

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

**Connecting Older Kansans with
Community Mental Health Resources:
A Pilot Study**

**Status Report for FY 2004
December 2004**

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Fiscal Year 2004 Status Report**

Purpose

The Kansas Department on Aging (KDOA) and the Department of Social & Rehabilitation Services (SRS) contracted with the University of Kansas School of Social Welfare's Office of Aging & Long Term Care (OALTC) to conduct "Connecting Older Kansans with Community Mental Health Resources: A Pilot Study". The purpose of this three year study is to provide training and a screening tool to Kansas aging service providers serving Medicaid eligible older adults 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 2004, the second year of the three-year study. The following sections provide background information about the project, including a summary of study activities accomplished during Years One and Two, and next steps.

Background

The mental health of older adults has become a policy issue of increasing importance. While it is difficult to estimate the prevalence of mental illness in older adults, and their illness is less likely to be identified and treated, based upon U.S. population estimates, 22% of adults over age 60 may have a mental illness¹. National studies and those conducted by the Office of Aging and Long Term Care (OALTC) estimate prevalence in assisted livings facilities (ALs) to be even higher, with nearly one-third of residents having a mental illness². On the basis of such findings, the OALTC, in partnership with state agencies and private foundations, 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' perspective³. In another study, we explored the relationship between mental health diagnosis and the ability to age in place. The analysis indicated that residents with a psychiatric disorder were nearly twice as likely to discharge to a higher level of care³. 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 services³. Results indicated that there was a lack of education/information about older adults' mental health needs, a lack of information about the referral process and reimbursement of mental health services and a lack of facility and community resources.

¹ Administration on Aging. (2001). "Older Adults and Mental Health: Issues and Opportunities". Retrieved from <http://www.aoa.gov/mh/report2001/introduction.html> February 10, 2004.

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

³ See our 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".

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 (FN2). 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: 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 to identify a potential mental health screening tool, and to test the efficacy of providing training about the tool and about mental health resources to Kansas AL/RHC, AAA and other aging service providers who serve predominantly Medicaid eligible older adults. The goal of the project is to enhance providers' ability to identify and refer older adults who may be experiencing mental health problems to appropriate resources. The intent is to pilot training, refine training and then complete state wide mental health training in FY 2005. This project, "Connecting Older Kansans with Community Mental Health Resources: A Pilot Study," began on July 1, 2002.

Year One Activities

In Year One, three main components of the project were identified:

1. Selection of a mental health screening instrument;
2. Development and piloting of mental health training; and
3. Collection of mental health referral data.

In order to obtain guidance and input from key stakeholders in the mental health and aging fields in Kansas, and to ensure the relevancy and usefulness of the study's activities, an Advisory Council comprised of various stakeholders was assembled. The Advisory Council began to meet three times per Fiscal Year, with Council members assigning themselves to Subcommittees that corresponded with the three project components. Subcommittees met after Advisory Council meetings and at additional occasions; they also communicated through email.

Project Component One: Mental Health Screening Instrument

Tasks completed by the OALTC during the first 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.

Project Component Two: Mental Health Training

The following tasks were completed:

- 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 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.

Project Component Three: Mental Health Referral Data

Tasks completed included:

- Discussed with several AAA and AL/RHC staff their ability to collect data about their referrals to mental health resources;
- Advisory Council Referral Subcommittee established;
- With guidance from the Subcommittee, developed AL/RHC and AAA referral survey instrument;
- Collected “baseline” survey of mental health referrals from Kansas AAAs and ALs for April, May, and June of 2003; and
- Requested Automated Information Management System (AIMS) data on all adults aged 60 or older in the system during calendar year 2002 (AIMS is the data collection system used by the CMHCs).

Year Two Activities

During the second year of the project, the Advisory Council continued to meet and provide input. The Advisory Council is comprised of: customers and representatives from AAAs, ALs/RHCs, 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. (see Appendix A for membership list). This FY, the Council met three times, on February 20, 2004 (see Appendix B for Agenda), and August 1, 2003 (see Appendix C for Agenda), and June 4, 2004 (see Appendix D for Agenda).

Project Component One: Mental Health Screening Instrument

Based upon our research and input from our Advisory Council, the K6 was selected as our mental health screening instrument (see Appendix E). Pilot training participants received information about: how to administer the tool with the customer, how to score the tool (a 13 or higher indicated a potential mental health problem for which it was suggested that a referral be made), and about the informed consent process. From February 2, 2004 to April 30, 2004, eighty-one K6 mental health screening tools were received from pilot training participants. The two Area Agencies on Aging that participated in the pilot, Southeast Kansas Area Agency (PSA 5) on Aging and Central Plains Agency on Aging (PSA 2), provided the majority of the screens, and most were given during initial administration of the Uniform Assessment Instrument (UAI).

K6 Data By Month (Table 1)

	February	March	April	Total
# of K6s received	24	40	17	81
Average score	6.0	7.0	6.9	6.3
# of K6 scores of 13 + (referral recommended)	3	6	3	12
# of total referrals made	2	5	1	8
# of referrals to CMHCs used by customer	1 of 1 made	2 of 3 made	1 of 1 made	4 of 5 made
# of referrals to primary care used by customer	0 of 0 made	1 of 2 made	0 of 1 made	1 of 3 made
# of referrals to psychiatrist used by customer	0 of 0 made	0 of 0 made	0 of 0 made	0 of 0 made
# of referrals whose outcome remained pending	0	0	0	0
# of referrals whose outcome was unknown	1	0	0	1
# of referrals customer refused to use	0	2	0	2
# Who had seen professional (Question 11) *	0	4	1	5
# Who answered "Yes" to Question 13 **	0	1	3	4

* Question 11: In the last 4 weeks, how many times have you seen a doctor or other health professional about these feelings? ___ Don't know___ Refused___

** Question 13: Is customer already receiving mental health services? (please indicate type)

As is indicated in the table above, 24 screens were received in February, 40 in March, and 17 in April. The average scores for those months were 6.0, 7.0, and 6.9, respectively. In February, of those 24, three (12.5%) were considered to be within the referral range, and two referrals were actually made. It is important to note that while a customer's score may have fallen in the referral range, that does not necessarily mean a referral was made. Additionally, a referral may have resulted from a score that was not in the referral range. These dynamics can be accounted for by the fact that the final decision to refer was left to the service provider and his/her judgment and consideration of all of the customer's circumstances.

One of the February referrals was made to a CMHC and the other was made to a psychiatrist. At the one month follow-up, the customer referred to a CMHC was receiving services, while the outcome of the other referral was unknown because the screen was done during a CARE Assessment, and the case manager had no further contact with the customer. No customers who received the K6 screen during February reported seeing a health care professional about mental health concerns in the past four weeks, nor were any reported to be currently receiving mental health services.

During March, 40 screens were received and of those, six (15%) were considered to be in the referral range. Five were referred to mental health resources, with three customers being referred to a CMHC and two to a primary care physician. At the one month follow-up, two customers were receiving CMHC services, one had seen his/her primary care physician, one customer refused a CMHC referral, and one refused a referral to a physician. Of the 40 March screens, four customers had seen a health care professional about their mental health concerns in the past four weeks, and one was currently receiving mental health services (at the time the K6 was administered).

In the month of April, of the 17 screens received, three (17.6%) were in the referral range, with one referral being made. That referral was to a CMHC, and at the one month follow-up, the customer was receiving CMHC services. Of the seventeen screens in April, one customer indicated having spoken to a health care professional during the past four weeks about his/her mental health concerns, and three were already receiving services. Note: It is not clear why the number of screens was significantly greater during March.

In the three months that K6s were received, some interesting trends in referrals were observed:

- In all three months, no referrals for informal resources (e.g. clergy, self help groups, etc.) were reported.
- Of the eight referrals made, CMHCs were the most frequent referral source (63%).
- During the three months of reporting, an average of 15% of customers' scores fell in the referral range. This number is relatively close to the percent of older adults that would be expected to be experiencing depression and/or anxiety.
- Approximately 10% of all customers screened were referred to some type of mental health resource.
- The majority of older adults who received referrals did follow up with those service providers (63%).

It was reported in February that three mental health conversations took place that did not result in referrals, but helped the service providers to better understand the customers' past experiences with mental health resources. In March, nine of these conversations were reported and four were reported in April.

Some examples of these conversations are as follows:

- Customer "has history of depression, but it is controlled now";
- Customer "talks with pastor and this helps a lot";
- Customer "feels she can talk with her doctor about these types of things";
- Customer "has talked with her doctor about her concerns and started an anti-depressant in the past month".

An encouraging result of the use of the K6 by service providers was the reports of discussions that occurred about customers' mental health status. And, regardless of their K6 scores, referrals to mental health resources would sometimes result. In fact, some of those who accepted referrals scored low on the K6. Therefore, the K6 may not only be useful in identifying those reporting heightened distress, but, also may be a valuable tool to begin a conversation between a service provider and an older adult that results in an intervention that occurs before the older adult's mental health has greatly decompensated.

Project Component Two: Mental Health Training

Building upon research conducted in Project Year One, as well as input from the Advisory Council, an additional literature review was completed (see Appendix F). The training script was enhanced through the use of this review.

Older Adult Focus Groups

At our August 1, 2003 Advisory Council meeting, members expressed an interest in having us talk with older adults about how best to approach them about mental health issues and the use of mental health services, so as to better inform our training. Consequently, on November 3, 2003, we held two focus groups at the largest senior center in Topeka. Two additional focus groups were held in May, 2004. One was with assisted living residents at The Gran Villas of Holton, and the other was with congregate housing residents from The Sunflower Apartments in Merriam.

The purpose of the focus groups were to gain the older adults' perspectives about:

- ✓ Utilization of the K6 screening tool to maximize its ability to engage older adults and identify potential mental health problems;
- ✓ Perceived barriers to acceptance of and access to mental health services;
- ✓ Perceived impact of stigma on acceptance of and access to mental health services;
- ✓ Presentation of information about mental health resources so as to maximize older adults' usage of referrals.

We asked questions about:

1. **Activities participants enjoy:** What kinds of things do you do for fun? What kinds of things are relaxing for you and bring you pleasure?
2. **Recognizing mental health problems:** How might you know if someone has a mental health problem and has difficulty finding pleasure in life? What are some of the things you might notice?
3. **How to approach someone about getting help:** What do you think someone might say to an individual who has a mental health challenge to help them think about getting help?
4. **K6 Screening instrument:** What suggestions do you have about giving the K6 to people so that they feel comfortable about answering the questions?
5. **Feelings about using mental health services:** How do you think older adults might feel about seeking mental health services? What kind of a role does stigma play in older adults seeking mental health treatment? What barriers exist for older adults who are in need of mental health services?
6. **Knowledge about mental health services:** What kinds of things would an older adult want to know about using a mental health service?

7. **What providers should not say:** What are some examples of things those working with older adults should not say when talking with an older adult about getting help with a mental health issue? What kinds of things might they inadvertently say that may cause the older adult to not want to follow their suggestion(s)?
8. **Advice to providers:** What advice would you give to professionals who are working with older adults who experience mental health challenges?

Question # 1: Activities participants enjoy

The first question was designed to be sort of an “ice breaker”. Participants quickly gave us a list of activities that they enjoy, including:

- Reading
- Sewing/Knitting/Embroidery/Quilting
- Crafts/Painting
- Bingo
- Crosswords
- Playing Cards/Other Games
- Watching television
- Playing/listening to music
- Talking with friends/”Getting out to visit old friends”
- Cooking and baking
- Exercising
- Gardening
- Shopping
- Camping
- Attending the Senior Center

Question # 2: Recognizing mental health problems

Participants said that they might know that someone was having a mental health problem if they had:

- Difficulty interacting: One participant gave the example of someone who might be hesitant to socialize because they might be afraid of what people would think of them.
- “Withdrawn”/”Isolated”/”Too quiet”/ “Stayed in their room/apartment”/”Wanted to be left alone”;
- “Bad temper”/”Erratic” temper;
- “Can’t sleep”/ “Agitated”;
- Appeared “Irritable”/”Shaky”;
- “Refused to eat”;
- Angry;

- Forgetfulness, specifically, when someone is experiencing dementia;
- Changes in “character”: One participant described someone who was “ok” one day, “and then the next day they won’t be”, and another said that, “they wouldn’t want to do certain things”, alluding to social activities, etc.;
- “Interrupts their... daily routines”;
- “Self involvement”: One participant said that a person with mental health problems could be “more concerned about themselves than anybody around them”. Another used the example, “we had an individual that was a constant hypochondriac; constantly self evaluating their health condition”;
- One participant said, “we each act differently” [when we aren’t feeling well].

Question # 3: How to approach someone about getting help

Some of the participants were hesitant about approaching an individual to talk to him/her about pursuing mental health resources. A mental health problem was described as a “touchy” subject, that, if broached incorrectly, could cause the older adult to think that “you’re superior to them”, or that you’re trying to “boss them”. One participant commented that [the phrase] “‘mental health’ scares people” and [providers should not] “come on too strong”. Another said, “I don’t know if any of us are really qualified to give advice. They need a professional”. Some respondents suggested:

- Being accepting and supportive without giving advice: One participant said, “the last thing you’d want to do would be to become judgmental of their conditions”. And, one participant summed up the words of several by advising to not address the issue directly: “not bringing out their problem, really not to bring out the problem to them although you know they’re having a problem.” Another said, “it’s best, I think, to let them work out their own problems”.

Overall, the groups appeared more comfortable with the idea of taking an active role in helping the older adult themselves. One participant stated, “those people [with depression or anxiety] need to be visited by us”; “we don’t know what they are going through, but we can listen”. Actions that they and providers could take to help the older adults included:

- Emphasizing strengths: One participant said, “sometimes you have to tell a person that... they’re good about things and that sometimes will bring people out of the woods.” Another responded, “I think that helps a lot. Tell a person that they’re doing good.” Another said, “Be encouraging. I’m a believer in having a sense of humor and being UP around these people”.
- “Keep them busy, involved”: This was a recurring theme throughout our discussions. Instead of conceptualizing older adults with a mental health problem as being someone in need of encouragement to seek formal mental health services, focus group participants instead seemed to view them as individuals whose problem stemmed from a lack of social interaction and meaningful activities. One participant said, “A wide range of activities is half the battle”. Another participant said, “Introducing people to others who are involved and active, with a good outlook could really help

them”. Another said, “Just tell your neighbors, if you get tired, if you get lonely, I just live next door”.

Question # 4: K6 Screening Instrument

We asked them to review the K6 screening instrument and then give us their feedback on it. Several participants did have positive feedback, including:

- [The K6 was] “very worthwhile”;
- “I think they are all good questions and they all apply”.

However, some voiced concerns, including, that:

- Asking may emphasize the problem: Several mentioned that asking a person questions such as how much they’d felt sad would cause them to focus all the more on how badly they felt. For example, several of the participants said that using words like “hopeless” and “worthless” were “awful down” and “even if you didn’t feel worthless or hopeless and someone asked you that, you may start to think about it and wonder if you should feel that way”.
- Asking about feelings was not as helpful as suggesting an activity: Many participants felt that giving older adults with mental health problems suggestions such as: taking a car ride, going shopping, etc., would be more helpful than dwelling on a problem that might be in their past.
- Asking about past problems will cause the older adult to dwell on them: One participant stated that, “I think that [it] would make them more depressed...” Another suggested that questions should be re-stated to include brainstorming about potential helpful actions; the example she gave was: “Hey, I’ve noticed you’ve been depressed these four weeks, what can I do to make you cheer up”. She said that this might cause the older adult to think, “What might I do to cheer up?”
- Other issues may mimic a mental health problem: One participant gave the example that: “I may not seem like myself or maybe I’m not as talkative, but it could be because I am getting ready to hear about test results from my doctor, or even have a family situation that I am stressed about”. Another participant said that asking questions such as “feeling like everything is an effort” applies to the physical aging process, rather than her mental health. For example, one said that, “We have everything done for us here and if we had to do it ourselves, everything would feel like an effort. Sometimes it feels like an effort to even get out of bed, but that’s because my body is not the same as it used to be. I’ve gotten older and everything is an effort [physically]”.
- Questions should come from someone you know: What several respondents said can be summed up by one person, who remarked, “I would say that she should meet this person several times to find out, instead of just coming right out with it”. Another said, “I believe they don’t realize they need to go [get help] and [it’s] the responsibility of a loved one to take care of that.”

Question # 5: Feelings about using mental health services

When asked about how someone might feel about accessing mental health services, participants responded:

- One woman said, “If I need it [mental health services], I’ll go”.
- [It would be] “pretty scary”.
- One said, “they would do that as a last resort”, and, when asked why, the participant said that, it was because “they [would] “feel they have failed in life”.
- “Stigma”: One participant volunteered that this reluctance to use services was due to the “stigma” that surrounded accessing a resource. It was felt that the “embarrassment” that people experienced was a significant barrier. One participant talked about how, “you can break a leg and no one thinks a thing of it, but you go to the psych ward and it’s bad”.
- “Denial”: One participant said that, “a lot of people have mental problems and are in denial. They think surely it’s not them.”
- “Costs of using services”: One participant said, “a lot of people wouldn’t do it because it costs a lot of money”. Another said, “Your finances could make you feel depressed, then you can’t afford to get help for the depression”.
- “Why Now”: Some participants remarked that, people may have lived with their mental health problems for many years, so, why bother getting help at this stage in life. “What would be the use?”, is the question that one participant said that an older adult might ask.

Again, participants emphasized informal supports, instead of traditional mental health services. For example, one said, “find somebody in that facility that is more upbeat than the person is that’s experiencing this [problem], and then introducing that more upbeat person to that individual and let them develop a relationship.... The person working with them might not be able to communicate to them effectively as maybe somebody who is upbeat and is living there and experiencing maybe the same thing and they can both help each other.” One said, “you know, I think a lot... could be done through a friend”.

Question # 6: Knowledge About mental health services

The knowledge level among older adults was varied:

- One participant stated that, “I would just go to the director [of my congregate living organization] and ask her to help me find a psychiatrist”. Another said, “My daughter is a social worker and knows where to send me”.
- When asked about places they would go to talk to someone about mental health, they responded, “talk to family”; “go to your doctor”; “talk with a good friend”; “go to therapy”; “see someone at Johnson

County Mental Health”. After this discussion, one said, “Those are all available, but transportation may not be”. Other participants reported having little or no knowledge about places to go.

- Some older adults believed services were less available in rural areas: One said, “I would think that, if there’s any place in the state of Kansas, I think maybe it would be here, in Topeka, in Shawnee County.... But, certainly not elsewhere, you know.”

Question #s 7 & 8: What providers should *not* say when talking about mental health issues

- Don’t tell the older adult how they feel: One person gave the example: “Boy, you’re really upset today”.
- Don’t dismiss the older adult because of their mental health problems: One participant said, “a lot of people are too quick to judge and say, ‘oh, don’t pay no attention to him or her, they’re crazy’”. Participants said that such statements made older adults want to isolate, that they made them lose their “self worth”, all of their “confidence”.
- Be careful what words you use: Many of the participants said that people should avoid words like “crazy”; also, they cautioned against making statements that sounded as if someone was talking at the older adult, instead of with them; for example, “you better get help”.

Question # 9: Advice to providers working with older adults with mental health problems

- Establish rapport: One participant stated, “Don’t tell them ‘I know you are feeling bad and I want to talk to you’”. She then said, “Ask if they want to talk”; “talk about the weather or play a game.”
- Recognize that, “Everyone has their own time frame”. One participant said, “don’t ever tell someone you don’t have the time to talk about this [a mental health concern]”. It is hard enough to get the courage up to start this conversation and if someone avoids it, the conversation may never take place.”
- Normalize the older adult’s feelings: Once again, this was a main theme in our discussions. Many voiced the importance of normalizing feelings. One participant said, “talk about how they aren’t alone”, and advised, “don’t be scared to be open and honest. Be a good friend and listener”.
- Make encouraging statements: One participant said, “I have noticed that older people, when they are in assisted living or nursing home or wherever, if they’re away from their family, they feel like they’re unloved and unwanted and that they’re useless... and you’ve got to kind of encourage them. Let them know that their family will come and visit them on visiting days and do what they can.”
- Ask the older adult how you can help;
- Be “Gentle”, “Caring”, Patient;
- Ask the older adult what they want to do: Again, many of the participants said to ask them what activity they like, then assist them in getting involved in it.

- Listen: One participant said, “Some of us may go on and on and it may be boring, but we just need to listen”. Another said, said, “Stop, make time, be positive, pay attention to us and be sincerely interested”.

Use of Focus Group Content in the Pilot Trainings

There were several main themes from the focus groups that we integrated into the pilot training content:

1. The mental health problem should be discussed with a person they know:

In all of their comments about how to approach an older adult experiencing a mental health problem, focus group participants stated that interaction should take place with a person with whom the older adult already had an established relationship. Therefore, establishing rapport was included in the K6 section.

2. Emphasis on informal supports and activities:

This was an important point to make in the training, because, many training participants voiced their frustration about not having formal mental health resources readily available, but, at the same time, they described an abundant array of informal resources, often that, they’d developed themselves. For example, one of the assisted living facilities has had its social worker organize a support group at its facility. In one of the early trainings, someone made the point that, perhaps the main reason that these resources aren’t viewed as equally appropriate as formal mental health services is that no one bills for them. Another reason might be that, if it isn’t part of the traditional medical model of care, it doesn’t have the ability to help the older adult as much. These are not views that we necessarily heard from the training participants themselves; it was more what we heard that they felt that their regulators, funders, and customers thought.

3. Inadequate transportation to services:

Older adults often report that they don’t know how to access transportation to mental health services and that this is a primary barrier to obtaining needed services. Additional specific information and local resources about transportation will be incorporated into the training.

4. Cost of using services:

Not only will providers receive specific information about the costs of mental health services; they will also be informed about the focus group participants’ lack of knowledge about how to pay for services, and how this may serve as a barrier.

5. Confidentiality:

Several participants were concerned about the confidentiality when obtaining services, which could serve as a barrier. Educating older adults about the confidentiality of mental health service providers will be a suggestion added to the training.

CMHC Interviews

In addition to the focus groups, we determined that input from the CMHCs regarding their perceptions about older adults' access to, knowledge of, and use of their services would enhance the training. To explore these issues, every CMHC was contacted by its respective SRS Mental Health Field Staff and asked to respond to a series of questions, shaped by the input of the project's Advisory Council, regarding services available and utilization by older adults (see Appendix G for survey questions). The assistance from the Mental Health Field Service Staff was invaluable in the collection of this information.

Approximately one-third of the CMHCs responded. Respondents represented a diverse cross-section of rural and urban Centers, population size, geographic size of catchment area, and access to services (i.e. aging specialist and geropsychiatric inpatient services). It was hypothesized that CMHCs across the state are more different than they are alike, and this was found to be the case based on the collection of this information. Services offered and the way in which older adults access CMHCs varied from center to center.

Different agency representatives responded, ranging from Community Support Services (CSS) Directors, to Executive Directors, to Aging Specialists. The staff completing the surveys were chosen by the SRS Mental Health Field Staff or center personnel.

The respondents were asked to estimate the number of non-SPMI older adults who access their center each month. They were also asked about: the way in which those people are referred, the major funding source for the older adults they see, the impact of stigma upon the older adults that seek services from their agency and how staff address that issue, the center's ability to provide in-home services, and the way in which access to transportation impacts service utilization patterns.

The general response to the question, "About how many non-SPMI older adults access your center for services each month?" was "not very many". This ranged from one or two new customers coming to the center via crisis referral, to "less than 10 per month" from other sources. One center, however, reported good success via self and physician referral. This center appears to have a strong community outreach program, and the Executive Director has been in that position for many years and is well-known in the community.

Many different referral sources were reported including: family members, some primary care physicians, community outreach workers, through the CMHC's crisis services, and self-referrals.

There was not a much variation reported with regard to funding source. The major funding source utilized was reported as Medicare. Medicaid was reported to then be billed secondly, if applicable.

Stigma was reported as a major barrier by all but one center. In the one center where it was not reported as a problem, the Executive Director has been involved in educating the community for many years. They also have a strong relationship with law enforcement and the health care community. For example, the center facilitates an Alzheimer's caregiver support group at the AAA.

Other centers reported several strategies for addressing stigma and making their services more accessible to older adults. One respondent emphasized couching the older adult's mental health issues in a medical

or physiological context. Also, they establish many relationships with primary care physicians, because “older adults tend to listen most to their doctors”. Another respondent reported being aware of the importance of language in working with older adults and, in doing so, normalizing mental health problems older adults may be experiencing. For example, she facilitated a community outreach program at the local Senior Center entitled “Mood Boosters”, in which she avoided using clinical terminology.

Most respondents indicated that their center does not provide in-home services for non-SPMI adults. Compounding this barrier is that transportation seems to be a significant issue for all centers, regardless of whether they are urban or rural. The general response was that lack of transportation negatively impacts older adults’ ability to access services and decreases service utilization.

The interviews with the CMHCs were used in the training curriculum by a) providing strategies for combating stigma, b) informing participants about the opportunities and limitations of CMHC service access by older adults, and c) to provide specific information about service reimbursement methods.

Pilot Trainings

This spring, we completed our pilot of the training content. The one day trainings, “Connecting Older Kansans with Community Mental Health Resources: Strategies for Aging in Place”, were held in:

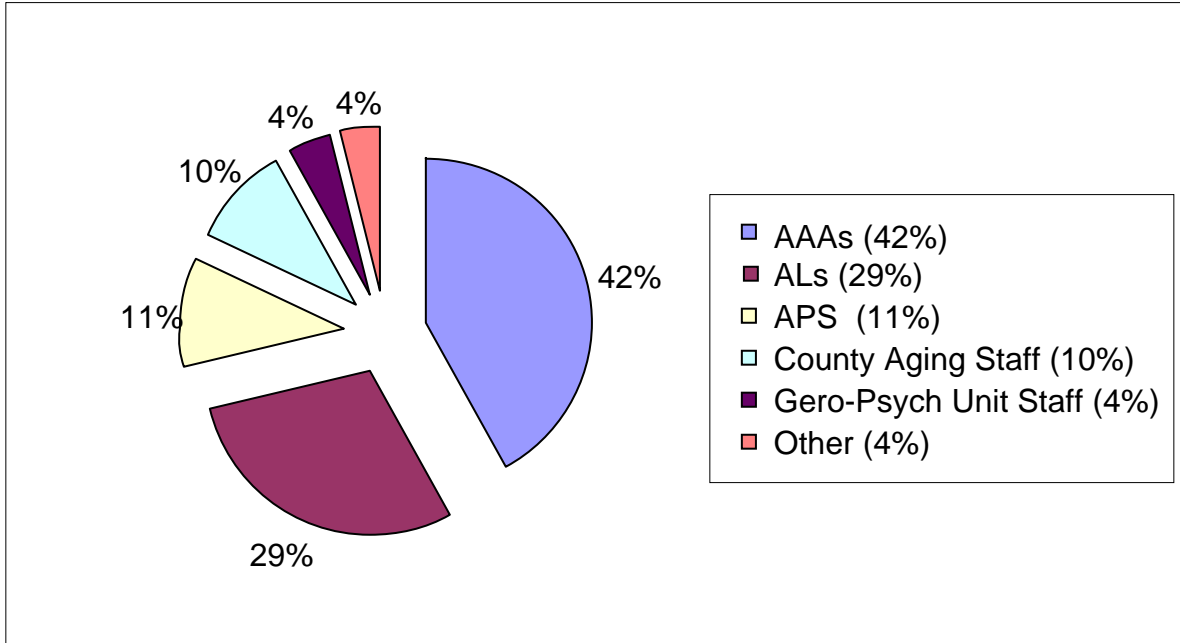
- Chanute: Jan. 28, 2003, where 11 aging service providers attended;
- Chanute: Jan. 29, 2003, where 17 aging service providers attended;
- Wichita: Feb. 4, 2003, where 24 aging service providers attended;
- Wichita: Feb. 5, 2003, where 20 aging service providers attended.

Additional participants registered for Wichita; however, snow and ice prevented them from attending.

Pilot sites were selected during the fall of 2003. We asked the Area Agencies on Aging (AAA) directors to volunteer as pilot sites, and, five did so. As the needs and experiences of older adults may be unique in rural and urban areas, we wanted to have one rural and one urban site. And, as this project is funded through a Medicaid contract, it was important to focus on areas with the highest concentration of Frail Elderly Medicaid Waiver recipients. Therefore, we selected as our urban site, Central Plains (CP) AAA, and our rural site was Southeast Kansas (SEK) AAA. Central Plains AAA serves: Sedgwick, Butler, & Harvey Counties, with Sedgwick County containing the largest city in Kansas, which is Wichita. Southeast KS AAA serves: Woodson, Allen, Bourbon, Wilson, Neosho, Crawford, Montgomery, Labette & Cherokee Counties, which are the nine counties in the southeast corner of Kansas.

We contacted all of the AL/RHCs in the 12 counties by telephone, then faxed registration forms to all of them. Through our contact at CP AAA, Annette Graham, and, at SEK AAA, Kristy Boaz, we were able to invite all of the AAA staff. Also through them, some of the county aging staff and various other types of aging providers asked whether they could attend, and, we invited them to do so. Rosalie Sacks, who supervises the SRS Adult Protective Staff requested that her staff be able to attend. And, we invited the CMHC in the SEK AAA area who is just beginning a program to provide home-based services to non-SPMI older adults. The makeup of the training participants was:

Pilot Training Participants (Chart 1)



As an incentive, training participants received:

- ✓ 6 CEU hours available for: Assisted Living Administrators, Licensed Social Workers, RNs and LPNs, Clergy, Registered Dietitians, Audiologists, Speech Pathologists;
- ✓ Breakfast and lunch;
- ✓ Travel reimbursement.

Training Agenda (See Appendix H)

The main elements of the training were:

- Overview of Mental Illness:

This included basic information about the prevalence, diagnosis and treatment of depression, anxiety, and other mental illnesses. During this time, we also discussed physical conditions that might co-exist with mental illness, as well as dementia. And, we talked about addictions, specifically, to: alcohol, prescription drugs, illegal drugs, and gambling. While we didn't want to duplicate the presentation that has already been developed in conjunction with the "Mental Health Guide for Older Kansans" project, our Training Subcommittee agreed that we needed to provide some basic information about mental illness to ensure that everyone had some working knowledge about it before we discussed resources and related topics. For those who wanted more in depth information about mental health, we gave contact information for the KS MH & Aging Coalition's Speaker's Bureau, and a copy of the "Mental Health Guide".

- Overcoming Stigma:

In this section, we discussed how stigma can negatively impact an older adult's willingness to utilize mental health resources, and, encouraged participants to share strategies that they found successful in combating stigma. This section ended with a short video of an address by former Surgeon General David Satcher.

- K6 Mental Health Screening Tool:

This section included information about the tool itself, and how to use it with customers. We also discussed the necessity of the informed consent, and, the procedure for sending completed copies of K6s to us. Finally, we talked about courses of action to take based on the outcome of the screening. In particular, this section, and the section about referrals, incorporated the information gathered from the older adult focus groups.

- Referral to Mental Health Resources

In our final section, we discussed how to access both formal and informal resources. We focused the majority of our information about formal resources on those service providers who serve Medicaid eligible older adults (e.g., the CMHCs, etc.).

Training Participant Questions and Comments

All four of the days, we were fortunate to have participants who asked many questions and gave us valuable insights, and, those discussions have been the basis of how we re-shape the training for our planned statewide implementation next fiscal year. Some of the most common questions and comments that we heard included:

- ? How do I know whether an older adult has a particular mental illness?

What we tried to emphasize was that, while an older adult's diagnosis could be important because it might impact what type of services he received, or whether services were reimbursed by public or private benefits, the training participants did not have to make a determination of diagnosis themselves. The only had to recognize that the older adult was experiencing a mental health problem, and then to assist the older adult in utilizing a resource that would help them address that problem.

- ? Would a particular problem cause an older adult's mental illness?

For example, could a financial or health crisis cause a person without a mental illness to have one. Again, we emphasized that the etiology of the problem was not the issue so much as assisting the older adult access resources that would help him to handle it.

- ? Explain a particular aspect of that statistic.

Participants did not take the statistics that we provided "at face value". Instead, they often asked for details about the study from which it originated.

? What can you do if someone won't go for help?

When this question was raised, we asked participants for their responses, and, we received many creative answers to this question. However, many voiced similar frustrations, and some commented that it was not always the older adult who was unwilling to access a resource, but that the family was resistant to it.

? How do I alert their doctor of a potential problem?

While HIPAA was mentioned as a barrier to communication with other providers, the primary issues were that the participants felt that the doctors either didn't understand the extent of an older adult's problem, and, in some cases, this was even when they and others involved were able to communicate concerns with the doctors; or, the doctor would continue to prescribe medication, but recommend no other type of treatment, even though the older adult didn't appear to improve. We discussed potential strategies for educating physicians and advocating for customers.

? Should the K6 be completed during a CARE Level I assessment?

After discussion with both pilot sites and with Valerie Merrow, KDOA CARE Manager, it was determined that those participants who administer CARE Level I assessments should administer the K6, as well. This decision was reached in hopes that it might assist in diversion efforts.

Pre/Post Training Questionnaire and Training Evaluation

In order to determine the effectiveness of our training, we asked participants to complete a nine item, multiple choice questionnaire. The results can be found in Appendix I. Also, at the end of each day, we also asked the participants to evaluate the training. They were asked to rank six statements, using:

1 – Strongly Agree 2 – Agree 3 – Neutral 4 – Disagree 5 – Strongly Disagree

The following displays the question and the score for each question:

Question # 1: The presenters were knowledgeable about the topics they presented.

Average Score: 1.4 (Strongly Agree)

Question # 2: The facilities were comfortable.

Average Score: 1.8 (Agree)

Question # 3: Training materials were useful to me.

Average Score: 1.7 (Agree)

Question # 4: The training presentation kept my interest.

Average Score: 1.8 (Agree)

Question # 5: I would recommend this to others.

Average Score: 1.8 (Agree)

Question # 6: Overall, I was satisfied with the training.

Average Score: 1.8 (Agree)

Comments at the bottom of the evaluation form included: “Good job of advocating for relationship building”; “include more sites on where statistics come from – liked the slides with web pages”; “add slide on resources and ways to connect with elderly [who are] reluctant customers on normalness of mental health”; “need slide that gives acronyms”; “used humor. A fun day”; “could have spent less time on elementary concepts, i.e. “stigma””; “I am anxious to use the assessment tool”; “I believe it will be helpful in practice”; “Thanks, we enjoyed the training! Very informative”.

The training is currently being revised based upon comments from training participants and other stakeholders. The most significant revisions are: 1) to include information about local mental health resources, and the reimbursement (in particular, Medicaid) and travel issues involved in accessing them; and 2) to “break out” part of the training between those working in congregate housing (including Section 8 housing, assisted living facilities, and nursing facilities) and those who do not (AAAs, county aging staff, etc.). Splitting the groups will allow for presentation of information that is more specific and based upon the needs of those staff and their customers.

In order to answer questions raised by training participants, and to maintain participation in the return of K6s/reporting of referral information, we began mailing a bimonthly newsletter to all participants and Advisory Council members (see Appendix J).

One Month Training Follow Ups

In March 2004, OALTC staff traveled to training participants’ agencies to collect their thoughts and impressions about the use of the content provided in the training, including the K6, and to address questions that may have arisen. More than half of the training participants attended these meetings, including representatives from: the Southeast Kansas Area Agency on Aging, the Central Plains Area Agency on Aging, Medicalodge of Coffeyville, Vintage Place at Halstead, and Park West Plaza of Wichita. The questions asked of the participants were divided into two sections: the first section addressed the usefulness of the training, itself, and the second section dealt with participant impression of the K6 screening tool. The questions and a summary of responses are as follows:

1. What areas of the training were most helpful to you? Why?
 - The mental health information was a “good refresher”.
 - Information on stigma was well-received. There were positive comments in reference to the discussion of the use of strengths based language as one way to combat stigma.
 - There was appreciation of the explanation of the CMHC system and how to access their services.

2. Since the training, has the number of referrals to mental health resources increased?
 - One respondent indicated that since the training, their supervisor has encouraged him to be even more creative with possible referral resources.
 - All participants voiced frustration with the lack of mental health resources for older adults.

3. Since the training, has the variety of resources to which you refer increased?
 - Overall, commensurate with the response to question number two, there was frustration voiced with a general lack of basic mental health resources for older adults.
4. Do you have any suggestions on how to improve the training?
 - All sites suggested including some case studies to discuss within the context of the tool training sections.
 - More specific skill training was requested in reference to talking with older adults about mental health. For example, one case manager had a customer who responded to the suggestion of a mental health referral with the comment, “I’ve felt this way my whole life. Why should I get help now?” The case manager indicated that she would like training to help her address this type of response.
5. Any other comments about the training?
 - All sites indicated the need for more specific referral resources and contact information.
6. Do you think that using the K6 has helped you identify older adults who are experiencing a mental health problem? If so, how has it been helpful to you? If not, why?
 - Several respondents indicated that they feel they are already able to identify customers’ mental health problems, and that identification is not the barrier, it is the lack of services.
7. Do you think that using the K6 has led to an increase in the number of referrals to mental health resources?
 - Again, many participants voiced frustration with the lack of services.
8. What are your impressions of using the K6 (a) at initial assessment, (b) during the full Uniform Assessment Instrument (UAI), (c) during the CARE Assessment, (d) at the time of triggers?
 - It was indicated by many participants that utilizing the K6 during the first meeting (whether that be the UAI or upon admission to an AL/RHC) was not as helpful as it might be at later meeting when some level of rapport has developed and the older adult is more comfortable with the service provider.
 - It was stated by several respondents that the K6 did not seem appropriate during a CARE Assessment because: 1) Older adults who they see within the context of a CARE Assessment have so many needs that the idea the older adult could be diverted via access of mental health services isn’t a reasonable expectation, and 2) results of a K6 given in this context are “skewed because it is generally such a sad time for them”.

- Several participants stated they would rather have the freedom to utilize the K6 at their discretion, rather than having the requirement to use it at the above times.
9. What is your impression of the identified triggers? Are they useful in accurately indicating the need for use of the K6? Are there any additional triggers that need included?
- The list of triggers was well-received and there were no suggested additions.
10. About how many older adults have refused to consent to KU receiving the K6 and what was different about instances in which customers didn't consent (why do you think they refused)?
- One site stated there was a 50% refusal rate. They noted that, in their opinion, those who refused were those who most needed the assessment. They believed that the refusals were mainly due to the process required to gain customers' informed consent, which they saw as awkward and somewhat threatening to the customers.
 - The AL who utilized the K6 reported no refusals, and did not see the informed consent process as problematic.
11. When customers refused consent, did you still administer the K6?
- No respondents indicated that the K6 was administered to customers who refused the consent.
12. Was there anything important that needed to be explained differently or in more detail during the training about the use of the K6? If so, what?
- One participant requested additional information about how older adults experiencing mental health problems present (in terms of symptoms).
13. Have you encountered any difficulties using the K6? If so, what are they?
- It was voiced by two sites that the informed consent process was awkward.
14. Any other comments or suggestions?
- It was suggested that the K6 be given before the verbal consent was read to the customer.
 - Several participants stated they liked the brief nature of the K6 and that it is a helpful way to begin to talk with customers about mental health concerns.

Final Training Follow Ups

In early June, OALTC staff once again traveled to training participants' agencies to collect additional information for the statewide implementation of the training. The following are the questions and summarized responses.

1. We've received feedback that aging service providers want specific, local information about the local mental health resources, both formal and informal. The information that we've heard requested is usually about costs of services, availability of support groups and other informal resources, and transportation resources. Do you have other suggestions? Do you have suggestions about local representatives of those resources who might be willing to give brief presentations at our future trainings?
 - One respondent said that due to the area and number of counties they serve, we would need to provide resources on all of the above in each of those counties. She said that, "Each county has its own group of resources and they each require different information in order to receive the service".
 - One respondent said, "Four County has a new Senior Outreach Program and we all need to know about that".
 - The Parsons Ministerial Group has an outreach program that was mentioned later in the discussion and could possibly benefit the training participants by informing them about their services.
 - "Could you please bring in COMCARE to speak about what happens when an older adult is referred?".
 - Information about: Prairie View, hospice, gero-psych units, spiritual resources, APS, CAPS (through COMCARE), and transportation services were all mentioned as helpful additions to the training.
2. What would you like to know about the relationship between spirituality and mental health? Any other issues about spirituality that you'd like to have information about?
 - One respondent discussed how church support does play a role in some older adults' lives; however, many older adults she works with have not been able to attend church due to lack of transportation.
 - Many respondents discussed that if older adults had transportation to church services or regular in-home support from their church, they felt it would contribute to their mental health.
3. Are there any sub-populations of older adults you would like to have more information about (in terms of their mental health)? If so, what might that be?
 - Several respondents mentioned the Native American population.
 - One participant said that they would like to know how a particular cultural group views mental health and how this affects them not seeking care or services.

4. What would you like to know about the relationship between low income and mental health?
 - Several respondents had a discussion about whether poverty or mental health problems was the primary challenge faced by those experiencing both; however, no one identified any specific information that they would like addressed as part of the training.

5. What do you see as the top three contributing factors to anxiety and depression in your customers?
 - Loneliness
 - Loss
 - Change in Health
 - Loss of Independence
 - Divorce/loss of spouse
 - Children dying before them
 - Self-neglect
 - Neglect, abuse, and exploitation from family members

6. What would be the top three things you would notice about a customer that was depressed or anxious? How do they look? Do you have any stories that you'd like to share that we might include in the training about a customer who may not have initially appeared to have a mental health problem, but who you learned was experiencing such a problem?
 - "Posture, like slouching";
 - "Out of control spending" such as through "FingerHut" or "Reader's Digest" Sweepstakes";
 - "Frequent moving from place to place to place";
 - "Crying";
 - "Not leaving the house or apartment";
 - "Inactive";
 - "Wearing pajamas all day";
 - "Hoarding" – though not by itself – participants said that other characteristics would need to also be present for it to indicate a mental health problem;
 - "Constantly living in the past, but not in the happy parts - rumination and guilt, not reminiscence";
 - "Using three or four doctors and pharmacies";
 - "Overusing their medications and self-medicating";
 - "I had a client who never showered, smoked all day, and the apartment smelled bad";
 - "Decline in personal hygiene", such as being unshaven, or having body odor – participants discussed that it was the change in hygiene that might indicate a mental health problem, not just poor hygiene itself;
 - "Change in memory";
 - "Increase in irritation";
 - "Loss of appetite".

7. What do you think most aging service providers would like to know about dementia? What would be helpful?
- Participants had no specific suggestions or comments.
8. Does anyone have another story we might incorporate into the training about mental health and your customers? Any stories about problems with gambling? Physical problems intermingled with mental health problems so significantly that it was hard to tell them apart? Overcoming stigma?
- One participant said: “Some people who need help don’t want it. I had a client who was in bad shape. She drank, her apartment smelled of urine and when I visited, she was irate - swearing, etc. She might not want the help. Do I quit offering?”
 - Another respondent stated: “One of my clients hasn’t left the house for 5 years. Even her doctor comes to the house to see her. She says she has ‘prayed to die’, and is in so much pain. This is a woman who could benefit from in-home therapy, but we don’t have it”.
 - One participant said: “What seems hopeless, many times, with the right services, can turn around”.
 - And one respondent reported about a client with intense anxiety who received additional services through a HUD housing program. The program included two – three weekly three-hour visits from a service coordinator. The respondent stated that her mental health problems had greatly improved.
9. Generally speaking, at what point in a relationship with a customer would the use of the K6 be most useful to you and your customer?
- One respondent inquired about the possibility of the K6 being included in the UAI and if that was the case, the best place for the K6 to be incorporated, in her opinion, was in the health module. Several others agreed with this.
 - One participant said, “They usually tell me this information [diagnosis of depression or anxiety] by the first visit”, so she didn’t see a problem with asking questions about mental health at the initial meeting.
 - Another responded that, “If you get to the nutritional assessment and they haven’t talked about mental health problems yet, another way to investigate this is through asking the poor appetite question. Sometimes a poor appetite is simply situational, like if they have been in the hospital for quite some time, but if they say they have a poor appetite and there are no health changes occurring, it could be a mental health problem”.
 - One respondent felt that the first home visit was the optimal time to conduct the K6, because that is, “when you are gathering all the other information”.

- Another participant felt that the third visit with the client was the best time to address mental health problems, because a stronger rapport was established by then. However, she said that, “If a person appears depressed on the first visit, I may want to talk about this then” [and complete the K6].

10. How long does it take you to complete the K6?

- One respondent said, “No more than five minutes if it’s uneventful”.
- Another said, “It depends, because if it brings up some issues, then you could be there for an hour”.
- One participant responded, “It depends on the client”.
- Another said, “Five to ten minutes, or 15 minutes to an hour!”

11. Other than the pilot consent process, have you ever had problems completing the K6 with a customer? If so, what are those problems?

- One participant said that there should be a mechanism in place to track a referral made as a result of the K6, stating: “We need a way to know if services are being accessed”.
- One respondent said, “A lot of clients just didn’t want to do it”.
- Another participant said, “It may be better received if there is some flexibility on when we could use the K6 and if some rapport is established before talking about MH problems”.

12. Did you feel you needed more training to complete the K6?

- Several respondents stated that they wanted some, “specific things to say” in order to, “counsel customers and get them ‘over that hump’ of admitting they have a mental health problem, and if they do seek help, what the provider is going to do to help them”.
- One participant said, “Mental health is a touchy issue, and more training is always good. People may start pouring it out [about their mental health problems] and I don’t know what to do”.
- Another respondent responded that, “You don’t want to open up a deep wound and then leave it unaddressed”.

In summary, most pilot training participants wanted additional information about mental health resources that were local to the areas they served. Also, while they were able to describe characteristics exhibited by older adults that could indicate the presence of a mental health problem, they stated that they wanted additional information about how to address the challenges of discussing mental health problems and potential referral sources with the older adult. And, as with the older adult focus groups, they discussed

the need to establish rapport with the older adult before addressing the issue of potential mental health problems. All such comments are being addressed in the revision of the training materials.

Project Component Three: Mental Health Referral Data (AIMS)

Because the project’s target population is Medicaid eligible older adults, it was determined that referral data collected should be focused on older adults accessing the CMHCs, as they comprise the publicly funded community-based mental health system. In order to determine the number of older adults who’d been referred or who had referred themselves to CMHCs in 2002, Automated Information Management System (AIMS) data for all adults aged 60 and over was requested from SRS. The final data set was received from the Consortium, Inc. in October, 2003.

In this report, the OALTC presents a preliminary analysis of data from AIMS. “The AIMS database was developed to collect outcome and service data from Community Mental Health Centers (CMHCs) and their Kansas affiliates. AIMS data have been used in grant applications to secure federal block grant money, to monitor compliance with inter-agency contracts, and to meet legislative mandates and the needs of multiple stakeholders in the Kansas public mental health system”⁴. AIMS data are updated annually or when a status change occurs (only for individuals with severe and persistent mental illness (SPMI)).

Our purpose for analyzing the AIMS data was to compile a profile of older adults age 60 and older who have accessed Kansas CMHCs, and to inform project training initiatives. We requested the following information for all persons whose records were active in the AIMS database between January 1, 2002 and December 31, 2002:

AIMS Data Requested (Table 2)

• Education	• CMHC
• Gender	• Impairment(s)
• Annual Income	• Functional Level
• Date of Birth	• Primary Diagnosis
• Race/Ethnicity	• Secondary Diagnosis
• Resident County	• Chronicity
• Initial Contact Date	• Prior Hospitalizations
• Appointment Date	• Payment Source(s)
• Admission Date	• CMHC Services utilized
• Referral Source	

Data were received from all 29 CMHCs. The resulting analysis has been organized in this report to first provide a descriptive profile of all customers on whom data was received; next, is a comparison of selected data for customers with and without a severe and persistent mental illness (SPMI).

⁴ Kansas Department of Social & Rehabilitation Services Department of Mental Health, Substance Abuse Prevention, Treatment & Recovery. (2003.) “Automated Information Management System Manual”. Retrieved from: www.srskansas.org/hcp/MHSIP/AIMS/AIMSManual8-27.pdf December 22, 2003.

Profile of Adults Age 60 and Over in AIMS Database in 2002

Descriptive statistics, primarily frequencies, were used to profile adults age 60 and older on which there were active records in the AIMS database between January 1, 2002 and December 31, 2002. There were 5,408 adults age 60 and older in the AIMS database during this time. Note: Service utilization for those older adults who do not have SPMI is not reported in AIMS; therefore, no conclusions about the number of older adults actually using CMHC services can be made. All that can be known is the number who were included in the AIMS database during calendar year 2002. Therefore, it is possible that some of the 5,408 older adults may have discontinued services before 2002, but were not removed from AIMS before the calendar year began.

Table 3, below, illustrates the frequency and percent of persons in the age categories 60-69, 70-79, and 80+. Nearly half were between the ages of 60 and 69 years of age.

Age of Older Adults Age 60+ in AIMS Database in 2002 (Table 3)

Age Group	Frequency	Percent
60-69	2632	48.7%
70-79	1495	27.6%
80+	1281	23.7%
TOTAL	5,408	100%

Chart 2, below, illustrates this information in chart form.

Age of Older Adults 60+ in the AIMS Database in 2002 (Chart 2)

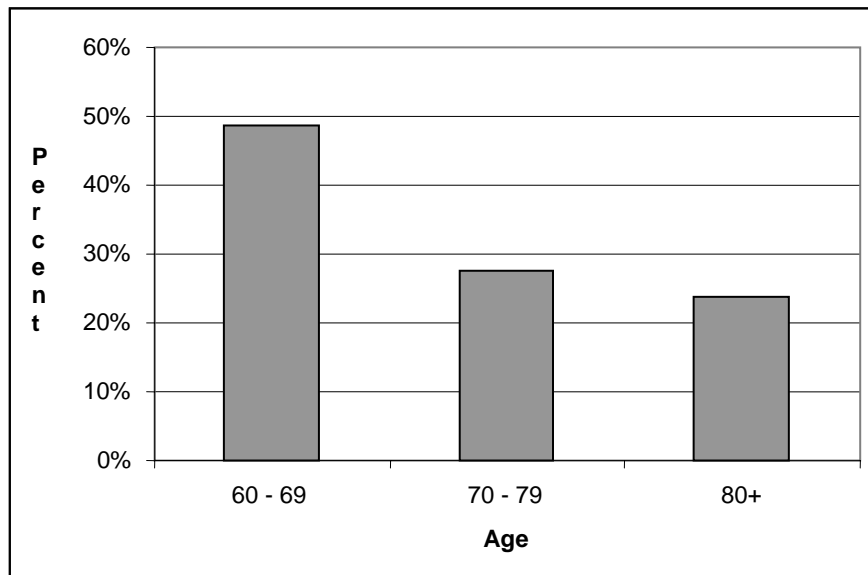


Table 4, below, details the gender of adults 60 and older who were in the AIMS database in 2002. About 33% of the older adults were men and about 67% were women.

Gender of Older Adults Age 60+ in AIMS Database in 2002 (Table 4)

Gender	Frequency	Percent
Female	3634	67.2%
Male	1771	32.7%
Missing/Other	3	0.1%
Total	5408	100%

The educational levels are presented below (Table 5). These data indicate that the majority of older adults had a high school education/equivalent or less (51%), and only a small percentage of older adults had a college degree or higher educational level (10%).

Education of Older Adults Age 60+ in AIMS Database in 2002 (Table 5)

Education	Frequency	Percent
Preschool or No Formal Education	74	1.4%
Grade School (grades K-5)	101	1.9%
Middle School (grades 6-8)	454	8.4%
Some High School (grades 9-11)	501	9.3%
High School Graduate	1459	27.0%
G.E.D.	156	2.9%
Vocational Training	106	2.0%
Some College	767	14.2%
College Graduate	290	5.4%
Some Graduate School	53	1.0%
Graduate Degree	141	2.6%
Terminal Degree (J.D., M.D., Ph.D.)	46	0.8%
Special Education	71	1.3%
Unknown	1077	19.9%
Missing	112	2.5%
Total	5408	100%

We also profiled the ethnicity of older adults age 60 and over (Table 6, below). These data indicate that the majority were Caucasian (90%), followed by African Americans (3%), and Hispanics (2%).

Ethnicity of Older Adults Age 60+ in AIMS Database in 2002 (Table 6)

Ethnicity	Frequency	Percent
Caucasian	4888	90.4%
African American	185	3.4%
Hispanic	94	1.7%
American Indian/Alaskan Native	42	0.8%
Asian	23	0.4%
More than one ethnicity	17	0.3%
Other/Unknown	158	2.9%
Missing	1	.0
Total	5408	100%

Table 7, below, profiles the annual income of persons age 60 and over in the 2002 AIMS database. As the data show, the majority of customers admitted to the CMHC had low incomes. About 10% of older adults had no income, and almost 1/3 had incomes of less than \$10,000. About 17% of persons had income between \$10,000-\$19,000, and 12% had income greater than \$20,000 but less than \$40,000. Only 6% of older adults had income greater than \$40,000. Nearly 1/4 of persons did not provide income information but, instead, paid the full fee for services.

Annual Income of Older Adults Age 60+ in AIMS Database in 2002 (Table 7)

Income Group	Frequency	Percent
No Income	521	9.6%
\$1.00-\$9,999.99	1568	29.0%
\$10,000.00-\$19,999.99	943	17.4%
\$20,000.00-\$39,999.99	670	12.4%
Over \$40,000.00	295	5.5%
Not Provided (Full Fee)	1316	24.3%
Missing	95	1.8%
Total	5408	100%

Chart 3, below, portrays this information in a chart:

Annual Income of Older Adults Age 60+ in the AIMS Database in 2002 (Chart 3)

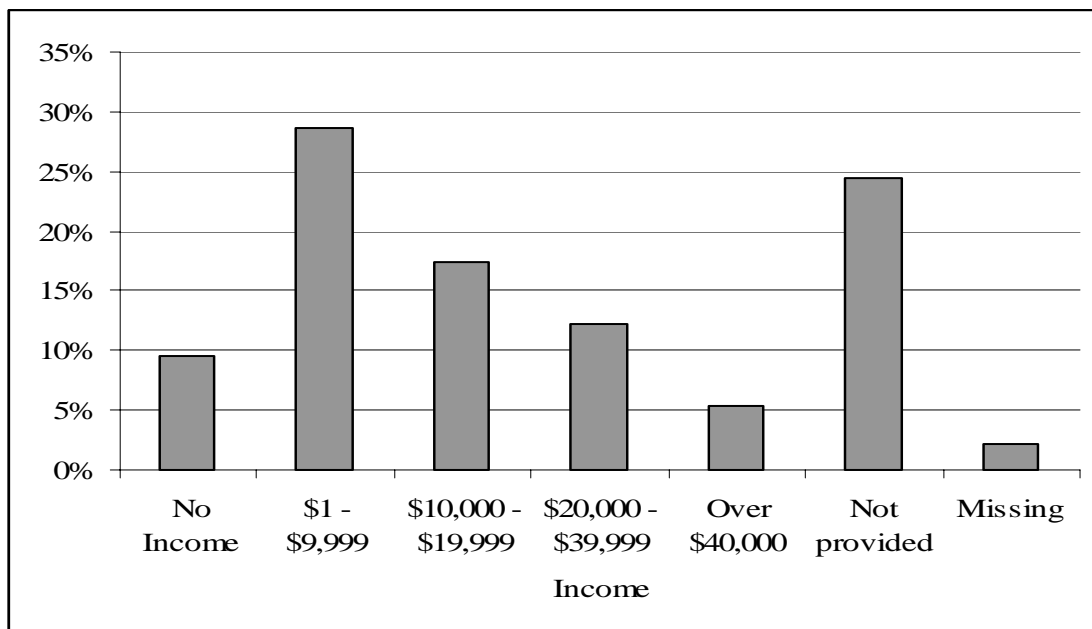


Table 8, below, lists the most common payment sources reported by all individuals age 60 and older in the AIMS database in 2002.

The most frequent payment source used was Medicare (65%), followed by Private Pay (41%), Medicaid (29%), Blue Cross/Blue Shield (28%), and Other Private Insurance (19%).

Payment Sources of Older Adults Age 60+ in AIMS Database in 2002 (N=5,408) (Table 8)

Payment Source*	Frequency	Percent
Medicare	3519	65.1%
Private Pay	2239	41.4%
Medicaid	1546	28.6%
Blue Cross/Blue Shield	1520	28.1%
Other Private Insurance	1021	18.9%

*These data are not mutually exclusive.

Using the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Treatment Revision* (DSM-IV TR)⁵, we collapsed the diagnoses into the categories displayed in Table 9, below. The most frequent category of diagnosis of older adults in the database is depressive disorders (33%). The next most frequent is “other disorders” (28%). And the third most frequent is schizophrenia and other psychotic disorders (18%).

Diagnoses of Older Adults Age 60+ in AIMS Database in 2002 (N=5,408) (Table 9)

DIAGNOSIS*	Frequency	Percent
Depressive Disorders	1802	33%
Schizophrenia and Other Psychotic Disorders	983	18%
Dementia	770	14%
Anxiety Disorders	646	12%
Bipolar Disorders	618	11%
Personality Disorders	196	4%
Other Disorders	1541	28%

*These data are not mutually exclusive.

In summary, the analysis of the 2002 AIMS database illustrates that the majority of persons age 60 and over: had low incomes, were Caucasian, were women, had a High School education or less, and that 50% were in the 60-69 age group. More than 1/3 were diagnosed with a depressive disorder. More than half had Medicare available as a payment source.

⁵ *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. (2000.) Washington, DC, American Psychiatric Association.*

Profile of Adults Age 60 and Over in AIMS Database in 2002 by SPMI and Non-SPMI Status

The Office of Aging and Long Term Care (OALTC) also analyzed Automated Information Management System (AIMS) data to examine the distribution of older adults who had severe and persistent mental illness (SPMI) and those who did not have SPMI on selected variables. Of the 5,408 older adults in the database in 2002, the SPMI status was known for 4,931 individuals (91% of total in the database). Of those (32%) had an SPMI, and (68%) did not have an SPMI. Of the remaining 9% of older adults in the database (477), 69 (1%) were coded as currently being severely emotionally disturbed (SED) children, although their ages indicated that they were older adults. The SPMI status was indicated as “unknown” for 118 individuals (2%), and “missing” for 290 individuals (5%).

SPMI Status of Older Adults Age 60+ in AIMS Database in 2002 (Table 10)

	Frequency	Percent
Non-SPMI	3334	61.6%
SPMI	1597	29.6%
Other (SED)	69	1.3%
Unknown (but not missing)	118	2.2%
Missing	290	5.3%
Total	5408	100%

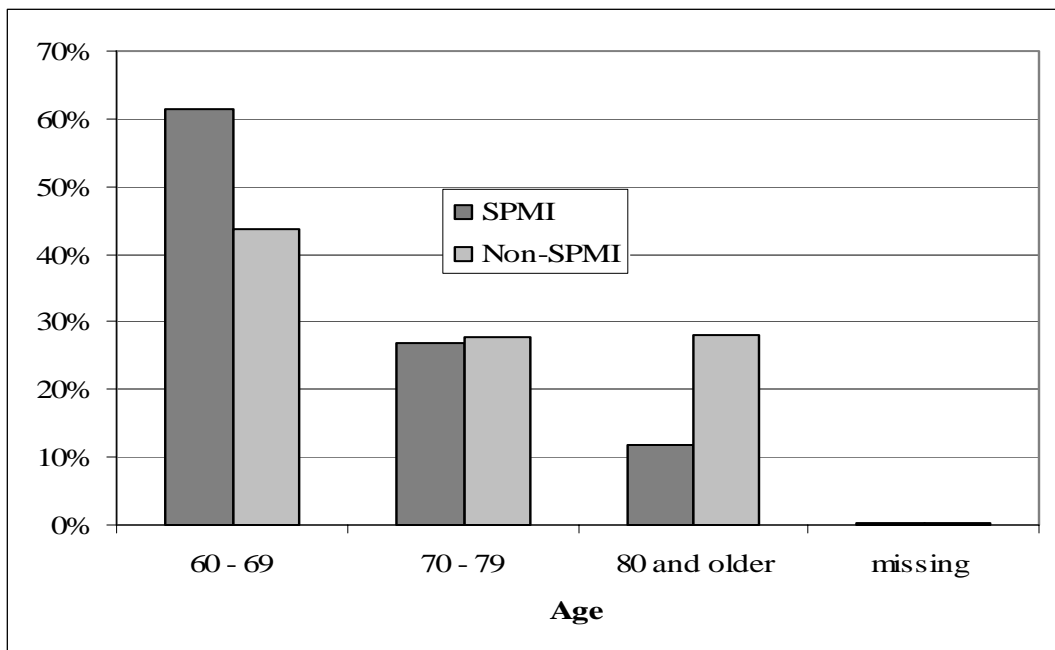
Table 11, below, profiles the ages by SPMI status. The majority of persons with SPMI were in the 60-69 age group (61%). In contrast, only approximately 44% of persons without SPMI were between 60-69 years of age. About the same percentage of older adults without SPMI were between the ages of 70-79 in comparison to older adults with SPMI (28% vs. 27%, respectively), while a much higher proportion of persons without SPMI were 80 and over (28% vs. 12%). Possible explanations for this disparity are that individuals with SPMI may have a shorter life span, or that they are no longer residing in the community, and therefore no longer receive community-based services.

Age of Older Adults Age 60+ in AIMS Database in 2002 by SPMI Status (Table 11)

Age	Frequency (Percent) Of SPMI	Frequency (Percent) Of Non-SPMI
60-69	977 (61.2%)	1461 (43.8%)
70-79	433 (27.1%)	927 (27.8%)
80+	187 (11.7%)	946 (28.4%)
Total	1597 (100%)	3334 (100%)

Chart 4, below, portrays this information in a chart.

Age of Older Adults Age 60+ in AIMS Database in 2002 by SPMI Status (Chart 4)



We examined the gender by SPMI status of the older adults in the database. As indicated in Table 12, women comprise about 69% of persons with SPMI, and men comprise 31%. Approximately the same percentage of women (67%) and men (33%) did not have SPMI.

Gender of Older Adults Age 60+ in AIMS Database in 2002 by SPMI Status (Table 12)

Gender	Frequency (Percent) Of SPMI	Frequency (Percent) Of Non-SPMI
Female	1094 (68.5%)	2228 (66.9%)
Male	502 (31.5%)	1105 (33.1%)
Missing	1 (< 1%)	0 (0%)
Total	1597 (100%)	3334 (100%)

Table 13 details education by SPMI status. Few sizeable differences in education level can be found between persons with SPMI and those without SPMI. The majority of persons with SPMI had a high school education/GED or less (61%), and only about 23% had attended college, graduate school, or obtained a terminal degree. In contrast, older adults without SPMI had slightly more education. Whereas, half had at least a high school diploma or equivalent, and about 37% had attended college, graduate school, or obtained a terminal degree.

Education of Older Adults Age 60+ in AIMS Database in 2002 by SPMI Status (Table 13)

Education	Frequency (Percent) Of SPMI	Frequency (Percent) Of Non-SPMI
Preschool or No Formal Education	35 (2.2%)	29 (.8%)
Grade School (grades K-5)	46 (2.8%)	49 (1.4%)
Middle School (grades 6-8)	182 (11.4%)	243 (7.3%)
Some High School (grades 9-11)	197 (12.3%)	279 (8.3%)
High School Graduate	449 (28.1%)	912 (27.3%)
G.E.D.	62 (3.9%)	87 (2.6%)
Vocational Training	37 (2.3%)	63 (1.9%)
Some College	210 (13.1%)	500 (15.0%)
College Graduate	93 (5.8%)	188 (5.6%)
Some Graduate School	16 (1.0%)	36 (1.1%)
Graduate Degree	34 (2.2%)	102 (3.1%)
Terminal Degree (J.D., M.D., Ph.D.)	11 (.7%)	34 (1.1%)
Special Education	19 (1.2%)	48 (1.5%)
Unknown (but not missing)	191 (12.0%)	678 (20.4%)
Missing	15 (1.0%)	86 (2.6%)
Total	1597 (100%)	3334 (100%)

The race/ethnicity was also analyzed (Table 14, below). These data illustrate that the ethnicity of persons with and without SPMI is similar, but those with SPMI are slightly less homogenous than those without SPMI. A smaller proportion of SPMI older adults were Caucasian (89% vs. 95%), and a greater proportion were African American (7% vs. 2%).

Ethnicity of Older Adults Age 60+ in AIMS Database in 2002 by SPMI Status (Table 14)

Ethnic Group	Frequency (Percent) Of SPMI	Frequency (Percent) Of Non-SPMI
Caucasian	1422 (89.0%)	3149 (94.5%)
African American	114 (7.1%)	60 (1.7%)
Hispanic	25 (1.6%)	59 (1.7 %)
Asian	12 (.8%)	11 (.4%)
American Indian/Alaskan Native	9 (.6%)	30 (.9%)
Other/Unknown	15 (.9%)	25 (.8%)
Total	1597 (100%)	3334 (100%)

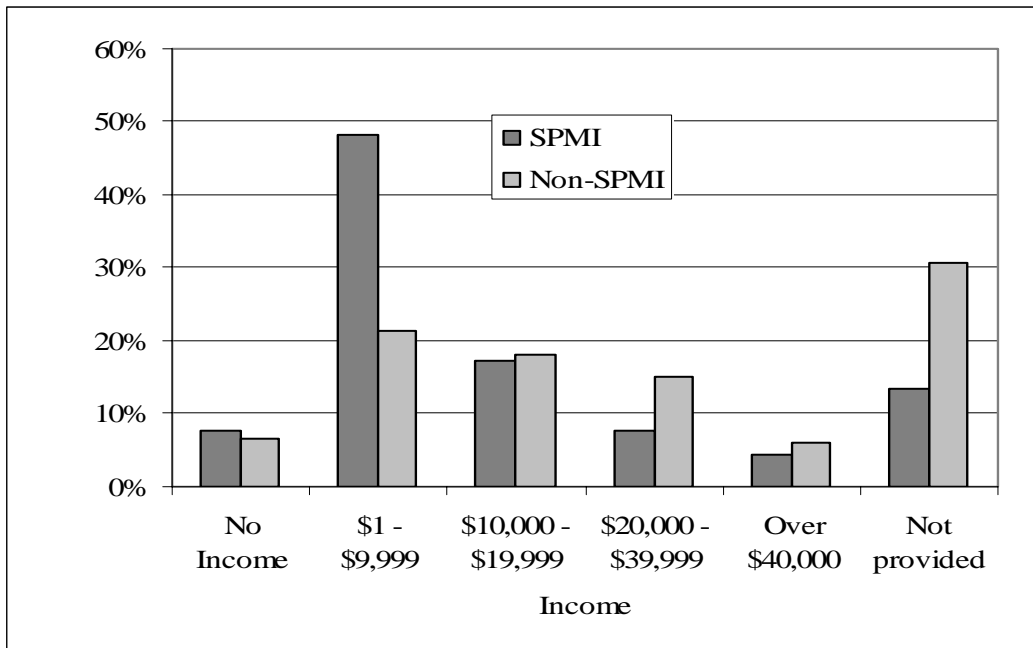
We also profiled older adults' income by SPMI status (Table 15, below). These data illustrated that a greater percentage of those with SPMI had lower incomes. Approximately 56% of persons with SPMI reported income of less than \$10,000, as compared to 28% of older adults without SPMI. A smaller percentage of persons with SPMI also had income of \$20,000 or greater, compared to persons without SPMI (12% vs. 21%).

Annual Income of Older Adults Age 60+ in AIMS Database in 2002 by SPMI Status (Table 15)

Income Group	Frequency (Percent) Of SPMI	Frequency (Percent) Of Non-SPMI
No income reported	124 (7.8%)	222 (6.7%)
\$1.00-\$9,999.99	774 (48.5%)	714 (21.4%)
\$10,000-\$19,999.99	275 (17.2%)	602 (18.0%)
\$20,000-\$39,999.99	126 (7.8%)	504 (15.1%)
Over \$40,000	72 (4.5%)	202 (6.1%)
Not Provided (full fee customer)	204 (12.8%)	1031 (30.9%)
Missing	22 (1.4%)	59 (1.8%)
Total	1597 (100%)	3334 (100%)

Chart 5, below displays this information in a graph.

Annual Income of Older Adults Age 60+ in the AIMS Database by SPMI Status (Chart 5)



Payment source by SPMI status was also profiled. While SPMI and non SPMI older adults had similar rates of Medicare as a payment source (66% and 65%), and private pay as a payment source (38% and 42%), those with SPMI were much more likely to have Medicaid (50% versus 20%). Also, those with SPMI were less likely to have Blue Cross/Blue Shield (16% versus 34%), or other private insurance (12% versus 22%).

**Payment Sources of Older Adults Age 60+ in AIMS Database in 2002 by SPMI Status (n=4931)
(Table 16)**

Payment Source*	Frequency (Percent) Of SPMI	Frequency (Percent) Of Non-SPMI
Medicare	1058(66.3%)	2177 (65.3%)
Private Pay	609 (38.2%)	1399 (42.0%)
Medicaid	798 (50.0%)	665 (20.0%)
Blue Cross/Blue Shield	258 (16.2%)	1135 (34.1%)
Other Private Insurance	187 (11.7%)	741 (22.3%)

*These data are not mutually exclusive.

In summary, the analysis of the 2002 AIMS database by SPMI status illustrates that older adults with SPMI are younger than older adults without SPMI. They are also more diverse racially, and have less education and income and less diversity in service payment resources than older adults without SPMI.

Summary of AIMS Data and Policy Implications

The analysis of the 2002 AIMS database reveals several key findings that have important implications for CMHCs, policymakers and other stakeholders:

- The records of more than 5,400 older adult Kansans were in the AIMS database in 2002. As CMHCs are serving significant numbers of older adults, policymakers and other stakeholders will need to determine how best they can support CMHCs in continuing to serve this population, particularly given the anticipated increase as the “baby boomers” age.
- The majority of older adults in the 2002 AIMS database were concentrated in low-income brackets and had a high school education or less; this was particularly true for older adults with SPMI. This information is important for policymakers and CMHCs to consider when crafting policies and budgets to meet the needs of persons who access the Kansas public mental health system.
- Though most older adults in the 2002 AIMS database were concentrated in low-income brackets, Medicaid was listed as a payment source for only 50% of those with an SPMI, and only 20% for those without an SPMI. Medicaid policymakers may want to consider targeted outreach to older adult CMHC customers to enroll those who are eligible but are not utilizing this resource.

AIMS data will be requested for FY 2003, then current findings will be compared. This will enable us to identify trends, which will enhance training materials and provide valuable information to policymakers and other stakeholders.

Summary of Year Two Activities

In summary, during the project's second year, the following activities were completed:

- ✓ Information provided during the training was enhanced by: an updated review of the literature, focus groups conducted with older adults, and, interviews with CMHC staff;
- ✓ Training was piloted in two PSAs;
- ✓ Data from K6 usage and subsequent referrals to mental health resources were collected for the three months following the pilot trainings;
- ✓ Input regarding use of the K6 and about the training itself received through follow up visits to training participants has been used to further enhance the training;
- ✓ Calendar year 2002 AIMS data have been collected and analyzed.

Training evaluations received indicate that participants benefited from the information provided, and, pre/post tests indicated that their knowledge about mental health and aging did increase. The demand for this training has been reported by project staff, who have been contacted about the availability of future trainings by numerous and diverse aging service providers who serve predominantly Medicaid eligible older adults. Training of aging service providers about mental health resources available for older adults was also ranked as one of the primary needs by those participating in the 2004 Kansas Mental Health and Aging Summit that preceded the Governor's Conference on Aging.

As discussed above, the K6 mental health screening instrument appears to be useful in assisting aging service providers identify older adults who may be experiencing a mental health problem and could benefit from referral to a mental health resource. As there has been some discussion about the timing of the K6 administration, this input will be incorporated into the final trainings.

Support for the K6 has also come from several CMHCs, at least one of which is currently using it in their aging program. In addition, KDOA is considering including it as part of the revised Uniform Assessment Instrument (UAI).

AIMS data have provided the training with a profile of older adults who access the CMHCs. This profile will be enhanced by the collection of additional years of data.

Year Three Activities

In Project Year Three, the revised training will be offered statewide to all aging service providers who serve predominantly Medicaid eligible customers, including:

- o AAAs,
- o ALs/RHCs,
- o the staff of primary care physician offices and clinics,
- o hospital discharge planners,
- o other CARE assessors.

Eleven trainings with a maximum of 75 attendees (prioritized by AAA and AL enrollment) will be held. At that time, final training revisions will be made, and “Train the Trainer” materials will be developed, so that any agency serving predominantly Medicaid eligible older adults can use the training with their staff. A CD will be developed as part of the materials. In addition, we have proposed to develop a computer module to train aging service providers to use the K6. Information from the finalized training will also be incorporated into the Basic Case Management training offered through the KU School of Social Welfare.

And, we have proposed to identify successful models of Kansas CMHCs providing aging programs, in order to develop evidence-based practices that may be replicated by those CMHCs who do not currently have aging programs. Specifically, we will identify staffing and financing practices, and document customer demographic, services needs, and service utilization.

Finally, 2003 AIMS data will be requested for all adults, so that variance in age group demographics and utilization can be determined, and so that trends can be developed by comparing with 2002 data.

Appendix

- Appendix A.....Advisory Council Members**
- Appendix B.....February 20, 2004 Advisory Council Meeting Agenda**
- Appendix C.....August 1, 2003 Advisory Council Meeting Agenda**
- Appendix D.....June 4, 2004 Advisory Council Meeting Agenda**
- Appendix E.....K6 Mental Health Screening Instrument**
- Appendix F.....Updated Review of the Literature**
- Appendix G.....Community Mental Health Center Interview Questions**
- Appendix H.....Training Agenda and PowerPoint Presentation**
- Appendix I.....Training Pre/Post Questions and Results**
- Appendix J.....Post Training Newsletter**