

## **The University of Kansas School of Social Welfare**

Office of Aging and Long Term Care

Connecting Older Kansans with Community Mental Health Services: A Pilot Study

Fiscal Year 2003 Status Report

### **Purpose**

The Kansas Department on Aging (KDOA) and the Department of Social & Rehabilitative Services (SRS) contracted with the University of Kansas School of Social Welfare's Office of Aging & Long Term Care (OALTC) to conduct the "Connecting Older Kansans with Community Mental Health Services: A Pilot Study". The purpose of this three year study is to provide training and a screening tool to Kansas Assisted Living and Area Agency on Aging service providers in order to enhance their ability to identify older adults who may be experiencing mental health problems and refer them to appropriate resources. This status report summarizes the work completed during fiscal year 2003, the first year of the three-year study. The following sections provide: background information on previous related research, rationale for the current study, an overview of the project design, detailed information about the goals and work completed related to each of the study components, a summary of study activities accomplished during Year One, and next steps.

### **Background**

The mental health of older adults has become a policy issue of increasing importance. National studies of assisted living populations indicate that nearly one-third of residents have depression and/or anxiety disorders. In order to examine the prevalence of mental health problems among assisted living residents in Kansas, OALTC conducted a study in collaboration with KDOA and SRS.

The national finding was confirmed in OALTC research; it was found that approximately one-third of residents were diagnosed as having depression, anxiety or a combination of the two disorders.

The OALTC conducted additional research on the mental health needs of the assisted living/residential health care (AL/RHC) population. In one study, we explored barriers to accessing mental health services from the older adults' perspective<sup>1</sup>. In another study, we explored the relationship between mental health diagnosis and the ability to age in place<sup>2</sup>. The analysis indicated that residents with a psychiatric disorder were nearly twice as likely to discharge to a higher level of care. In addition, we surveyed assisted living facility administrators to: document the percentage of residents with mental health diagnoses; identify policies related to the admission and discharge of older adults with mental health needs; assess administrators' awareness of available mental health services and referral patterns; and identify barriers to accessing mental health services. Results indicated that there was a lack of education/information about older adults' mental health needs, a lack of information about the

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<sup>1</sup> See report "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".

<sup>2</sup> See report "Meeting the Mental Health Needs of Elders in Assisted Living and Residential Health Care Facilities: Community and Facility Factors".

referral process and reimbursement of mental health services and a lack of facility and community resources.

Finally, we also convened a focus group of key stakeholders, including community mental health center (CMHC) aging specialists, CMHC directors, members of advocacy groups, and state level policy makers from KDOA and SRS. At the meeting, we presented our findings, requested that they provide additional information regarding barriers to accessing needed mental health services, and, asked for their assistance in identifying strategies to overcome barriers.

Lack of appropriate staff training was identified as a major barrier to accessing mental health services among AL/RHC residents. Among the workgroup's primary recommendations to address this barrier was the need for increased education of AL/RHC staff, administrators, social workers and physicians about older adults' MH needs, training to improve AL/RHC staff and AAA case managers' ability to detect and appropriately refer older adults for needed services, and increased outreach to older adults and their families to decrease the stigma associated with mental illness.

In summary, the findings from our previous research indicated the need for staff training, adequate assessment of mental health problems, and increased access to community mental health services for community dwelling older adults. Therefore, in 2002, KDOA and SRS contracted with the OALTC study to provide training and a screening tool to Kansas AL/RHC and Area Agency on Aging (AAA) service providers in order to enhance their ability to identify and refer older adults who may be experiencing mental health problems and refer them for appropriate resources. This project, "Connecting Older Kansans with Community Mental Health Services: A Pilot Study," began on July 1<sup>st</sup>, 2002.

### **Year One Project Activities**

In order to obtain guidance and input from key stakeholders in the mental health and aging field and to ensure the relevancy and usefulness of the study's activities, an Advisory Council was assembled to include: customers and representatives from AAAs, ALs, Kansas Association of Homes and Services for the Aging (KAHSA), Assisted Living Federation of America-Kansas Chapter (ALFA-KAN), NAMI, SRS-Department of Mental Health, the Kansas Mental Health and Aging Coalition, the Kansas Association for the Medically Underserved, the Governor's Mental Health Services Planning Council, the Consortium, Inc., KDOA, CMHCs, and KU Med Center. The Advisory Council members represent a wide range of backgrounds, including: family members of older adults with mental health problems, a geriatrician, AL/RHC administrators, aging specialists, AAA directors, case management supervisors, state policy analysts, etc. Representatives from the Kansas Department of Health and Environment, SRS Mental Health's Consumer Advisory Council and Office of Consumer Affairs and the Association of Community Mental Health Centers were invited to participate or to send representation to the Advisory Council but have been unable or declined to attend.

On February 7, 2003, we convened the organizational meeting of the Advisory Council (see Appendix A for meeting Agenda). During that meeting, we educated Council members as to previous research that led to the current study. We then reviewed our project plan, and discussed each component. And, we informed them about how they could assist us in our efforts. We explained that the role of the Advisory Council is to provide ongoing consultation for the strategic direction of each intervention planned. Specifically, Council members are to provide input to questions such as:

- Is the most critical data being collected, particularly in reference to questions that policymakers want answered?
- Is the most critical information being provided to customers, aging service providers and other stakeholders?
- Is the planned intervention likely to be successful and executed in such a way as to encourage the target audiences' participation?
- Is the information being collected in such a way that it may be utilized to bring about policy change?

In order to effectively meet the goals of the study, the Advisory Council has been divided into three Subcommittees, each focusing on one of the study components. The subcommittees are as follows:

#### Subcommittee 1: **Mental Health Screening Tool**

This subcommittee is charged with the development, implementation, and evaluation of mental health screening tool for AL/AAA service providers and their customers.

#### Subcommittee 2: **Mental Health Training**

The purpose of this subcommittee is the development, implementation, and evaluation of mental health training for AL/AAA service providers.

#### Subcommittee 3: **Referral Survey**

This subcommittee will provide guidance about the survey of referral patterns of older adults by ALs and AAAs to mental health resources.

**The following section provides detailed information on the work completed during Year One related to each of the study's three components.**

#### **Component One: Mental Health Screening Tool**

The first component of the study is to identify a mental health screening tool for customers of aging service providers (predominantly those who provide Medicaid services) to use in identifying potential mental health problems. The utilization of a screening tool is helpful in several ways. Not only does it facilitate identification of a need for services, but it also provides a way in which to begin a dialogue about feelings and situations that can be difficult to discuss. It also serves to reduce stigma, in that no one person or group of persons receiving services are singled out and asked about their mental health. This “normalizes” concerns about mental health and conveys the idea that this type of struggle is one that anyone can experience.

Tasks completed during the initial fiscal year of the study related to this component include:

- Surveyed other states and local sources of data for a screening tool already in use;
- Developed literature review of tools and evaluation methods;
- Assessed and compiled literature review and survey findings;
- Established Advisory Council Screening Tool Subcommittee; and
- Utilized findings and tool subcommittee guidance to develop an evaluation method for pilot sites.

During the process of surveying other states for the training component of this study, agency personnel in other states were contacted to ask about whether they were utilizing any type of mental health screening. Additionally, KDOA was contacted in reference to any tool of this nature that was being utilized within the state. Within these contexts, no screening tools were found that would be appropriate for this study.

Initially, the idea of developing a screening tool unique to the study was considered. This idea was discarded, however, as the process of designing and scientifically validating a tool such as this can take years. Additionally, the team was confident that an appropriate tool could be located, thus enabling the focus of the work to remain on the study, itself.

The search for an appropriate screening tool continued with: a comprehensive literature review, examination of National Institute on Mental Health (NIMH) resources, a survey of reference materials listing published mental health tests, and a thorough internet search. As a result of the internet search, several resources were contacted, including: Charlotte Kauffman from the Statewide Training for Local Geriatric Services in Illinois; Susan Meyer from the Older Adult Reach Program of Ohio; Shelia Harper from “The Blues is Not A Normal Part of Aging” – National Study; and Gerry MacKenzie from the Health Promotion Initiative of New Jersey. While some these contacts provided ideas for the training component of this study (discussed later), none of them were utilizing a screening tool appropriate for this study.

During attendance at a workshop, “Understanding and Managing Mental Health Problems in the Older Adult”, the presenter, Mary Doucette, R.N., referenced the Manual of Rating Scales for the Assessment of Geriatric Mental Illnesses. We obtained this manual, and considered the various scales documented there. In addition, our internal workgroup examined a number of other instruments. They included:

- ✓ The Geriatric Depression Scale (GDS),

- ✓ The Structured Clinical Interview for DSM (SCID),
- ✓ The Composite International Diagnostic Interview (CIDI) & Short Form (CIDI-SF),
- ✓ The Resident Assessment Instrument-Mental Health (RAI-MH),
- ✓ The Beck Depression Inventory – II (BDI - II),
- ✓ The Geriatric Behavioral Rating Scale (GBRS),
- ✓ The Symptom Checklist (SCL-90-R),
- ✓ The Cornell Scale for Depression in Dementia (CSDD),
- ✓ The Hamilton Depression Rating Scale (HRSD or Ham-D),
- ✓ The Multiple Affect Adjective Check List, Revised (MAACL-R),
- ✓ The Psychological Screening Inventory (PSI),
- ✓ The Holden Psychological Screening Inventory (HPSI),
- ✓ The Beck Anxiety Inventory (BAI),
- ✓ The Enderler Multidimensional Anxiety Scales (EMAS),
- ✓ The Center for Epidemiologic Studies – Depression Scale (CES-D),
- ✓ The Kessler-10 (K-10), and,
- ✓ The Kessler-6 (K-6).

The guiding ideology behind this tool is to provide AAA case managers and AL staff with a short, easily administered, and highly validated tool that does not require clinical expertise to utilize, and, that does not rely upon information about physical conditions to make determinations. It is important that the tool is brief and easily administered in order to facilitate and encourage usage. It is not reasonable to expect busy service providers to utilize a lengthy and cumbersome instrument. Despite the need for ease of administration, however, scientific validation is still a top priority. Information based on physical conditions is avoided because of the significant level of co-morbidity in some older adults and reliance on somatic symptoms can lead to false positives when screening for mental health issues. It is important to note that this is not intended to be a diagnostic instrument, but a mechanism to assist customers in identifying potential mental health problems for which they might benefit from referral to community-based mental health service providers.

Through our analysis of the various tools, we found that the K-6 is the instrument that most closely fits these criterion. The K-6 (see Appendix B) is a brief, six-item questionnaire that was developed by Dr. Ronald Kessler of the Department of Health Care Policy, Harvard Medical School for use in the annual U.S. National Health Interview Survey. It has also been used in the biennial Canadian National Population Health Survey, has been part of the Canadian Community Health Survey, was used in the Australian National Survey of Mental Health and Well-Being, and was part of the New South Wales Older People's Health Survey of 1999. The K-6 is considered to be a highly validated instrument (Kessler, R., et al, in press). Dr Kessler is being kept apprised of the utilization of the K-6 on this study, as well as providing information in the near future regarding calibration of the instrument.

The Screening Tool Subcommittee (see Appendix C for membership list) received the K-6 at their organizational meeting. They also received abstracts for the three articles that have been written about the K-6:

Kessler, R.C., Andrews, G., Colpe, L.J., Hiripi, E., Mroczek, D.K., Normand, S.-L.T, Walters, E.E. & Zaslavsky, A., (2002). Short Screening Scales to Monitor Population Prevalences and Trends in Nonspecific Psychological Distress. Psychological Medicine 32 (6), 959-976.

Kessler, R.C., Barker, P.R., Colpe, L.J., Epstein, J.F., Gfroerer, J.C., Hiripi, E., Howes, M.J., Normand, S.-L.T., Manderscheid, R.W., Walters, E.E., Zaslavsky, A.M., (in press). Screening for Serious Mental Illness in the General Population. Archives of General Psychiatry.

Furukawa, T.A., Kessler, R.C., Slade, T., Andrews, G., (in press). The Performance of the K6 and K10 Screening Scales for Psychological Distress in the Australian National Survey of Mental Health and Well-Being. Psychological Medicine.

In the process of approving the tool for use, the Subcommittee provided important feedback regarding use of the instrument. One of the Subcommittee members reviewed evidence-based practice guidelines for assessing mental health problem in older adults, and offered feedback regarding the specific criterion that the internal workgroup had identified in selecting the final tool.

Many others raised issues regarding the tool's administration, including:

- Who should administer the tool?
- When should the tool be administered?
- Should the tool be administered to everyone receiving services?
- What triggers might indicate the need for screening?

The Tool Subcommittee is currently in the process of answering these questions.

Finally, an evaluation method was developed to determine whether the screening tool met its intended purpose. This evaluation method has been presented to and approved by the Tool Subcommittee. In the process of approving the evaluation method, suggestions were given regarding the wording of some questions, a means by which to inquire about false positives, and ways to collect a more accurate count of people screened with the K-6. During focus groups to be facilitated after the training, this evaluation instrument will be collected from all service providers who utilized the screening tool during the pilot implementation. The input of the Tool Subcommittee will be gathered in order to further shape the evaluation method.

The Screening Tool will be provided to attendees during training to pilot sites in two AAA PSAs in study Year Two, and then will be included in statewide training in Year Three.

## **Component Two: Mental Health Training**

The second component of the study is to research, develop, implement and evaluate materials for training of aging service providers statewide (predominantly those providing Medicaid services). The training will focus on:

- Enhancing aging providers' knowledge of older adults' mental health needs;
- Increasing older adults' comfort with accessing mental health resources, particularly those available for Medicaid eligible older adults;

- Enhancing providers' understanding of the mental health referral process, including Medicaid reimbursement and utilization of other financial resources by Medicaid eligible older adults.

The following tasks have been completed during the first fiscal year of this study:

- Surveyed other states and regional sources regarding training modules/programs similar to this study;
- Conducted literature review regarding training materials and validation methods used;
- Obtained information from State and Federal sources of information regarding Medicaid reimbursement of mental health services and utilization of other financial resources by Medicaid eligible older adults;
- Established Advisory Council Training Subcommittee; and
- Utilized findings regarding training methods and Subcommittee guidance to develop initial draft of training for the pilot sites (see Appendix D for outline).

Through examination of websites and other data of states with similar geographic and demographic characteristics, several were identified as likely to have developed a mental health training process. Telephone interviews were conducted with: Charlotte Kauffman from the Statewide Training for Local Geriatric Services in Illinois, Susan Meyer from the Older adult Reach Program of Ohio, Shelia Harper from "The Blues is Not A Normal Part of Aging" – National study, and Gerry MacKenzie from the Health Promotion Initiative of New Jersey. Such contact yielded some materials; however, no significant training program was identified.

An extensive literature review was conducted regarding each element of the training, as well as to gather information about evidence-based practices in facilitating adult learning opportunities. A list of the material reviewed is included in Appendix E. The literature provided us with many invaluable pieces of information; they have been incorporated into the training. Among them include: practical solutions to addressing the barrier of stigma that prevents older adults from acknowledging their mental illnesses and from seeking treatment, information about treatment payment opportunities and gaps, issues related to the prevention of mental illnesses, and, practical solutions for aging provider facilitation of social supports.

Input from the Training Subcommittee was gathered at its organizational meeting on February 7, 2003. After the initial meeting, e-mail was utilized to obtain their comments and ideas regarding the content of the training, and the components of the training evaluation. A follow up meeting of the Training Subcommittee on April 11, 2003 allowed the group to identify the most critical information to be imparted in the training. Three of the most critical issues identified were:

- ✓ Overcoming barriers perceived by training attendees regarding mental health services referrals,
- ✓ Information about physical/mental illness co-morbidity, and
- ✓ Information about medication interactions.

An outline of the finalized elements of the training is included in Appendix D.

The training will be provided to pilot sites in two AAA PSAs in study Year Two, and then provided statewide in Year Three. Initially, it was planned that only AL/RHC and AAA staff would be attendees; when information regarding this study was provided to the community (through aging provider newsletters and meetings, and as part of a presentation at the 2003 Governor's Conference on Aging), we received numerous requests to receive the training. Included among the individuals requesting training were SRS Adult Protective Services (APS) staff and additional Medicaid providers (i.e., nursing facilities, etc.). Therefore, for Years Two and Three, we have requested that SRS and KDOA allow us to provide additional training to APS staff and Medicaid providers (first in the pilot PSAs, then, statewide), and to distribute the "Train the Trainer" materials that we will be developing in Year Two to them, as well.

The training will be evaluated utilizing a pre and post-test that will indicate whether training objectives were met. They will also receive a brief, post training evaluation regarding the efficacy of the training itself.

### **Component Three: Referral Survey**

The third component of the study is to conduct a statewide survey of the referral rate of AL/RHC and AAA older adults to various mental health resources and to better understand what happens as a result of those referrals. Initially, it was planned that we would survey only about their referrals to Community Mental Health Centers (CMHCs); however, several Advisory Council members commented that such referrals comprised a small portion of the referrals for assistance with mental health issues. Therefore, the survey was expanded to include AL/RHC and AAA referrals to: CMHCs, private therapists, psychiatrists, primary care physicians, consumer run organizations, inpatient behavioral healthcare units (including State Psychiatric Hospitals), and members of the clergy or spiritual/religious resources. A "baseline" survey, developed in conjunction with the Referral Survey Subcommittee, is currently being conducted through mailings to all AL/RHCs and AAAs; it will be completed at the end of the Fiscal Year. Additional surveys will be completed after implementation of the pilot and statewide trainings.

Collecting the "baseline" and post training data will be beneficial in several ways. First, it will influence the design of training materials included in Purpose Two of this study. For example, rural ALs may refer older adults less frequently for mental health services because resources are not as prevalent as in urban areas. This dynamic would dictate that training materials be appropriately structured regarding this factor. Second, information regarding the referral rates of Medicaid eligible older adults to mental health resources is of interest because these data can provide a profile of these older adults and their unique needs, thus improving service delivery to them. And, third, it will serve as one indicator of the effectiveness of the training and tool.

Tasks completed during the initial fiscal year of the study include:

- Discussed with several AAA and AL/RHC staff their ability to collect needed data,
- Advisory Council Referral Survey Subcommittee established,
- Developed survey instrument with guidance from Subcommittee for collecting AL/RHC and AAA mental health referrals (survey instrument attached as Appendix F), and

- Presently collecting “baseline” survey of mental health referrals from all Kansas AAAs and ALs for April, May, and June of 2003.

Initially, a significant amount of informal surveying was done to gain an understanding of what type of utilization information could be accessed through CMHCs. The CMHC’s contacted (Johnson County, Iroquois Center for Human Development, and Area Mental Health) reported that data identifying an AL/RHC or AAA as a referral source was not tracked and, consequently, could not be reported. Several ALs and AAAs were then contacted to ascertain whether existing databases were available which could provide referral information. Those ALs and AAAs included: Alterra Sterling House of Lawrence, Medicalodge of Kinsley, Assisted Lifestyles of Olathe, Alterra Sterling House of Augusta, Northwest Kansas AAA, Northeast Kansas AAA, and Johnson County AAA. It was reported by these facilities and agencies that, through file review, referral to any mental health service could be tracked; however, many AAAs reported that, due to the lack of CMHC staff able to provide home-based services, they made few referrals to CMHCs. Therefore, the research team designed its own data collection instrument, and, is currently utilizing it to collect referral pattern data from AAAs and ALs.

In addition, in January of 2003, we requested data from SRS regarding the use of CMHC services by older adults. As CMHCs comprise the majority of the publicly funded community mental service system and provide a significant portion of Medicaid-reimbursed mental health services, it is important to ascertain the incidence of Medicaid-eligible older adults' utilization of services and to identify demographic, diagnostic, and income-related trends that might indicate barriers needing to be addressed by policymakers, CMHCs, and other stakeholders. We have recently received notice that SRS has approved our request, and await delivery of the data from the Consortium, Inc.

## **Year Two Activities**

We anticipate that we will soon receive data regarding CMHC service usage by older adults. Once received, we will analyze for any trends that become evident, and incorporate into the training any information that appears relevant. We plan to request the same data toward the end of FY 2004, so as to compare with this year’s data. We hypothesize that CMHCs in the two pilot PSAs will report an increase in the number of older adults who contact the CMHCs about being served.

During FY 2004, the training and tool will be provided to AL/RHC and AAA staff in two pilot PSAs. PSAs will be selected based upon, in part, the prevalence of Medicaid eligible older adults residing in their catchment area. In addition, AL/RHCs will be chosen based upon, in part, whether they serve Medicaid customers.

During a previous study, “Meeting the Mental Health Needs of Older Adults in Assisted Living and Residential Health Care Facilities: Community and Facility Factors”, a focus group comprised of AL/RHC and CMHC management staff, SRS and KDOA representatives, and other stakeholders reported a lack of clear understanding regarding the CMHC reimbursement opportunities for Medicaid eligible older adults. In order to gain additional information regarding reimbursement, and, to better understand local issues that may impede Medicaid eligible older

adults from accessing CMHC services, a focus group of community mental health center financial and/or intake staff will be conducted. The resulting information will be incorporated into the training of the AL/RHC and AAA staff, and will be analyzed as part of the study's final report.

We will evaluate the training and the tool and refine the presentations based on the evaluation. Part of the evaluation will include focus groups of trainees who have utilized the tool and the information from the training in practice. The results of the evaluation will also be incorporated into work on the "Train the Trainer" approach that will enable entities providing services to Medicaid eligible older adults to train their staff and others once the study has ended.

Due to enthusiastic response by other aging providers who have heard about the study, the training may be extended to additional entities providing services to Medicaid eligible older adults as part of statewide implementation of the training and tool in study Year Three. Throughout Years Two and Three, additional information about community mental health referral patterns and barriers to mental health service usage will continue to be collected through a variety of methods, including several focus groups. Also, during Year Two (FY 2004), the OALTC will also explore the development of a pocket guide that could be used by various Medicaid aging service providers when assisting a customer with a potential mental health problem.

## **Appendix**

**Appendix A..... February 7<sup>th</sup>, 2003 Advisory Council Meeting Agenda**

Appendix B..... Mental Health Screening Tool

Appendix C..... Advisory Council Membership List

Appendix D..... Training Outline

Appendix E..... Reference List

Appendix F..... Referral Survey

**Appendix A**

**MENTAL HEALTH AND AGING PROJECT ADVISORY COUNCIL**

**AGENDA  
for**

FEBRUARY 7, 2003  
Adams Alumni Center: Phillips Board Room  
University of Kansas

- 11:00 Welcome and Introduction of Members: Rosemary Chapin, Ph.D.
- 11:10 Introduction to the Office of Aging and Long Term Care: Roxanne Rachlin
- 11:30 Research Leading to the Conception of the Project: Jeanne Hayes
- 12:00 Lunch

**Overview of MH & Aging Project**

- 12:45 Project Component One: Mental Health Screening Tool: Tara Swaim
- 1:00 Project Component Two: Aging Service Providers Training: Judith LeRoy
- 1:15 Project Component Three: Referral Rates for Mental Health Services: Tara Swaim
- 1:30 Role of the Advisory Council and Next Steps: Kimberly Reynolds
- 1:45 Discussion/Q & A: Facilitator: Kimberly Reynolds
- 2:15 Voluntary Assignments to Subcommittees
- 2:25 Schedule Next Council Meeting
- 2:30 Break
- 2:40 Organizational Meeting of Subcommittees
- 3:00 Adjourn

## **Appendix B**

DRAFT

University of Kansas School of Social Welfare

**Office of Aging and Long Term Care**

February 7, 2003

The K6 scale was developed specifically for use in the “core” of the annual US National Health Interview Survey. It has also been used in the biennial Canadian National Population Health Survey, has been part of the Canadian Community Health Survey from September 2000 (Statistics Canada, 2002), was used in the

Australian National Survey of Mental Health and Well-Being, and was part of the New South Wales Older People's Health Survey of 1999.

Please review the tool and attached abstracts (cited below), and direct all comments to Kimberly Reynolds, at: kerker@ku.edu, by March 15, 2003.

Kessler, R.C., Andrews, G., Colpe, L.J., Hiripi, E., Mroczek, D.K., Normand, S.-L.T, Walters, E.E. & Zaslavsky, A., (2002). Short Screening Scales to Monitor Population Prevalences and Trends in Nonspecific Psychological Distress. Psychological Medicine 32 (6), 959-976.

Kessler, R.C., Barker, P.R., Colpe, L.J., Epstein, J.F., Gfroerer, J.C., Hiripi, E., Howes, M.J., Normand, S-L.T., Manderscheid, R.W., Walters, E.E., Zaslvsy, A.M., (in press). Screening for Serious Mental Illness in the General Population. Archives of General Psychiatry.

Furukawa, T.A., Kessler, R.C., Slade, T., Andrews, G., (in press). The Performance of the K6 and K10 Screening Scales for Psychological Distress in the Australian National Survey of Mental Health and Well-Being. Psychological Medicine.

**PROPOSED MENTAL HEALTH SCREENING TOOL**

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

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

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

**In the last 4 weeks, how many times have you seen a doctor or other health professional about these feelings?** \_\_\_\_\_ Don't know \_\_\_\_\_ Refused \_\_\_\_\_

Note: Scoring of the instrument will be tailored to meet the needs of this project.

## Appendix C

Screening Tool Subcommittee – ST  
Training Subcommittee – T  
Referral Subcommittee - R

### ADVISORY COUNCIL MEMBERS

#### **SRS**

**Christy McMurphy, Community Integration Specialist - R**

**Leslie Rutschmann, Quality Enhancement Coordinator, Topeka Area Office - ST**

**Anita Cooper, Quality Enhancement Coordinator, Chanute Area Office - T**

**Leslie Huss, Aging Specialist - ST**

**KDOA**

**Elaine Schwartz, Senior Policy Analyst - R**

**AAA**

**Phyllis Brittain, Hays - T**

**Elizabeth Maxwell, Ottawa - ST**

**Annette Graham, Wichita - R**

**Kristy Boaz, Chanute – T**

**Brandon Ziph, Topeka – ST, R**

**CMHC**

**Rosemary Mohr, Chair of Gov.'s MH Serv.Plan.Council & Exec Director, MHA of SC KS - ST**

**Nancy Trout, Chair, MHAC, Outpatient Therapist, Johnson CMHC - T**

**LuAnn Sanderson, Aging Specialist, Bert Nash MHC - R**

**KS Association for the Medically Underserved**

**Daryl Rutschmann, Program Coordinator - R**

**KU Med Center**

**Sally Rigler - ST**

**ALFA-KAN**

**Jeanine Bahmani, Executive Director - R**

**Gary Aull, President - T**

**ALF**

**Cynthia Steel, Onaga - R**

**Consumers**

**Bryce Miller - T**

**KAHSA**

**Dana Barton – ST**

**KSU**

**Linda Gray - T**

## **Appendix D**

University of Kansas School of Social Welfare Office of Aging & Long Term Care  
"Connecting Older Kansans with Community Mental Health Services: A Pilot Study"  
FY 2003 Progress Report  
Appendix D

### **TRAINING ELEMENTS**

#### **I. Introduction**

**Pretest**

**Purpose of Training**

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

**Depression**

**Anxiety**

**SPMI**

**Addictions**

**Co-Morbidity**

**Treatment and Recovery**

**III. Overcoming Stigma**

**IV. Mental Health Screening Tool**

**V. Referral to Mental Health Resources**

**Accessing Service Providers and Other Resources**

**Service Reimbursement**

**VI. Closing**

**Post-Test**

**Refer to Additional Materials**

**Appendix E**

**PROVIDERS' REFERRALS FOR MENTAL HEALTH MENTAL HEALTH RESOURCES \*\***

**June 1, 2003 – June 30, 2003**

Staff Completing Form \_\_\_\_\_

Client # \_\_\_\_\_ County of Residence \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Payment Source \_\_\_\_\_ Name of Staff Making Referral \_\_\_\_\_

Why Referred? \_\_\_\_\_

<b>MENTAL HEALTH RESOURCES TO WHICH CLIENT WAS REFERRED:</b> (Check all that apply)					
<b>CMHC</b>		<b>Attending Physician</b>		<b>Private Therapist</b>	
Referred & Receiving		Referred & Receiving		Referred & Receiving	

Referred but <u>Not</u> Utilized*		Referred but <u>Not</u> Utilized*		Referred but <u>Not</u> Utilized*	
Unknown/Pending		Unknown/Pending		Unknown/Pending	
<b>Psychiatrist</b>		<b>Inpatient Hospitalization</b>		<b>Other:</b>	
Referred & Receiving		Referred & Receiving		Referred & Receiving	
Referred but <u>Not</u> Utilized*		Referred but <u>Not</u> Utilized*		Referred but <u>Not</u> Utilized*	
Unknown/Pending		Unknown/Pending		Unknown/Pending	

**\*If Client was referred but did not utilize, was it because (check all that apply):**  **Lack of Transportation**

- No Longer a Client  Client Refused  Guardian Refused  Cannot Afford Service  Client Died
- Client Requires Home-Based Service & None Is Available  Other \_\_\_\_\_

OTHER COMMENTS

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\*\*Please see Instruction Sheet for further information about how to complete form.  
as needed. PLEASE RETURN FORM TO:

Please reproduce form

Kimberly Reynolds, Project Coordinator  
 KU School of Social Welfare, OALTC  
 Room 9, 1545 Lilac Lane  
 Lawrence, KS 66044-3184  
**FAX: (785)864-3677**

**Please return by the 7<sup>th</sup> (SEVENTH) OF JULY. Thank you!**

**Page \_\_\_ of \_\_\_**

## PROVIDERS' REFERRALS FOR MENTAL HEALTH RESOURCES INSTRUCTION SHEET

Sheets should be completed monthly, and returned to the address listed at the bottom of the form. They may be faxed or mailed. For any questions about the form, please contact Kimberly Reynolds, at: (785)864-3797, or, kerker@ku.edu.

**Client #:** Unique number assigned by your agency so that you are able to identify the client. The number should not be the Social Security number, nor should it include the person's name or other information that would allow the client to be identified by others outside of your agency. **\*Please keep track of your assignment of this number, as follow up information may be requested.**

**County of Residence:** Name of the County in which the client currently lives.

**Age/Gender:** Client's current age/gender.

**Payment Source:** The payment source that the client would most likely use to pay for mental health services (ex. Medicaid, private insurance, Medicare, VA, self pay, etc.).

**Name of Staff Making Referral:** The staff person at your agency who referred the client to the resource.

**Why Referred:** Brief explanation of the cause for the referral for mental health resources – what triggered the referral?

**MENTAL HEALTH RESOURCES TO WHICH CLIENT WAS REFERRED: (Check ALL that apply)**

- Only check boxes when client was referred for a mental health need; do not check if client was referred for a physical health, substance abuse, or other need.
- Only check boxes when client was referred by your agency. Do not check boxes if client was referred by someone outside of your agency or if client received the referral before becoming your client.
- Some clients are referred for mental health resources at several points in time, and all of those instances should be recorded on the forms in the months in which the referrals occurred.

**CMHC:** Client was referred by your agency to a Community Mental Health Center.

**Attending Physician/Private Therapist/Psychiatrist:** Client was referred by your agency to their primary health care physician/to a therapist or professional counselor/ to a psychiatrist.

**Inpatient Hospitalization:** Client was referred by your agency to a private or public hospital, gero-psychiatric unit, etc.

**Other:** Please write in a brief description of the resource to which client was referred by your agency (example: "self help group", "consumer run organization", "grief group", "helpline", "minister", etc.).

**Referred & Receiving:** If you are reasonably certain that the client followed up on your referral by making an appointment, scheduling an intake, attending a meeting, etc., please check this box.

**Referred but Not Utilized:** If you are reasonably certain that the client did nothing to pursue the resource that you gave him/her, please check this box, and explain why in the space provided below.

**Unknown/Pending:** If you are unsure of whether the client utilized the referral, or, if you believe that the client intends to utilize the referral but has not yet done so, please check this box.

**Appendix F**

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