagnosis.

Based on the finding in the concurrent study that a mental health diagnosis was a risk factor for discharge from AL to a higher level of care, in this study we were interested in whether residents planned on remaining in AL, even if their physical or mental health needs increased. Most of the residents were very clear that they wanted to remain in AL regardless if their needs increased. They spoke of their AL residence as being “my last address” and the only reason I would move is if “I kicked the bucket” or “I can’t think of any reason I’d have to move” Only a few stated that if their level of care needs increased, they would have to go to a nursing facility.

### **Feedback from Community Mental Health Center Directors**

After analyzing the preliminary themes from resident narratives, we sent a three-page briefing sheet with a summary of the study findings, to the 29 community mental health center (CMHC) directors for their feedback. We also collected information from the CMHC directors about their staffing, services and programs available for older adults, as well as information about the use of these services and programs.

We received completed questionnaires from 21 out of the 29 questionnaires from CMHC directors. Seven of the 21 respondents had an aging specialist in their CMHC. Five of the remaining fourteen centers that did not have an aging specialist indicated that they did have a person assigned specifically to work with the Severe and Persistently Mentally Ill older adult population as well as the age 60 and older population.

We also collected information about the number of persons 60 and older served by each CMHC. Fifteen of the 21 CMHCs reported the number of persons 60 and older who had received services at their center in the last six months. Those figures are shown in Table 1. The number of persons age 60 and older served by CMHCs ranged between 4 and 150 with an average of 79 persons 60 and older. A comparison was also made between the average number of 60 and older persons served in CMHCs with an aging specialist versus CMHCs without an aging specialist. The results of this comparison are also in

Table 1. Many more elders were served in CMHCs with aging specialists. While the number of elders residing in these CMHC catchment areas is higher than in the areas without aging specialists, it is clear that when aging specialist services are available, more elders get treatment for their mental health problems.

**Table 1:**

**Older Adults Age 60 and Older Served by CMHCs in Kansas for Six Months (N=15)**

	<b>Range of the Number of Clients 60 and older</b>	<b>Average Number of Clients 60 and older</b>
All CMHCs (N=15)	4 to 150	79
CMHCs with aging specialist (N=6)	40 to 150	116
CMHCs without aging specialist (N=9)	4 to 110	51

**Assisted Living Residents Served By CMHCs**

We asked CMHC respondents how many of the older adults who had been seen for services at their CMHC resided in assisted living or residential health care facilities. Only six of the CMHC respondents of the 21 were able to provide us with this information. The number of older adults in the six CMHCs ranged between 1 and 18. It was apparent to our research team that AL residence is not information that CMHCs typically track. In order to better address the needs of older adults in ALs, researchers and CMHC staff may need to collaborate about ways to best collect this information.

**Services and Programming for Older Adults Offered at CMHCs**

We asked the CMHC respondents what types of programming and services they offer for persons age 60 and older. Four of the 21 CMHC respondents reported that they do not have special services or programs for the older adult population, just the normal programming. The remaining 17 CMHC respondents listed a variety of services that included individual and group therapy specifically for older adults, case management, medication management, depression screenings, and chemical and substance abuse treatment. One of the CMHCs (Prairie View) has an older adult program and in addition to all of

the above services listed, they also offer inpatient hospitalization for older adults with dual diagnoses such as schizophrenia, caregiver support groups, neuropsychological evaluations, and adjustment disorder therapy.

### **CMHCs Education and Outreach to AL/RHC Residents**

We also asked CMHC directors if their staff had made presentations about the center's services and programs to ALs, Senior Centers, or churches and synagogues. Staff from 14 of the CMHCs had, and staff from 7 of the 21 CMHCs had not, made any presentations to these locations. Staff from 7 of the CMHCs had made presentations about their services to AL/RHCs as well as Senior Centers and churches/synagogues. Staff from 6 of the 7 CMHCs' who had made presentations to ALs did have an aging specialist or someone who worked specifically with the age 60 and older population. More CMHCs had made presentations to senior centers than to churches/synagogues or AL/RHCs. Churches and synagogues, however, had a higher average number of presentations made. The higher average number of presentations to churches could be due to the larger number of churches/synagogues available for presentation compared to senior centers or AL/RHCs. The number of CMHCs that made presentations by location is shown in Table 2.

One apparent advantage for CMHCs with aging specialists is their ability to do education and advocacy in the community. For example, four of the CMHCs with aging specialists indicated they did education and outreach to older adults with numbers ranging between 100 and 400 older adults receiving information about mental health services vis-à-vis presentations at Senior Centers, the Older Women's League meetings, etc. One example given of education and advocacy was CMHC's aging specialists presenting The Mental Health and Aging power point presentation that has been developed by the Kansas Mental Health and Aging Coalition.

**Table 2: CMHC Presentations by Location of Presentation (N=14)**

<b>Location</b>	<b>Number of CMHCS that made presentations*</b>	<b>Range of number of presentations at each location</b>	<b>Average number of presentations</b>
<b>ALs</b>	7	1-2	1.6
<b>Senior Centers</b>	10	1-10	3.8
<b>Churches/Synagogues</b>	8	2-10	4.2

\*categories are not mutually exclusive

We also collected open-ended responses from CMHC directors about their CMHC's role in addressing AL residents' mental health needs. Specifically, we asked what they thought the reasons would be for the lack of awareness of available mental health services in their area? The responses to this question can be grouped into four areas, 1) resources; 2) exposure to the issue of mental health in the media; 3) lack of education among health care providers; and 4) poor coordination among aging providers to meet mental health needs.

#### Resources

Many of the CMHC directors cited inadequate funding for education and outreach for mental health services to the older adult population as a reason for the lack of awareness of available community mental health services. Similarly, directors cited lack of available staffing resources to do education and outreach to the AL population. Other CMHC respondents reported lack of funding to have an aging specialist at their CMHC as a reason for the lack of awareness about community mental health services in their area. With the exception of the High Plains CMHC, aging specialists were located in urban CMHCs such as Bert Nash in Douglas County, Johnson County MHC, Wyandotte County MHC and Valeo MHC. A fourth reason given related to resources was that there are not enough resources in some areas that have large catchment areas. For example, even though High Plains and Johnson County CMHCs have an aging specialist, geography, distance and the sheer number of persons residing in AL facilities in their catchment area act as barriers to promoting community mental health services to residents in AL facilities. Comparatively, Prairie View MHC reported that there is not a problem with

lack of awareness in their area because they have done extensive outreach and educational programming for older adults in their community since 1977.

#### Media Exposure Regarding Mental Health

More than half of the directors cited lack of advertising/media exposure directed at the older adult population about the availability and benefits of mental health services as a reason for the lack of awareness.

#### Lack of Education

CMHC directors explained that many older adults refer to their primary care physician when they have a health problem. Primary care physicians do not, in turn, appropriately refer older adults for treatment to mental health providers in the community. Another explanation related to the lack of education of providers is the mental health providers themselves not focusing on community dwelling elders. The reason given by one respondent for this was because historically, mental illness is clinically based.

#### Lack of Coordination Among Aging Providers to Meet Mental Health Needs

A number of the CMHC respondents cited poor coordination among aging providers to address mental health needs as a reason for the lack of awareness of community mental health services in ALs. There is no organized system for referring residents in ALs for community mental health services. Also, AL providers do not commonly refer residents with mental health needs to CMHCs for services.

#### **Collaboration with Spiritual Advisors**

In the earlier sections of this report it was indicated that residents used spiritual advisors as a common resource when they are in need of emotional guidance. We asked CMHC respondents to identify ways they can collaborate with spiritual advisors to meet the mental health needs of the older adult population. Some of the CMHC respondents reported that their center has done education and outreach to the ministerial alliance in their catchment areas. Other directors indicated that their center relies on clergy and ministerial alliances for potential referrals of persons needing mental health services. Also, CMHC respondents indicated that they currently offer a series of mental health topics to clergy. One suggestion

from one CMHC respondent was to make sure that pastoral counseling is clearly indicated as a service for residents in ALs that can be provided either in the facility or in the community.

### **Barriers to Accessing Mental Health Services**

CMHC directors were asked how the barriers to accessing mental health services affect their specific areas. It was found that regardless of geographic location, the responses were similar to the responses about lack of awareness of mental health services, which included resources, staff education, and primary care physician training. In addition, all directors mentioned reimbursement issues as a major barrier to accessing mental health services. Having qualified Medicare providers available to diagnosis and treat older adult's mental illness is the dominant issue facing CMHCs. Qualified Medicare providers include: doctors, clinical psychologists, clinical social workers, clinical nurse specialists, nurse practitioners and physician assistants. Not all areas have enough of these qualified providers.

Transportation was mentioned as a barrier in some of the rural CMHCs, particularly in the rural frontier areas where the population is so sparse and there is so much area to cover for some of the CMHCs. While each county is served by a CMHC, time and distance in these rural frontier areas make nearly impossible, at times, to meet the needs of AL residents. A similar related issue is whether ALs would have the transportation and staffing resources to transport residents to the services.

Stigma was mentioned by several of the CMHC directors as a barrier to meeting the needs of the older adult population. Mental illness is still stigmatized by older adults and their families. It will take education about the benefits of receiving treating for mental illness to overcome this barrier.

### **Policy, Practice and Research Implications of Study Findings**

Implications are provided regarding the risk and protective factors of elder mental health and wellness and how these risks and protection, influence mental wellness. These implications are based on findings from resident interview data, GDS and social support data, analysis of resident longitudinal data, and feedback from CMHC respondents, a number of policy, practice and research implications are discussed in the following section. Subsequent discussion addresses recommendations for diminishing barriers to mental health services for older adults in assisted living settings.

## **Mitigating Mental Health Risks**

The prevalence of depression is quite high among respondents, with nearly one third of AL residents interviewed having GDS scores at clinical and sub-threshold levels (five residents with scores above clinical cut-off of 11 and five residents with sub-threshold scores of 8-10). Still, the GDS scores may not reveal other incidences of masked depression. Further, sub-clinical scores are more common among older adults for whom depression may exist at similar levels of severity to younger adults who would have higher scores on the standardized measure (George, 1993; Lewisohn et al., 2000). Taking this into account, respondents with GDS scores of 6 or 7 may also experience significant depression. These research findings suggest the need for even greater cautions that depression largely goes under-diagnosed among older adults (George, 1993).

Despite the prevalence of depression among respondents, none of the respondents reported ever being referred for mental health services by assisted living facility staff. Four respondents with mental health diagnoses had GDS scores ranging from 11 to 14, all above the cut-off for clinical depression (11) and did not receive mental health services. Similarly, the participant who responded affirmatively to the anxiety questions was neither referred nor received services. One respondent of the three who reported receiving mental health services had a GDS score below sub-threshold levels yet described her/himself as depressed and in need of treatment. Of the eleven residents who have mental health service needs as evidenced by their diagnoses, responses to anxiety questions, and GDS scores, only three received mental health services, but were not referred. All three were receiving services prior to admission into AL.

The frequent overlap of depression and physical illness may lead to under diagnosis and consequent lack of treatment for depression. This is particularly common when depression is considered a “normal” response to physical illness (NIMH, 2001). However, depression makes physical problems worse, costs more, is not “normal”, leads to increased suicide, and can be treated successfully. Improved assessment and diagnosis of mental illness in older adults could potentially resolve the problem of under diagnosis and lack of treatment for this population. For example, the American Psychological Association (1998) guidelines for working with older adults details specific steps for comprehensive

diagnoses tailored to the older adult population. The implementation of these diagnostic techniques in the AL settings is key to addressing the heightened risk of adults who are not only older, but also live in a semi-institutional setting. Once diagnosed, a myriad of treatments could be used to successfully treat mental illness, including individual and/or group therapy strategies such as cognitive/behavioral and reminiscence, medications, and solution focused empowerment strategies.

### **Augmenting Protective Factors**

In addition to diagnosis and treatment, protective factors such as social can prevent mental illness from occurring in elders who reside in AL. A search of the literature revealed a number of ways to augment social contacts, opportunities to provide social support, and autonomy and choice (Cohen, 1995; Rosswurm, 1983; Rowe & Kahn, 1997). Training for AL administrators and staff could yield increases in structured opportunities for social contact within the AL. Benefits from increased contact include the reduction of isolation and sense of disconnection associated with moving to AL. AL administrators and staff could create opportunities for AL residents to give social support to peers and community members, and even by caring for plants and animals.

While spiritual advisors and religious leaders were identified as likely confidants for residents who are depressed, no mention was made of the religious leader making a mental health referral. CMHC staff could engage community spiritual/religious leaders in training about mental health needs of older adults and about ways to connect elders to needed mental health services. Also, distribution of materials published by The Kansas Mental Health and Aging Coalition (e.g., Mental Health and Aging Guide, bookmarks, tear sheets, brochures) to spiritual leaders can help inform them on how to identify older adults with mental health problems and refer them for appropriate community based services. Spiritual leaders could also be actively recruited to be members of the Coalition.

Our findings indicated that residents who were involved in planning their own move to AL avoided difficulties associated with adjusting to the AL environment. In order to circumvent risks associated with necessary moves, community providers and agencies and family members linked with the older adult can involve the older adult in the process and procedures of relocating to the AL (Rosswurm,

1983). For example, case managers need to engage elders in decision-making regarding the living space and disposition of personal items to the extent possible. Collaboration between the elder, her/his family, health care providers, case managers and AL staff could lead to a plan for relocation that allows the elder sufficient time to prepare for the move and thus, increases the possibility for a successful adjustment.

An even greater potential benefit exists if protective factors were augmented prior to having to relocate to AL. With creative efforts involving the elder, family, neighborhood groups, community agencies and service providers, elder's sense of safety could be heightened allowing her/him to choose to stay in the community with these activated supports. For example, local police could partner with an Area Agency on Aging to establish a neighborhood watch of young people who could interact with neighborhood elders and address elders' safety concerns.

### **The Implications for Aging in Place in AL**

There were a number of study findings that have implications for aging in place in AL. First, residents with mental illness were twice as likely to be discharged to an NF as residents without mental illness. Secondly, residents prefer to remain in AL environments and avoid having to relocate to a higher level of care. However, some of the residents interviewed indicated that if they needed mental health services, the services would not be available in the facility or the surrounding community. If residents in AL who have mental illness do not get their mental health needs met, because of either lack of awareness or lack of availability of services, there is a potential for further physical and mental health decline. As a result, these residents need more care. If AL facilities do not have the capacity and resources to meet these increased care needs, there is a great potential for residents with mental illness to be discharged to a higher level of care such as an NF.

Because residents prefer residential care settings, state policymakers, CMHCs and AL providers may want to consider ways to prevent relocation for this population to settings that are more institutionalized. Further, because nursing facility care is largely state funded, state policymakers have a stake in delaying unnecessary nursing facility placement for residents in AL. Having resources in place to meet the mental health needs of these residents is one way of preventing early discharge.

One recommendation to meet residents' expectations of aging in place is for facilities to conduct a pre-move in screening prior to initial assessment. According to the Assisted Living Workgroup for Federal Policies, the pre-move in screening would include, among other things, resident and family expectations of facility staff. Resident and family expectations in writing, prior to initial assessment and moving in, would avoid misunderstandings between residents, their families, and providers, as to whether the facility would be able to meet increasing physical and mental health needs of the resident.

### **Addressing Barriers to Mental Health Service Delivery**

The lack of awareness about mental health services for the AL population has consequences for policy and practice. The low use of mental health services is directly linked to the lack of awareness of the services available in the surrounding community for the assisted living residents. Most residents were not aware of either the existence of CMHCs or their services. CMHCs with aging specialists reported making efforts to acquaint elders with their services through community education and outreach. If CMHCs were equipped to further develop outreach initiatives, including specific outreach to residents in AL settings, awareness of community-based mental health services could be increased. Additional strategies for education and outreach include presentations by the Kansas Mental Health and Aging Coalition and targeted efforts by the Kansas Department on Aging using print and electronic media outreach to older adults about mental health. Television and print advertisement designed to normalize mental health treatment for older adults could be very useful. Similar media campaigns have been developed by the Kansas Health Foundation to target troubled youth at risk for suicide and drug use. These strategies could also reduce stigma of mental health, which was indicated by both residents and CMHC respondents as a major barrier to accessing services.

The lack of mental health referrals by AL staff, for residents with mental health needs, further exacerbated residents' general lack of awareness of community mental health services. Collaboration between CMHC staff and AL staff about MH services available to treat AL residents with mental illness could further increase both awareness and service use. While all elders are eligible for mental health services without a referral from their primary care physician, some health plans will only pay for mental

health treatment when a primary care physician refers the patient. Integrating referral efforts with primary care physicians is generally important and particularly so in these instances. Furthermore, joining efforts between AL staff, primary care physicians and mental health service providers establishes a firm basis from which to offer comprehensive services to AL residents. Additional benefits of this collaboration include opportunities for AL staff training about MH and aging and CMHC staff training about the mental health needs of older adults residing in AL. Possible benefits of this training include increased detection by both AL and CMHC staff of unmet mental health needs of this population.

Resources play an important role in the capacity of CMHCs to serve the MH needs of AL residents in Kansas. As the study findings indicated, CMHCs with an aging specialist served a higher proportion of older adults than centers without an aging specialist. Not unlike challenges to mental health service provision described in the literature, CMHCs experience other factors that may affect the lower number of older adults served, including geographic location, financial considerations, transportation and reimbursement regulations related to staffing (Bane & Bull, 2001).

For example, CMHC directors interviewed for this study talked about the “resource rich” urban centers and the “resource poor” rural centers. With the exception of High Plains CMHC which, according to the director covers approximately 19,000 square miles and has over 100,000 people in their catchment area, other CMHCs located in rural areas indicated they did not have the resources to have an aging specialist and therefore to serve more older adults. Future research studies may want to consider the percentage of older adults in each catchment area in order to examine more thoroughly the proportion of older adults within each catchment area being served.

Bane and Bull (2001) suggest that successful models of rural mental health service delivery to older adults include features similar to those employed by Prairie View Mental Health Center. The Prairie View exemplar of community outreach successfully illustrates Bane and Bull’s (2001) recommendations to collaborate with community leaders, to provide training for mental health professional tailored to rural elders and to build strong linkages with existing services and programs.

Another barrier that needs to be addressed is the uncertainty on the part of providers and residents about how mental health services are reimbursed. CMHC respondents cited reimbursement issues as well as a lack of qualified Medicare providers to diagnose and treat resident mental illness as major barriers. One possible way of clarifying how services are reimbursed is for CMHC staff to conduct training workshops about funding of mental health services for AL staff who can, in turn, inform residents about reimbursement and funding issues related to mental health services.

### **Conclusion**

Now is the time for key actors in Kansas to partner to improve MH services for older adults in assisted living settings. Based on the findings of this study a number of recommendations have been identified relating to the need for, awareness of, access to, and use of mental health services by older Kansans living in assisted living settings. Initial mental health screenings could identify mental illness, elders with risk factors for mental illness, as well as elders' mental health protective factors. Policy makers can establish and support collaboration between CMHCs and ALs to ensure proper training for mental health assessments and to adequately bridge assessment information with service provision. Public education could raise awareness of consumers and their families about mental health issues for older adults.

Increased awareness could also contribute to mental health service use for elders with mental health needs. The Kansas Mental Health and Aging Coalition (KMHAC) is one avenue for building awareness of elder mental health issues. Recruitment and inclusion of AL staff and religious/spiritual leaders to the KMHAC could maximize the potential for service connections made by these liaisons. The KMHAC could partner with CMHCs to make and evaluate specific outreach efforts in AL facilities. Further, state agencies, such as the Kansas Department on Aging, could target older adults and their families through print and electronic media based public service announcements to increase awareness of both mental health needs and service availability.

With increased awareness of mental health needs and of available services, efforts could be turned to addressing access to mental health services for the AL population. Training for AL facility

administrators and staff in ways to build elders' capacity for mental wellness through protective factors could result in increased access to health building opportunities. All stakeholders need education about mental health service reimbursement issues to increase access to mental health services for elders in AL. In addition, state policy makers could spearhead federal policy development and amendment, targeting specific challenges faced by a predominantly rural state like Kansas. In this way, CMHCs could be better equipped to meet and maintain appropriate staffing to meet mental health needs of AL residents while managing challenges associated with rural mental health service provision. CMHCs could also augment their existing collaborations with religious leaders and spiritual advisors to include detailed information about referring elders to mental health services.

Exemplary strategies of CMHCs that perform outreach and education to communities could be examined and replicated with setting specific modifications across the state. Unmet mental health needs of older adults means increased health services use and cost. Costs of illness and increased service use negatively impact the elder, her family, and the state. Findings from this study suggest the issues of AL residents' needs for, awareness of, access to, and use of mental health services are best approached with a two-pronged approach including prevention, augmenting mental health protective factors, and assessing and treating elders with mental illness.

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## Appendix A – Interview Guide